CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

October 1, 2010

PLAN 8 ($500/80%)

Benefit Booklet

SPD00244-8 1010 PLAN 8 (500/80) Z132/BG60

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. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

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 Anthem Blue Cross Life and Health Insurance Company, P. O. Box 60007, Los Angeles, CA 90060-0007 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:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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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. They have agreed to provide *members* with health care at a special low cost. 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.anthem.com/ca**. 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 *negotiated 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, such as skilled nursing 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 Transplant Facilities. A Centers of Medical Excellence (CME) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **These procedures are covered only at a CME.** These "CME" agree to accept the *CME negotiated rate* as payment in full for covered services. A *participating provider* in the Prudent Buyer Plan network is not necessarily a *Centers of Medical Excellence* transplant facility.

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 http://www.anthem.com/ca 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 Anthem Blue Cross Life and Health Insurance Company, 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 Anthem Blue Cross Life and Health Insurance Company with ideas or questions about this statement on *member* rights and responsibilities. Your letter can be sent to Quality Improvement Department, Attn: Rights and Responsibilities, Mailstop AC-6G, P.O. Box 70000, Van Nuys, CA 91470-0001.

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 Anthem Blue Cross Life and Health-sponsored 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 A COVERED EXPENSE. 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 "COVERED EXPENSE") 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.

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 Covered Expense And Your Co-Insurance: *Covered expense* 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 **$500**
- Family Deductible **$1,500**

  Exceptions:

  – The Calendar Year Deductible will not apply to *covered expense* incurred for Hospice Care.

  – The Calendar Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator*. See AUTHORIZATION 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** **$35**

  – **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 *covered expense* you incur.

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

  Exceptions:

  – No Co-Insurance will be required for *covered expense* incurred for Hospice Care.

– No Co-Insurance will be required for the transplant travel expenses authorized by the *claims administrator*. See AUTHORIZATION PROGRAM.

– No Co-Insurance will be required to *covered expense* 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 expense* he or she incurs during a *calendar year* equal to **$2,000**, 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 *covered expense***

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 *covered expense* 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**

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*

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

Benefits will be paid for *covered expense* you incur under this *plan*. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and Centers of Medical Excellence (CME). The maximum *covered expense* for services provided by a *participating provider* or *CME* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* and *CME* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider,* you will not be responsible for any amount in excess of the *negotiated rate*. If you receive an authorized, specified organ transplant at a *CME*, you will not be responsible for any amount in excess of the *CME negotiated rate* for the covered services of a *CME*.

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 *covered expense* for services provided by a *non-participating provider* will always be the lesser of the billed charge or the *scheduled amount*.

Exceptions: *Covered expense* for the following will **not** be based on the *scheduled amount*:

- The maximum *covered expense* for *non-participating providers* 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*.
- *Covered expense* for services of an acupuncturist who is a *non-participating provider* will be the lesser of the billed charge or the *customary and reasonable charge*, as determined by the *claims administrator*.

You will be responsible for any billed charge which exceeds the maximum *covered expense* for services and supplies provided by *non-participating providers* in connection with Cancer Clinical Trials, the *customary and reasonable charge* for services of acupuncturists who are *non-participating providers*, or the *scheduled amount* for all other services provided by *non-participating providers* (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS and the definition of "Scheduled Amount" in the DEFINITIONS section).

Other Health Care Providers. The maximum *covered expense* for services provided by an *other health care provider* will always be the lesser of the billed charge or a *reasonable charge*. You will be responsible for any billed charge which exceeds a *reasonable charge* for the services of an *other health care provider*.

Exception: If Medicare is the primary payer, *covered expense* does not include any charge:

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or
2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of the *customary and reasonable charge*, or the approved amount as determined by Medicare; or

4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the *customary and reasonable charge*, or the limiting charge as determined by Medicare.

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

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 amount of *covered expense,* 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 charges that are considered *covered expense* 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 expense* 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 expense* 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 amount of *covered expense* remaining.

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 amount of *covered expense* 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 *covered expense* you incur 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 which are not considered *covered expense*; 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 considered as *covered expense*.

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 expense* 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 considered *covered expense*.
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 amount considered *covered expense* for *non-participating providers*) and is, subject to the maximums, conditions, exclusions and limitations of this *plan*. This *scheduled amount* will not apply to *physician* services if: (a) Medicare is the primary payer and the *non-participating provider* or *other health care provider* accepts Medicare assignment; or (b) Medicare is the primary payer and the *other health care provider* does not accept Medicare assignment. See HOW COVERED EXPENSE IS DETERMINED above for more details.

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, covered expense* 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 amount of *covered expense* allowed 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 allowable *covered expense* 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 allowable *covered expense,* in addition to any Co-Payment and/or Co-Insurance required under this *plan*.

If you want assistance in determining the maximum allowable *covered expense* 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 not to charge any more for their services than the *negotiated rate,* leaving you only the amount of your Co-Payment and/or Co-Insurance described in the SUMMARY OF BENEFITS.

UNIT ALLOWANCE SCHEDULE

Service Area	Surgery	Anesthesia	Medicine	Radiology	Pathology
1	**$110.00**	**$25.00**	**$4.80**	**$9.50**	**$1.05**
2	**110.00**	**25.00**	**4.80**	**9.50**	**1.05**
3	**120.00**	**26.00**	**5.10**	**10.50**	**1.15**
4	**120.00**	**26.00**	**5.10**	**10.50**	**1.15**
5	**120.00**	**26.00**	**5.10**	**10.50**	**1.15**
6	**110.00**	**25.00**	**4.80**	**9.50**	**1.05**
7	**110.00**	**25.00**	**4.80**	**9.50**	**1.05**
8	**110.00**	**25.00**	**4.80**	**9.50**	**1.05**
9	**110.00**	**25.00**	**4.80**	**9.50**	**1.05**
10	**120.00**	**26.00**	**5.10**	**10.50**	**1.15**

UNIT VALUE SCHEDULE
(Partial Listing)

PROC CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Skin		
10060	Incision and drainage of abscess	0.58
11100	Biopsy of skin, including closure	0.43
11770	Excision of pilonidal cyst or sinus	1.59
Breast		
19120	Excision of breast tumor, unilateral	2.80
19200	Radical mastectomy, including pectoral muscles and axillary nodes	7.25

Fractures

21315	Nasal, simple, closed reduction	1.16
25565	Closed radial and ulnar shafts, manipulative reduction	3.71
27232	Femur and neck, manipulative reduction, including traction	5.63

Heart

33400	Aortic valvuloplasty, with bypass	14.79
33420	Valvotomy, mitral valve, closed	11.04

Throat

42650	Dilation, salivary duct	0.42
42820	Tonsillectomy and adenoidectomy, under 12 years	2.64

Digestive

43620	Total gastrectomy	10.25
44950	Appendectomy	3.96
47600	Cholecystectomy	5.67

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 following Unit Values apply unless otherwise stated in this Schedule:

Major procedure	**100%** of the Unit Value
Second procedure	**50%** of the Unit Value
Third procedure	**25%** of the Unit Value
Fourth procedure	**25%** of the Unit Value
Fifth procedure	**25%** of the Unit Value

SURGERY (assistant surgeon). The Unit Value for the services of an assistant surgeon is **20%** of the unit value 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 charge considered *covered expense* for outpatient care provided by a *hospital* which is a *non-participating provider* is the *reasonable charge*.

2. The maximum charge considered *covered expense* 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

Service Area	Mental or Nervous Disorders and Substance Abuse	All Other Conditions
1	**$250**	**$540**
2	**250**	**540**
3	**270**	**540**
4	**270**	**580**
5	**270**	**540**
6	**250**	**540**
7	**250**	**540**
8	**250**	**540**
9	**250**	**540**
10	**270**	**580**

NOTE: *Covered expense* for *mental or nervous disorders* and *substance abuse* services provided by a non-contracting *psychiatric health facility* is further limited to **60%** of the amounts listed in the above table. Actual benefit payments as stated elsewhere in the *benefit booklet* for those services will be applied to the additionally limited amounts.

CHARGES BY A DAY TREATMENT CENTER WHICH IS A NON-PARTICIPATING PROVIDER

The maximum charge considered *covered expense* for outpatient care provided by a *day treatment center* which is NOT part of, or affiliated with, a *hospital* which is a *participating provider* is shown in the schedule below. The amount varies by the service area of the *day treatment center.*

DAY TREATMENT CENTER SCHEDULE

Service Area	Per Day
1	**$250**
2	**250**
3	**270**
4	**270**
5	**270**
6	**250**
7	**250**
8	**250**
9	**250**
10	**270**

NOTE: Actual benefit payments as stated elsewhere in the *benefit booklet* for those services will be applied to the additionally limited amounts.

CHARGES BY AN AMBULATORY SURGICAL CENTER WHICH IS A NON-PARTICIPATING PROVIDER

The maximum charge considered *covered expense* 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

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

CHARGES BY OTHER SPECIFIC PROVIDERS WHICH ARE NON-PARTICIPATING PROVIDERS

The maximum charge the *claims administrator* considers *covered expense* for services and supplies provided by the following providers which are *non-participating providers* is the lesser of the billed charge or the *reasonable charge:*

1. A *home health agency;*
2. A *home infusion therapy provider;*
3. A *skilled nursing facility;* or
4. A durable medical equipment outlet.

NON-PARTICIPATING PROVIDER EXCEPTIONS

Under certain circumstances, CVT makes exceptions to the amount accepted as *covered expense* incurred for the services provided by a *non-participating provider*. These exceptions are:

- The first 48 hours of *emergency services* provided by a *hospital* (this exception will continue beyond the first 48 hours if, in the *claims administrator's* judgment, you cannot be safely moved);
- *Emergency services* provided by other than a *hospital;*
- An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider*;
- Cancer clinical trials;
- Acupuncture by an acupuncturist; or
- Charges of a *physician* who has a specialty which is not represented in the Prudent Buyer Plan network.

For these exceptions, *covered expense* for the services of a *non-participating provider* is the lesser of the billed charge or the amount shown below.

Cancer Clinical Trials...................... the amount that ordinarily applies when services are provided by a *participating provider*

All services not in connection with a cancer clinical trial:

Physicians...............................the Customary and Reasonable Charge

All Other Non-Participating Providers................ a Reasonable Charge

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*. *Covered expense* 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.

Covered expense 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.

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

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 expense*.

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.

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

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.

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.

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.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment

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.

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. *Covered expense* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. *Reasonable charges* 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. *Covered expense* 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 considered *covered expense*.** 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 us 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.

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:** *Covered expense* 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*.

Routine physical exam services may be provided by Exemplar International, Inc. ("Health Examinetics").

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*.

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*.

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*.

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*.

Specialty Drugs provided under your medical plan ONLY. Only *specialty drugs* payable under the medical plan are covered under this specialty drug program (ex. self-injectable drugs or home infusion drugs). You can only have your prescription for a *specialty drug* filled through the specialty drug program unless you qualify for an exception. Anthem Blue Cross Life and Health - Specialty Drug Program only fills *specialty drug* prescriptions. The specialty drug program will deliver up to a 30-day supply of your medication to you by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health). If your *physician* orders the *specialty drug* to be administered in their office, only the medication needed for the visit will be delivered.

Non-duplication of benefits applies to *specialty drugs* under this *plan*. When benefits are provided for *specialty drugs* under the *plan's* medical benefits, they will not be provided under your separate prescription drug benefits. Conversely, if benefits are provided for *specialty drugs* under your separate prescription drug benefits, they will not be provided under the *plan's* medical benefits.

To obtain a *specialty drug* for home use, you must have a prescription for the drug that states the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, that is signed by a *physician*. Your *physician* will be responsible for ordering the *specialty drug* for administration in their office.

You or your *physician* may order your *specialty drug* from specialty drug program by calling 1-800-870-6419. When you or your *physician* call Anthem Blue Cross Life and Health – Specialty Drug Program, a Dedicated Care Coordinator will guide you or your *physician* through the process up to and including actual delivery of your *specialty drug* to you or your *physician*. (If you order your *specialty drug* by telephone, you will need to use a credit card or debit card to pay for it.) If you order a *specialty drug* for home use, you may also submit your *specialty drug* prescription with the appropriate payment for the amount of the purchase (you can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health – Specialty Drug Program at the address shown below. Once you have met your deductible, if any, you will only have to pay the cost of your Co-Insurance, if any. If your *physician* orders the *specialty drug* for

administration in their office, you will be responsible for any applicable Co-Insurance.

If you order a *specialty drug* for home use, the first time you get a prescription for a *specialty drug* you must complete an Intake Referral Form. The Intake Referral Form is completed by telephone by calling 1-800-870-6419. You need only enclose the prescription or refill notice, and the appropriate payment for any subsequent *specialty drug* prescriptions, or call the toll-free number, 1-800-870-6419. Your Co-Insurance can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* available through specialty drug program or order forms by contacting Member Services at the number shown below or online at www.anthem.com/ca.

Anthem Blue Cross Life and Health – Specialty Drug Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-800-870-6419
Fax 1-800-824-2642

Prior Authorization. Certain *specialty drugs* require written prior authorization of benefits in order for you to receive them. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if the *claims administrator* determines that it should be clinically effective for you. However, if the *claims administrator* determines through prior authorization that the drug originally prescribed is *medically necessary*, you will be provided the drug originally requested. (If, when you first become a *member*, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, they will not require you to try a drug other than the one you are currently taking.) If approved, *specialty drugs* requiring prior authorization for benefits will be provided to you after you make the required co-insurance.

In order for you to get a *specialty drug* that requires prior authorization, your *physician* must make a request to the *claims administrator* for you to get it. The request may be made by either telephone or facsimile. At the time the request is initiated, specific clinical information will be requested from your *physician* based on the *claims administrator's* medical policy and/or clinical guidelines, based specifically on your diagnosis and/or the *physician's* statement in the request or clinical rationale for the *specialty drug*.

If the request is for urgently needed drugs, after the *claims administrator* gets the request:

- The *claims administrator* will review it and decide if benefits will be approved within 72-hours. (As soon as they can, based on your medical condition, as *medically necessary*, they may take less than 72-hours to decide if benefits will be approved.) They will tell you and your *physician* what has been decided - by telephone and in writing by facsimile to your *physician,* and in writing by mail to you.

- If more information is needed to make a decision, or the *claims administrator* cannot make a decision for any reason, they will tell your *physician*, within 24-hours after they get the request, what information is missing and why they cannot make a decision. If, for reasons beyond their control, they cannot tell your *physician* what information is missing within 24-hours, they will tell your *physician* that there is a problem as soon as they know that they cannot respond within 24-hours. In either event, the *claims administrator* will tell you and your *physician* that there is a problem – in writing by facsimile, and by telephone, to your *physician*, and in writing by mail to you.

- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, but, not more than 48-hours after they have all the information they need to decide if benefits will be approved, they will tell you and your *physician* what has been decided in writing - by fax to the *physician* and by mail to you.

If the request is not for urgently needed drugs, after the *claims administrator* gets the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on your medical condition, as *medically necessary*, the *claims administrator* will review it and decide if benefits will be approved within 5-business days. They will tell you and your *physician* what has been decided in writing - by fax to your doctor, and by mail, to you.

- If more information is needed to make a decision, the *claims administrator* will tell your *physician* in writing within 5-business days after they get the request what information is missing and why they cannot make a decision. If, for reasons beyond their control, the *claims administrator* cannot tell your *physician* what information is missing within 5-business days, they will tell your *physician* that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, the *claims administrator* will tell you and your *physician* that there is a problem by telephone, and in writing by facsimile, to your *physician*, and in writing to you by mail.

- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, within 5-business days after they have all the information they need to decide if benefits will be approved, they will tell you and your *physician* what has been decided in writing - by fax to your *physician* and by mail to you.

While the *claims administrator* is reviewing the request for a *specialty drug*, a 72-hour emergency supply of medication may be dispensed to you if your *physician* determines that it is appropriate and *medically necessary*. You may have to pay the applicable co-insurance, if any, shown in SUMMARY OF BENEFITS: MEDICAL BENEFITS: CO-PAYMENTS AND CO-INSURANCE for the 72-hour supply of your drug. If the *claims administrator* approves the request for the *specialty drug* after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the drug after payment of any applicable additional co-insurance that could apply.

If you have any questions regarding whether a *specialty drug* requires prior authorization, please call customer service at 1-800-274-7767.

If the *claims administrator* denies a request for prior authorization of a *specialty drug*, you or your prescribing *physician* may appeal the decision by calling customer service at 1-800-274-7767.

Exceptions to specialty drug program. This program does not apply to:

a. The first two months supply of a *specialty drug* which is available through a participating retail pharmacy;

b. Drugs, which due to medical necessity, must be obtained immediately; or

c. A *member* who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the specialty drug program. If you believe that you should not be required to get your medication through the specialty drug program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed. If you need a copy of the form, you may call customer service at 1-800-274-7767 to request one. You can also get the form on-line at www.anthem.com/ca. If the *claims administrator* has given you an exception, it will be in writing and will be good for 12 months from the time it is given. After 12 months, if you believe that you should still not be required to get your medication through the specialty drug program, you must again request an exception. If the *claims*

administrator denies your request for an exception, it will be in writing and will tell you why they did not approve the exception.

Urgent or emergency need of a *specialty drug* subject to the specialty drug program. If you are out of a *specialty drug* which must be obtained through the specialty drug program, the *claims administrator* will authorize an override of the specialty drug program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and *medically necessary*. You may have to pay the applicable co-insurance shown in SUMMARY OF BENEFITS: MEDICAL BENEFITS: CO-PAYMENTS AND CO-INSURANCE for the 72-hour supply of your drug.

If you order your *specialty drug* through the specialty drug program and it does not arrive, if your *physician* decides that it is *medically necessary* for you to have the drug immediately, the *claims administrator* will authorize an override of the specialty drug program requirement for 30-day supply or less, to allow you to get an emergency supply of medication from a participating pharmacy near you. A Dedicated Care Coordinator from the specialty drug program will coordinate the exception and you will not be required to make an additional co-insurance.

Unless you qualify for an exception, if you don't get your *specialty drug* through the specialty drug program, you will not receive any benefits under this *plan* for them.

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 *covered expense*.

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.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

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.

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.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided by CVT or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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 specialty drug program, 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 you should have obtained from the specialty drug program**.

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 expense* 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 expense* 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 expense* 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 expense* 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 *covered expense*, 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 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.
- *Facility-based care* for the treatment of *mental or nervous disorders* and *substance abuse*.
- Transplant services.
- 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.

- 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 advanced 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).

    - *Facility-based care* for the treatment of *mental or nervous disorders* and substance abuse.

    - Transplant services.

    - 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.

- 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.

   - *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.

   - 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.

- 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 three 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) An unmarried *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 31 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 (Anthem Blue Cross Life and Health 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.

SENIOR COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of the required monthly contributions as stated in the *plan,* coverage under this *plan* may be continued for the *subscriber,* the *subscriber's spouse,* and the *subscriber's* former *spouse* (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former *spouse*" means: (a) an individual who is divorced from the *subscriber;* or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

Requirements. The *subscriber* and *spouse* may continue coverage under this *plan* if:

1. The *subscriber,* or the *subscriber* on behalf of himself or herself and the *spouse,* was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;

2. The *subscriber* or *spouse* has not elected to continue coverage under any other available continuation;

3. The *subscriber* has worked for the employer for at least the prior five years; and

4. The *subscriber* is at least 60 years old on the date employment with the employer ended.

The former *spouse* may continue coverage under this *plan* in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding sections.

Notice and Election. CVT will notify the *subscriber* or *spouse* and the former *spouse* of the right to continue coverage within 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the *subscriber* and *spouse*, this continuation may be chosen for both, for the *subscriber* only, or for the *spouse* only. The former *spouse* may elect this continuation for himself or herself only.

To elect this continuation, you must notify CVT in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this 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 this continuation.

Cost of Coverage. This continuation is subject to payment of the required monthly contributions to CVT at the time they are due. CVT requires that you pay the entire cost of your continuation coverage. The rate for continuation coverage under this section shall be 102% of the rate charged for an active employee of the same age as the former employee or former *spouse* continuing coverage. For the purpose of determining the required monthly contributions payable, the *spouse* or former *spouse* continuing coverage alone will be considered to be a *subscriber*.

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

1. The end of the period for which the required monthly contributions are last paid;

2. The date the *plan* terminates;

3. The date, following the election of Senior COBRA continuation coverage, the *subscriber, spouse,* or former *spouse* first becomes covered under any group health plan not maintained by the employer;

4. The date, following the election of Senior COBRA continuation coverage, the *subscriber, spouse,* or former *spouse* first becomes entitled to Medicare;

5. The date the *subscriber, spouse,* or former *spouse* reaches age 65; or

6. For the *spouse* or former *spouse,* five years from the date the *spouse's* or former *spouse's* COBRA or CalCOBRA continuation coverage ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage. If your continuation under this *plan* ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. 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 (Anthem Blue Cross Life and Health 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 including Senior COBRA, 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 any 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-California Providers. The Blue Cross and Blue Shield Association, of which the *claims administrator* is a member, has a program (called the "BlueCard Program") which allows you to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or 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 Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, the *plan* must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to the *claims administrator.*

Often, the negotiated price referred to above will consist of a simple discount which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *member* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *member* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this provision, or require a surcharge, your co-payment for any covered health care services would then be calculated using the methods outlined by the applicable state statute in effect at the time you received your care.

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 *contracting hospitals, participating providers* and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you or one of your *family members* receives services from *non-contracting 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-contracting 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. When the amount paid exceeds CVT's liability under this *plan*, CVT has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

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.

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*.

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 expense*. 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:

Anthem Blue Cross Life and Health Insurance Company
CVT Customer Service Unit
P. O. Box 60007
Los Angeles, CA 90060-0007

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.

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 Medication 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*.

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

Centers of Medical Excellence (CME) are health care providers which have a Centers of Medical Excellence Agreement in effect with Anthem Blue Cross, an affiliate of the *claims administrator*, at the time services are rendered. CME agree to accept the *CME negotiated rate* as payment in full for covered services. A participating provider in the Prudent Buyer Plan network is not necessarily a CME. A provider's participation in the Prudent Buyer Plan network or other agreement is not a substitute for a Centers of Medical Excellence Agreement.

Centers of Medical Excellence negotiated rate (CME negotiated rate) is the fee *CME* agree to accept as payment for covered services. It is usually lower than their normal charge. CME negotiated rates are determined by Centers of Medical Excellence Agreements.

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

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross 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.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

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, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by *the claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

CVT is the California's Valued Trust.

Day treatment center is an outpatient psychiatric facility which is part of or affiliated with a *contracting hospital*. It must be licensed according to state and local laws to provide outpatient care 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) 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 for the acute phase of a *mental or nervous disorder,* “hospital” also includes *psychiatric health facilities*.

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.

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.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payer, the negotiated rate may be determined by Medicare's approved amount (see HOW COVERED EXPENSE IS DETERMINED)

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; or
9. A *home infusion therapy provider*.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

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

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; or

9. A *home infusion therapy provider*.

Participating providers agree to accept the *negotiated rate* 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, 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/uspstfix.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 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 charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Residential treatment center is an inpatient treatment facility where the *member* 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 will not be considered *covered expense*. **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.

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*.

YOUR RIGHT TO APPEALS

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the *plan*. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the *plan* for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the *plan* for which you have received the service.

If your claim is denied:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure the *claims administrator* will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the *claims administrator's* notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific *plan* provision(s) on which the *claims administrator*'s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an ex*plan*ation of why the additional material or information is needed;
- a description of the *plan's* review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the *claims administrator*'s notice will also include a description of the applicable urgent/concurrent review process; and

- the *claims administrator* may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The c*laims administrator*'s review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The *claims administrator* shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the *claims administrator* to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. 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 file an appeal for a claim involving urgent/concurrent care, 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 appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Upon request, the *claims administrator* will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or
- is a statement of the *plan*'s policy or guidance about the treatment or benefit relative to your diagnosis.

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

How Your Appeal will be Decided

When the *claims administrator* considers your appeal, the *claims administrator* will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not *medically necessary*, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the *claims administrator* will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the *claims administrator* will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the *claims administrator* will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the *claims administrator* will include all of the information set forth in the above subsection entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals

If you are dissatisfied with the *Plan*'s mandatory first level appeal decision, 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 the *claims administrator's* 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:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

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 *Plan*'s final decision on the claim or other request for benefits. If the *Plan* decides an appeal is untimely, the *Plan*'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 against the *Plan*.

If your health benefit *plan* is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

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.