CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

October 1, 2022

PLAN 1 ($0-$10/100%)

Benefit Booklet

Dear Plan Member:

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

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

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

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

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. 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, 21215 Burbank Blvd., Woodland Hills, CA 91367 marked to the attention of the CVT Member Services 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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COMPLAINT NOTICE ..... **Inside back cover**

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The *Consolidated Appropriations Act of 2021 (CAA)* is a federal law that includes the No Surprises Billing Act as well as the provider transparency requirements that are described below.

The CAA provisions within this *plan* apply unless state law or any other provisions within this *plan* are more advantageous to you.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- *Emergency* services provided by *non-participating provider*s;
- Covered services provided by an *non-participating provider* at a *participating provider* facility; and
- *Non-participating provider*s air ambulance services.

No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, *emergency medical conditions* are covered under your *plan*:

- Without the need for pre-certification;
- Whether the provider is a *participating provider* or *non-participating provider*;

If the *emergency medical conditions* you receive are provided by a *non-participating provider*, Covered services will be processed at the *participating provider* benefit level.

Note that if you receive *emergency* services from a *non-participating provider*, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *participating provider*. However, *non-participating provider* cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating *non-participating provider* determines you are stable, meaning you have been provided necessary *emergency* care such that your condition will not materially worsen and the *non-participating provider* determines: (i) that you are able to travel to a *participating provider* facility

by non-emergency transport; (ii) the *non-participating provider* complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the *non-participating provider* after you are stabilized, you will be responsible for the *non-participating provider* cost-shares, and the *non-participating provider* will also be able to charge you any difference between the *maximum allowable amount* and the *non-participating provider*'s billed charges. This notice and consent exception does not apply if the covered services furnished by a *non-participating provider* result from unforeseen and urgent medical needs arising at the time of service.

Non-Participating Services Provided at a Participating Provider Facility

When you receive covered services from a *non-participating provider* at a *participating provider* facility, your claims will be paid at the *non-participating provider* benefit level if the *non-participating provider* gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the *non-participating provider* can also charge you any difference between the *maximum allowable amount* and the *non-participating provider's* billed charges. This requirement does not apply to ancillary services. Ancillary services are one of the following services: (A) *emergency* care; (B) anesthesiology; (C) pathology; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (I) hospitalists; (J) intensivists; and (K) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to you if Anthem does not have a *participating provider* in your area who can perform the services you require.

Non-participating providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or

2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Anthem is required to confirm the list of *participating provider*s in its provider directory every 90 days. If you can show that you received inaccurate information from Anthem that a provider was in-network on a particular claim, then you will only be liable for the *participating provider* cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your *participating provider* cost-shares will be calculated based upon the *maximum allowed amount*. In addition to your *participating*

provider cost-shares, the *non-participating provider* can also charge you for the difference between the *maximum allowed amount* and their billed charges.

How Cost-Shares Are Calculated

Your cost shares for *emergency* care services or for covered services received by a *non-participating provider* at a *participating provider* facility, will be calculated using the median *plan* a *participating provider* contract rate that we pay *participating providers* for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay to a *non-participating provider* for either *emergency* services or for covered services provided by a *non-participating provider* at a *participating provider* facility will be applied to your *Participating Provider* Out-of-Pocket Limit.

Appeals

If you receive *emergency* care services from a *non-participating provider* or covered services from a *non-participating provider* at a *participating provider* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a *Surprise Billing Claim* is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Grievance Procedures" section of this Benefit Book.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to *Surprise Billing Claims* by providers;
- Estimates on what *non-participating providers* may charge for a particular service;
- Information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements.

Upon request, Anthem will provide you with a paper copy of the type of information you request from the above list.

Anthem, either through its price comparison tool on anthem.com or through Member Services at the phone number on the back of you ID card, will allow you to get:

- Cost sharing information that you would be responsible for, for a service from a specific *participating provider*;

- A list of all *participating provider*s;
- Cost sharing information on a *non-participating provider's* services based on Anthem's reasonable estimate based on what Anthem would pay a *non-participating provider* for the service.

In addition, Anthem will provide access through its website to the following information:

- *Participating provider* negotiated rates;
- Historical *non-participating provider* rates; and
- Drug pricing information.

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

CVT will provide you with a directory of participating providers upon request. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You may call the Member Services number listed on your ID card and ask Member Services to send you a directory. You may also search for a *participating provider* using the "Find a Doctor" 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.

If you receive covered services from a *non-participating provider* after we failed to provide you with accurate information in our provider directory, or

after we failed to respond to your telephone or web-based inquiry within the time required by federal law, covered services will be covered at the *participating provider* level.

Connect with Us Using Our Mobile App. As soon as you enroll in this plan, you should download our mobile app. You can find details on how to do this on our website, www.anthem.com.

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, www.anthem.com.

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care *physicians* and specialty care providers. To see a primary care *physician*, simply visit any *participating provider physician* who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any *participating provider* specialty care provider you choose (certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy), see "Physician," below). Referrals are never needed to visit any *participating provider* specialty care provider including a behavioral health care provider.

To make an appointment call your *physician's* office:

- Tell them you are a PPO Plan *member*.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, bring your Member ID card.

After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. Call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive *non-emergency* care and non-*urgent care* within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

Participating Providers Outside of California

If you are outside of our California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a *participating provider* in the area you are in. A directory of PPO Providers for outside of California is available. You can get a

directory from your plan administrator (usually your employer).

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

The *claims administrator* has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from *non-participating providers* could be balance billed by the *non-participating provider* for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

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

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

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

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be

covered under your *plan* and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call us at the Member Services telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Centers of Medical Excellence and Blue Distinction. The *claims administrator* is providing access to *Centers of Medical Excellence* (CME) networks, *Blue Distinction* (*BD*) and *Blue Distinction+ (BD+) Facility*. The facilities included in each of these networks are selected to provide the following specified medical services. Please refer to the DEFINITIONS section for a further description of these facilities:

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

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a *CME*.**

  A *participating provider* in the Prudent Buyer Plan network is not necessarily a *CME* facility.

- **Orthopedic Surgery Facilities.** Hospital facilities have been organized to provide inpatient services only for hip replacements, knee replacements and certain spine procedures listed in this *benefit booklet*. **These procedures are covered only when performed at a *Blue Distinction+ (BD+) Facility*.**

Blue Distinction.

- The Blue distinction requirement does not apply to the following:
  - Members under the age of 18
  - Emergencies
  - Urgent surgery to treat a recent fracture
  - Surgeries performed in the course of other heroic treatment such as cancer treatment
  - You have primary coverage with Medicare or another carrier

Benefits for services performed at a designated *CME, BD* or *BD*+ will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan or the Blue Cross and/or Blue Shield Plan network is not necessarily a *CME, BD* or *BD*+ facility.

Transgender, Transplant, Bariatric, Hip, knee replacement or spine surgery travel expense and the Travel Benefit reimbursement is supported through our vendor, HealthBase. When services are not available in state or required to travel to obtain services, contact claims administrator.

For reimbursable expenses by HealthBase, the Member must first call Member Services who will submit the referral to HealthBase.

HealthBase will contact the Member to begin travel arrangements. Hip, knee replacement or spine surgery travel expense will only be covered through HealthBase.

Care Outside the United States—BlueCross BlueShield Global Core

Prior to travel outside the United States, call the Member Services telephone number listed on your ID card to find out if your plan has BlueCross BlueShield Global Core benefits. Your coverage outside the United States is limited and the *claims administrator* recommends:

- Before you leave home, call the Member Services number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with *urgent care* or an *emergency* when travelling outside the United States.**
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The BlueCross BlueShield Global Core Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a *physician* appointment or hospitalization, if needed.

Payment Information

- **Participating BlueCross BlueShield Global Core hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCross BlueShield Global Core *hospitals* except for the out-of-pocket costs you normally pay (non-covered services, deductible, co-payments, and co-insurance). The *hospital* should submit your claim on your behalf.

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

Claim Filing

- **Participating BlueCross BlueShield Global Core hospitals will file your claim on your behalf.** You will have to pay the *hospital* for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and *physician* care, or inpatient *hospital* care not provided by a participating BlueCross BlueShield Global Core *hospital*. You will need to pay the health care provider and subsequently send an international claim form with the original bills to the *claims administrator*.

Additional Information About BlueCross BlueShield Global Core Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.
- Exchange rates are determined as follows:
  - For inpatient *hospital* care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

- International claim forms are available from the *claims administrator*, from the BlueCross BlueShield Global Core Service Center, or online at:

  www.bcbsglobalcore.com

  The address for submitting claims is on the form.

TIMELY ACCESS TO CARE

The *claims administrator* has contracted with health care service providers to provide covered services in a manner appropriate for your condition, consistent with good professional practice. The *claims administrator* ensures that its contracted provider networks have the capacity and availability to offer appointments within the following timeframes:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with specialists:** within fifteen (15) business days of the request for an appointment;
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not urgent care:** within fifteen (15) business days of the request for an appointment.

For Mental Health and Substance Use Disorder care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment;
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment;
- **Non-Urgent appointments with mental health and substance use disorder providers who are not psychiatrists:** within ten (10) business days of the request for an appointment;
- **Non-Urgent appointments with mental health and substance use disorder providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only.

If a provider determines that the waiting time for an appointment can be extended without a detrimental impact on your health, the provider may schedule an appointment for a later time than noted above.

The *claims administrator* arranges for telephone triage or screening services for you twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes. If the *claims administrator* contracts with a provider for telephone triage or screening services, the provider will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform you of the wait time for a return call from the provider or how the *member* may obtain *urgent care* or *emergency services* or how to contact another provider who is on-call for telephone triage or screening services.

If you need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an appointment with a *participating provider*.

SUMMARY OF MEDICAL BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR COVERED UNDER THIS PLAN. CONSULT THIS BENEFIT BOOKLET OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

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

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

Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A *plan* that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the *plan*.

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of non-quantitative treatment limitations (NQTL). An example of a non-quantitative treatment limitation is a precertification requirement.

Also, the *plan* may not impose deductibles, co-payments, co-insurance, and out of pocket expenses on mental health and substance use disorder benefits that are more restrictive than deductibles, co-payments, co-insurance and out of pocket expenses applicable to other medical and surgical benefits.

Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

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.

After Hours Care. After hours care is provided by your *physician* who may have a variety of ways of addressing your needs. You should call your *physician* for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive *non-emergency* care and non-*urgent care* within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an *emergency*, call 911 or go to the nearest emergency room.

All benefits are subject to coordination with benefits under certain other plans. The benefits of this *plan* may also be subject to the SUBROGATION AND REIMBURSEMENT section.

MEDICAL BENEFITS

Co-Payments and Co-Insurance

- **Emergency Room Co-Payment:**

  -- Emergency visit **$100**

  -- Non-emergency visit..... **$175**

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

- **Outpatient Hospital Co-Payments:**

  -- Outpatient laboratory..... **$50**

  -- Outpatient radiology **$75**

  -- Outpatient surgery..... **$250**

  Exceptions:

  - The above copay will only apply if the outpatient procedure is performed at an outpatient hospital. Benefits will remain the same if the outpatient procedure is performed at an independent lab/imaging center/ambulatory surgical center.

  - Rural areas where the acute care facility in the area is not in close proximity to an independent lab and there are limited independent lab options county wide, the facility will be excluded from the outpatient laboratory copay. Please contact member services to confirm if your area qualifies as rural.

  - Rural areas where the acute care facility in the area is not in close proximity to an independent Ambulatory Surgical Center (ASC) and there are limited independent ASC options county wide, the facility will be excluded from the outpatient surgery copay. Please contact member services to confirm if your area qualifies as rural.

- **Office Visit Co-Payments:**

  --Non-Specialist **$10**

  -- Specialist **$10**

  Note: This Co-Payment applies only to the charge for an office visit to a *physician*. It does not apply to any other charges incurred during that visit, such as for testing procedures, surgery, physical therapy, etc.

- **Co-Insurance.**
  - No Co-Insurance will be required for all covered charges incurred.

Note: You will be required to pay any amount in excess of the *maximum allowed amount* for the services of an *other health care provider* or a *non-participating provider*.

Medical and Prescription Drug Out-of-Pocket Amount. After you have made total out-of-pocket payments for covered charges you incur during a *calendar year,* you will no longer be required to pay a Co-Payment or Co-Insurance for the remainder of that *year*, but you remain responsible for costs in excess of the *maximum allowed amount* and the *prescription drug maximum allowed amount.*

- *Member*..... **$1,250**
- Family **$2,500**

Note: Any expense applied to any deductible and any co-payments for prescription drugs (provided under your CVS Caremark drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

Exception:

– Expense which is incurred for non-covered services or supplies, or which is in excess of the *maximum allowed amount* or the *prescription drug maximum allowed amount,* will not be applied toward your Out-of-Pocket Amount and is always your responsibility to pay.

MEDICAL BENEFIT MAXIMUMS

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

Skilled Nursing Facility

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

Home Health Care

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

Home Infusion Therapy

- All covered services and supplies received during any one day **$600***

  ***Non-participating providers* only

Outpatient Hemodialysis

- For all covered services and supplies ..... **$350*** per visit

***Non-participating providers** only

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*

MDLIVE

Medical and Dermatology Consultations:

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

Services are provided either via secure, private video or telephonically through your computer or mobile device. No co-payment is required for each visit. The doctor will ask you some questions to help determine your health care needs. Based on the information you provide, the advice will include general health care and pediatric care of you or your dependent's condition.

When to use MDLIVE medical services:

- If you are considering the ER or urgent care center, or retail clinic for *non-emergency* medical use.
- Your primary care doctor is not available.
- Traveling and in need of medical care.
- During or after normal business hours, nights, weekends and holidays.
- To request prescriptions or get refills.

When to use MDLIVE dermatology services:
Waiting to see a dermatologist could take days, weeks or even months. MDLIVE gives you fast access to a network of leading, board certified dermatologists who can diagnose and treat more than 3,000 skin, hair and nail conditions virtually.
Common conditions MDLIVE dermatology can address:

- Acne
- Rashes
- Eczema
- Warts and other abnormal bumps
- Suspicious spots and moles
- Inflamed or enlarged hair follicles
- Rosacea
- Psoriasis
- Alopecia
- Insect bites
- Cold sores

Behavioral Health Consultations:

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

Services are provided through secure, private video sessions with an experienced counselor or psychiatrist who is licensed in your state. No co-payment is required for each visit.

Common conditions MDLIVE behavioral health can address:

- Depression
- Anxiety
- Life Transitions
- Trauma and Loss
- Substance Use
- Relationships
- And more

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

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

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

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

**Surprise billing claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet. Please refer to that section for further details.*

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

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

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

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

- The *member* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *member's* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of $1,000, or $500. The plan pays the remaining 50% of $1,000, or $500. In addition, the *non-participating* surgeon could bill the *member* the difference between

$2,000 and $1,000. So the *member's* total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

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

Provider Network Status

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

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

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 and Other Health Care Providers.*

Providers who are not in the Prudent Buyer network are *non-participating providers* or *other health care providers,* subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. Except for *surprise billing claims*, for covered services you receive from a *non-participating provider* or *other health care provider* the *maximum allowed amount* will be based on the applicable *non-participating provider* rate or fee schedule for this *plan*, an amount negotiated by the *claims administrator* or a third party vendor which has been agreed to by the *non-participating provider,* an amount derived from the total charges billed by the *non-participating provider,* or an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, the *claims administrator* will update such information, which is unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product, but are contracted for other products, are also considered *non-participating providers*. For this *plan*, the *maximum allowed amount* for services from these providers will be one of the methods shown above unless the provider's contract specifies a different amount or if your claim involves a *surprise billing claim*.

For covered services rendered outside the Anthem Blue Cross service area by *non-participating providers*, claims may be priced using the local Blue Cross Blue Shield plan's *non-participating provider* fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the *maximum allowed amount* for out of area claims may be based on billed charges, the pricing used if the healthcare services had been obtained within the Anthem Blue Cross service area, or a special negotiated price.

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

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

***Exceptions:**

-- For emergency services provided by non-participating providers or at non-contracting hospitals, reimbursement is based on the reasonable and customary value. Non-participating providers (both inside and outside of California) may also bill you for any charges over the plans reasonable and customary value or maximum allowed amount, respectively.

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

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

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

2. By a *physician* who is a *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 *maximum allowed amount*, or the approved amount as determined by Medicare; or

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

- **Acupuncture by an acupuncturist.** The *maximum allowed amount* for services of an acupuncturist who is a *non-participating provider* will be the lesser of the billed charge or the *maximum allowed amount,* as determined by the *claims administrator*.

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

MEMBER COST SHARE

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

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

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

Rebate Impact on *Prescription Drugs* You get at *Retail Pharmacies* or Home Delivery

The *claims administrator* and/or its *pharmacy benefits manager* may also, from time to time, enter into agreements that result in the *claims administrator* receiving rebates or other funds ("rebates") directly or indirectly from *prescription drug* manufacturers, *prescription drug* distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by the *claims administrator* from rebates on *prescription drugs* purchased by you from a *retail pharmacy*, home delivery or specialty pharmacy under this section. If the *prescription drug* purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the *maximum allowable amount* for the *prescription drug*. Any deductible or coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all *members* enrolled in coverage of this type.

It is important to note that not all *prescription drugs* are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the *prescription drug*, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

AUTHORIZED REFERRALS

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

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

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

After subtracting any applicable Co-Payment and/or Co-Insurance, the benefits of this *plan* will be paid up to the *maximum allowed amount,* not to exceed the applicable Medical Benefit Maximum. The Co-Payments, Co-Insurance, Medical and Prescription Drug Out-of-Pocket Amount, and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CO-PAYMENTS AND CO-INSURANCE, AND MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET AMOUNT

Your Co-Payment and/or Co-Insurance will be subtracted from the *maximum allowed amount* 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.

Office Visit Co-Payment. You will be responsible for paying the Office Visit Co-Payment for each outpatient visit to a *physician*. However, this Co-Payment applies only to the charge for the office visit itself. It does not apply to any other charges incurred during that visit, such as for testing procedures, surgery, physical therapy, etc.

Outpatient Hospital Co-Payment. You will be responsible for paying an outpatient hospital co-payment if the outpatient procedure is performed at an outpatient hospital. Benefits will remain the same if the outpatient procedure is performed at an independent lab/imaging center/ambulatory surgical center.

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

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

Note: Any expense applied to any deductible and any co-payments for prescription drug (provided under your CVS Caremark drug plan) will apply toward the satisfaction of the Out-of-Pocket Amount.

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

- Charges for services or supplies not covered under this plan;
- Charges which exceed the *maximum allowed amount;* and
- Charges which exceed the *prescription drug maximum allowed amount*.

MEDICAL BENEFIT MAXIMUMS

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

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

CONDITIONS OF COVERAGE

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

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

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

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

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

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

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

7. All services and supplies must be ordered by a *physician*.

SCHEDULES FOR NON-PARTICIPATING PROVIDERS

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

SERVICE AREAS

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

- **Service Area 1:** Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.
- **Service Area 2:** Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.
- **Service Area 3:** Counties of Marin, San Francisco, San Mateo and Santa Clara.
- **Service Area 4:** Counties of Los Angeles and Riverside (City of Palm Springs only).
- **Service Area 5:** Orange County.
- **Service Area 6:** Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.
- **Service Area 7:** San Diego County.
- **Service Area 8:** Counties of Fresno, San Joaquin, Sonoma and Stanislaus.
- **Service Area 9:** Imperial County.
- **Service Area 10:** Outside California.

CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER

The *maximum allowed amount* for inpatient and outpatient 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).

HOSPITAL SCHEDULE

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

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

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

AMBULATORY SURGICAL CENTER SCHEDULE

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

MEDICAL 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:

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

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum (12 visits) for that *year*.

Ambulance. Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
  - From your home, or from the scene of an accident or medical *emergency*, to a *hospital*,
  - Between *hospitals*, including when you are required to move from a *hospital* that does not contract with the *claims administrator* to one that does, or
  - Between a *hospital* and a *skilled nursing facility* or other approved facility.
- For air or water ambulance, you are transported:
  - From the scene of an accident or medical *emergency* to a *hospital*,
  - Between hospitals, including when you are required to move from a hospital that does not contract with the *claims administrator* to one that does, or
  - Between a hospital and another approved facility.

Non-emergency ambulance services are subject to medical necessity reviews. *Emergency* ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a *non-emergency*. When using an air ambulance in a *non-emergency* situation, the *claims administrator* reserves the right to select the air ambulance provider. If you do not use the air ambulance the *claims administrator* selects in a *non-emergency* situation, no coverage will be provided.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes *medically necessary* treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a *hospital*. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your *family members* or *physician* are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A *physician's* office or clinic;
- A morgue or funeral home.

If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical *emergency* existed even if you are not transported to a *hospital*.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a *hospital* than the ground ambulance can provide, this *plan* will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a *hospital* that is not an acute care *hospital* (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a *physician's* office or to your home.

Hospital to hospital transport: If you are being transported from one *hospital* to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the *hospital* that first treats you cannot give you the medical services you need. Certain specialized services are not available at all *hospitals*. For example, burn care, cardiac care, trauma care, and critical care are only available at certain *hospitals*.

For services to be covered, you must be taken to the closest *hospital* that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your *physician* prefers a specific *hospital* or *physician*.

* 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.

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

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

Bariatric Surgery. Services and supplies in connection with *medically necessary* surgery for weight loss, only for morbid obesity and only when performed at a designated *CME* facility. See UTILIZATION REVIEW PROGRAM for details.

You must obtain pre-service review for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a *CME* will not be covered.**

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.

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 mammogram will be covered initially under the Preventive Care Services benefit.

2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a *preventive care service*, BRCA testing will be covered under the Preventive Care Services benefit.

3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

4. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.

5. 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.

Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

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

1. Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination;
2. Adjustments;
3. Radiological x-rays and laboratory tests; and
4. *Medically necessary* therapy when provided in conjunction with the visit specifically for spinal or joint adjustment.

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

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum (13 visits) for that *year*.

If you receive chiropractic services from a *non-participating provider* and you need to submit a claim to the *claims administrator*, please send it to the address listed below. If you have any questions or are in need of assistance, please call the Member Services telephone number listed on your ID card.

American Specialty Health
P.O. Box 509001
San Diego, CA 92150-9002

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.

Clinical Trials. Coverage is provided for routine patient costs you receive as a participant in an approved clinical trial. .A "qualified enrollee" means that you meet both of the following conditions:

a) You are eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

b) Either of the following applies:
   i. The referring health care professional is a *participating provider* has concluded that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

You provide medical and scientific information establishing that your participation in the clinical trial would be appropriate because you meet the conditions of subparagraph (a).

The services must be those that are listed as covered by this plan for *members* who are not enrolled in a clinical trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by the *plan,* including:

- Drugs, items, devices, and services typically covered absent a clinical trial;
- Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service;
- Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service;
- Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service;

- Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Cost sharing (co-payments, coinsurance, and deductibles) for routine patient care costs will be the same as that applied to the same services not delivered in a clinical trial, except that the *participating provider* cost sharing and Out-of-Pocket Amount will apply if the clinical trial is not offered or available through a *participating provider*.An "approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The term "life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Coverage is limited to the following clinical trials:

1. Federally funded trials approved or funded by one or more of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
    g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The Department of Veterans Affairs,
        ii. The Department of Defense, or
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your *physician* after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

If one or more *participating providers* are conducting an approved clinical trial, your *plan* may require you to use a *participating provider* to utilize or maximize your benefits if the *participating provider* accepts you as a clinical trial participant. It may also require that an approved clinical trial be located in California, unless the clinical trial is not offered or available through a *participating provider* in California.

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

1. The investigational item, device, or service.

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

3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

4. Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of change for any enrollee in the trial.

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

Covered Prescription Drugs. To be a covered service, *prescription drugs* must be approved by the Food and Drug Administration (FDA) and, under federal law, require a *prescription*. *Prescription drugs* must be prescribed by a licensed *physician* and *controlled substances* must be prescribed by a licensed *physician* with an active DEA license.

Compound drugs are a covered service and are subject to prior authorization. All the ingredients of the *compound drug* are FDA approved in the form in which they are used in the *compound drug*, require a *prescription* to dispense, and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved, non-

proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Your *plan* also covers certain over-the-counter *drugs* that must be covered under federal law, when prescribed by a *physician*, subject to all terms of this *plan* that apply to those benefits. Please see the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED, for additional details.

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 except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *member* is less than seven years old, (b) the *member* is developmentally disabled, or (c) the *member's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.3.

   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.

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

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

Diabetes. 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*.

The following items are covered as medical supplies:

a. Insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered.

b. Testing strips, lancets, and alcohol swabs.

Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

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

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. Hearing aids are not a covered benefit.

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.

Foreign Travel Immunizations. Immunizations for foreign travel.

Gene Therapy Services. Your *plan* includes benefits for gene therapy services, when the *claims administrator* approves the benefits in advance through precertification. See the "Utilization Review Program" for details on the precertification process. To be eligible for coverage, services must be *medically necessary* and performed by an approved *physician* at an approved treatment center. Even if a *physician* is a *participating provider* for other services it may not be an approved provider for certain gene therapy services. Please call the claims administrator to find out which providers are approved *physicians*. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your *plan* does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved provider or at a non-approved facility; or

iii. Services not approved in advance through precertification.

Hemodialysis Treatment. This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

Treatment provided by a freestanding outpatient hemodialysis center which is a *non-participating provider* is limited to **$350** per visit.

Hip, Knee Replacement or Spine Surgery. Inpatient services and supplies provided for *medically necessary* hip, knee replacement or spine surgery when performed by a designated *Blue Distinction+ (BD+)* hospital facility. Benefits for the following services are as follows:

- Total Knee Replacement
- Revision Knee Replacement
- Total Hip Replacement
- Revision Hip Replacement
- Discectomy
- Decompression (without fusion)
- Primary Fusion
- Revision Fusion

Hip, knee replacement or spine surgery services are subject to pre-service review to determine medical necessity. Benefits are provided for inpatient services for medically necessary hip replacement, knee replacement or spine surgery. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home Health Care. Benefits are available for covered services performed by a *home health agency* or other provider in your home. The following are 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. Other organizations may give services only when approved by the *claims administrator*, and their duties must be assigned and supervised by a professional nurse on the staff of the *home health agency* or other provider as approved by the *claims administrator*.
5. *Medically necessary* supplies provided by the *home health agency*.

When available in your area, benefits are also available for *intensive in-home behavioral health services*. These do not require confinement to the home. These services are described in the BENEFITS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER section below.

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

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

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

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. You are eligible for *hospice* care if your *physician* and the *hospice* medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access *hospice* care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating *physician*. Disease modifying therapy treats the underlying terminal illness.

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. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Covered services include:

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 (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the *member's* death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the *member's* death.

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.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a *member* in *hospice*. These services are covered under other parts of this *plan*.

This *plan's hospice* benefit will meet or exceed Medicare's *hospice* benefit. If you use a *non-participating provider*, that provider may also bill you for any charges over Medicare's *hospice* benefit unless your claim involves a *surprise billing claim*.

Hospital

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

2. Services in *special care units*.

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

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

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

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

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

Infusion Therapy. The following services and supplies, when provided in your home by a *home infusion therapy provider* or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), 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; maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

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.

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

Certain birth control is covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Jaw Joint Disorders. The *plan* will pay for splint therapy or surgical treatment for disorders or conditions directly affecting the upper or lower jawbone or the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Mental Health or Substance Use Disorder. Covered services shown below for the *medically necessary* treatment of *mental health* or substance use disorder, or to prevent the deterioration of chronic conditions.

1. Inpatient *hospital* services and services from a *residential treatment center* as stated in the "Hospital" provision of this section, for inpatient services and supplies.

2. Partial hospitalization, including intensive outpatient programs and visits to a *day treatment center*. *Partial hospitalization programs* are covered as stated in the “Hospital” provision of this section, for outpatient services and supplies.

3. *Physician* visits during a covered inpatient *stay*.

4. *Physician* visits (including virtual visits and *intensive in-home behavioral health programs*) for outpatient psychotherapy or psychological testing or outpatient rehabilitative care for the treatment of *mental health* or substance use disorder. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa

5. Behavioral health treatment for autism spectrum disorders. See the section BENEFITS FOR AUTISM SPECTRUM DISORDERS for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

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

Examples of providers from whom you can receive covered services include the following:

- Psychiatrist,
- Psychologist,
- Registered psychological assistant, as described in the CA Business and Professions Code,
- Psychology trainee or person supervised as set forth in the CA Business and Professions Code,

- Licensed clinical social worker (L.C.S.W.),
- Associate clinical social worker functioning pursuant to the CA Business and Professions Code,
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to the CA Business and Professions Code,
- Licensed professional counselor (L.P.C.),
- Associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to the CA Business and Professions Code, and

Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals. See the definitions of these in the "Benefits for Autism Spectrum Disorders" section below.

Virtual Visits (Telemedicine / Telehealth Visits). Covered services include virtual Telemedicine / Telehealth visits that are appropriately provided through the internet via video chat or voice. This includes visits with *physicians* who also provide services in person, as well as online-only *physicians*.

- "Telemedicine / Telehealth" means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app or website. Covered services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. Benefits for Telehealth are provided on the same basis and to the same extent as the same covered services provided through in-person contact. In-person contact between a health care *physician* and the patient is not required for these services, and the type of setting where these services are provided is not limited.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all *physicians* offer virtual visits.

Benefits do not include the use of facsimile, audio-only telephone, texting (outside of our mobile app), website, electronic mail, or non-secure instant

messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to *physicians* outside our network, benefit precertification or *physician* to *physician* discussions.

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

For *mental health or substance use disorder* virtual care visits, please see the "Benefits for Mental Health and Substance Use Disorder" section for a description of this coverage.

Orthopedic Surgery Facilities. Hospital facilities have been organized to provide inpatient services only for hip replacements, knee replacements and certain spine procedures listed in this *benefit booklet*. **These procedures are covered only when performed at a *Blue Distinction+ (BD+) Facility*.**

Blue Distinction.

- The Blue distinction requirement does not apply to the following:
  - Members under the age of 18
  - Emergencies
  - Urgent surgery to treat a recent fracture
  - Surgeries performed in the course of other heroic treatment such as cancer treatment
  - You have primary coverage with Medicare or another carrier

Benefits for services performed at a designated *CME, BD* or *BD+* will be the same as for *participating providers*. A *participating provider* in the Prudent Buyer Plan or the Blue Cross and/or Blue Shield Plan network is not necessarily a *CME, BD* or *BD+* facility.

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed *medically necessary*.

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

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

of care which are customarily provided by physical therapists and osteopaths.

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

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum (13 visits) for that *year*.

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

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

There is no limit on the number of covered visits for *medically necessary* physical therapy and physical medicine. But additional visits in excess of the number of visits stated above must be authorized in advance.

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.

Pregnancy and Maternity Care

1. All medical benefits for an enrolled *member* when provided for pregnancy or maternity care, including the following services:

    a. Prenatal, postnatal and postpartum care. Prenatal care also includes participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health

    b. Ambulatory care services (including ultrasounds, fetal non-stress tests, *physician* office visits, and other *medically necessary* maternity services performed outside of a *hospital*);

    c. Involuntary complications of pregnancy;

d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and

e. Inpatient *hospital* care including labor and delivery.

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. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* (for additional information, please see the "Important Note for Newborn and Newly-Adopted Children" under HOW COVERAGE BEGINS AND ENDS. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

3. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

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

Prescription Drugs Obtained From Or Administered By a Medical Provider.

Your *plan* includes benefits for *prescription drugs,* including *specialty drugs*, that must be administered to you as part of a *physician* visit, services from a *home health agency* or at an outpatient *hospital* when they are covered services. This may include *drugs* for home infusion therapy, chemotherapy, blood products, certain injectable and any drug that must be administered by a *physician*. This section describes your benefits when your *physician* orders the medication and administers it to you.

Benefits for *drugs* that you inject or get at a *retail pharmacy* (i.e., self-administered *drugs*) are not covered under this section. Benefits for those and other covered *drugs* are described under YOUR PRESCRIPTION DRUG BENEFITS, if included.

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

Prior Authorization. Your *plan* includes certain features to determine when *prescription drugs* should be covered, which are described below. As part of these features, your prescribing *physician* may be asked to give more details before the *claims administrator* can decide if the *drug* is eligible for coverage. In order to determine if the *prescription drug* is eligible for coverage, the following criteria has been established.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific *physician* qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one *prescription drug*, *prescription drug* regimen or treatment be used prior to use of another *prescription drug*, *prescription drug* regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated, and
- Use of a *prescription drug formulary*.

You or your *physician* can get the list of the *prescription drugs* that require prior authorization by calling the phone number on the back of your identification card or check the claims administrator's website at www.anthem.com. The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under your *plan*. Your *physician* may check with the *plan* to verify *prescription drug* coverage, to find out which *prescription drug* are covered under this section and if any drug edits apply. However, if it is determined through prior authorization that the *drug* originally prescribed is *medically necessary* and is cost effective, 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, the *claims administrator* will not require you to try a *drug* other than the one you are currently taking.

In order for you to get a *specialty pharmacy drug* that requires prior authorization, your *physician* must submit a request to the *plan* using the required uniform prior authorization request form. If you're requesting an exception to the step therapy process, your *physician* must use the same form. The request, for either prior authorization or step therapy exceptions, may be made by mail, telephone, facsimile, or it may be made electronically. At the time the request is initiated, specific clinical information will be requested from your *physician* based on 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 pharmacy drug*.

After the *plan* receives the request from your *physician,* the *claims administrator* will review the request and respond within the following time periods:

- 72 hours for non-urgent requests, and
- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the *plan*.

If you have any questions regarding whether a *specialty pharmacy drug* requires prior authorization, please call the number on the back of your ID Card.

If a request for prior authorization of a *specialty pharmacy drug* is denied, you or your prescribing *physician* may appeal the decision by calling the number on the back of your ID Card.

Preventive Care Services. Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means for *preventive care services*, the *calendar year* deductible will not apply to these services or supplies when they are provided by a *participating provider.* No co-payment will apply to these services or supplies when they are provided by a *participating provider.*

1. A *physician's* services for routine physical examinations.
2. Immunizations prescribed by the examining *physician.*
3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury.

Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.

4. Health screenings as ordered by the examining *physician* for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood led levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.

5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis, including screenings for pre-exposure prophylaxis (PrEP) for prevention of HIV infection.

6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.

7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    a. All FDA-approved contraceptive *drugs*, devices and other products for women, including over-the-counter items, if prescribed by a *physician*. This includes contraceptive *drugs* as well as other contraceptive medications such as injectable contraceptives and patches devices such as diaphragms, intrauterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the *drugs*, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

        At least one form of contraception in each of the methods identified in the FDA’s Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a *physician*, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

In order to be covered as preventive care, contraceptive *prescription drugs* must be either *generic* oral contraceptives. *Brand name drugs* will be covered as *preventive care services* when *medically necessary* according to your attending *physician*, otherwise they will be covered under your *plan's* prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS).

Note: For FDA-approved, *self-administered hormonal contraceptives*, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense *drugs* or supplies.

b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

c. Gestational diabetes screening.

d. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your *physician*, based on clinical expertise.

This list of *preventive care services* is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment and will not apply to the *calendar year* deductible when provided by a *participating provider*.

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

You may call Member Services using the number on your ID card for additional information about these services. You may also view the federal government's web sites:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Professional Services

1. Services of a *physician*.

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

Prosthetic Devices

1. Breast prostheses and surgical bras 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, including but not limited to cochlear 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.
    e. Benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Reconstructive Surgery. Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy. This also includes *medically necessary* dental or orthodontic services that are an integral part of *reconstructive surgery* for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

This does not apply to orthognathic surgery. Please see the “Dental Care” provision below for a description of this service.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, limited to **$300** per *calendar year*.

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

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

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

Sleep apnea appliances. We cover custom-fitted dental device appliances developed for the treatment of snoring and obstructive sleep apnea, if *medically necessary*, up to **$1,350** per appliance.

Speech Therapy and Speech-language pathology (SLP) services. Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

After your initial visit to a *physician* for speech therapy, pre-service review must be obtained prior to receiving additional services. There is no limit on the number of covered visits for *medically necessary* services. However, visits must be authorized in advance. Please refer to utilization review program for information on how to obtain the proper reviews.

Transgender Services. Benefits are provided for services and supplies in connection with Gender Transition when a Physician has diagnosed you with Gender Identity Disorder or Gender Dysphoria. This coverage is provided according to the terms and conditions of this Booklet that apply to all other medical conditions, including Medical Necessity requirements, utilization management, and exclusions for Cosmetic Services.

Coverage includes, but is not limited to, Medically Necessary services related to Gender Transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Booklet that apply to that type of service generally, if the Plan includes coverage for the service in question.
If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Booklet's Prescription Drug benefits. Some services are subject to prior authorization in order for coverage to be provided. Please refer to "Utilization Review Program" for information on how to obtain the proper reviews.

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

1. The recipient; or

2. The donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered *members* under this *plan*, each will get benefits under their plans.

- When the person getting the organ is a covered *member* under this *plan*, but the person donating the organ is not, benefits under this *plan* are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If a *member* covered under this *plan* is donating the organ to someone who is **not** a covered *member*, benefits are not available under this *plan*.

The *maximum allowed amount* for a donor, including donor testing and donor search, is limited to expense incurred for *medically necessary* medical services only. The *maximum allowed amount* for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The *plan's* payment for unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

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

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. The *claims administrator* will help you maximize your benefits by giving you coverage information, including details on what is covered

and if any clinical coverage guidelines, medical policies, *Centers of Medical Excellence (CME)* rules, or exclusions apply.

Call the Member Services phone number on the back of your ID card and ask for the transplant coordinator.

You or your *physician* must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an inpatient or outpatient setting. Prior authorization is required before benefits for a transplant will be provided. Your *physician* must certify, and the *claims administrator* must agree, that the transplant is *medically necessary*. Your *physician* should send a written request for prior authorization to the *claims administrator* as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your *physician* may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved.

However, such an approval for HLA testing, donor search, or collection and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

You must obtain the *claims administrator's* prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at *Centers of Medical Excellence (CME)*. **Charges for services provided for or in connection with a specified transplant performed at a facility other than a *CME* will not be covered.**

Call the toll-free telephone number for pre-service review on your identification card if your *physician* recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a *CME*. See UTILIZATION REVIEW PROGRAM for details.

Travel expense reimbursement is supported through our vendor, Healthbase for the following travel benefit maximum payment:

- $10,000 per transgender surgery
- $10,000 per transplant
- $6,000 per bariatric surgery
- $6,000 per hip, knee replacement or spine surgery

For reimbursable expenses by Healthbase, the Member must first call Member Services who will submit the referral to Healthbase, if the following criteria is met.

- Precertification is required to be eligible for travel expense reimbursement.
- The member's place of residence is
    - Fifty (50) miles from nearest participating provider facility for transgender surgery
    - Fifty (50) miles from nearest designated CME facility for transplant surgery
    - Fifty (50) miles from nearest designated CME facility for bariatric surgery
    - Fifty (50) miles from nearest designated BDC+ facility for hip, knee replacement or spine surgery

HealthBase will contact the Member to begin travel arrangements, if travel expense reimbursement criteria is met. Covered travel expenses are not subject to the deductible or copayments.

Urgent Care. Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not *emergency services*. Services for urgent care are typically provided by an *urgent care center* or other facility such as a physician's office. Urgent care can be obtained from *participating providers* or *non-participating providers*.

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.)

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.

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by the *claims administrator*.

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

Autopsies. Autopsies and post-mortem testing.

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

Clinical Trials. Any investigational *drugs* or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this *plan* for non-Investigative treatments, except as specifically stated in the “Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.

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

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

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

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

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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.

Dental Devices for Snoring. Oral appliances for snoring.

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

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

This exclusion does not apply to the following:

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

Diabetic Supplies. Prescription and non-prescription diabetic supplies. Not applicable if you have primary coverage with Medicare.

Drugs Given to you by a Medical Provider. The following exclusions apply to *drugs* you receive from a medical provider:

- **Delivery Charges.** Charges for the delivery of *prescription drugs*.

- **Clinically-Equivalent Alternatives.** Certain *prescription drugs* may not be covered if you could use a clinically equivalent *drug*, unless required by law. "Clinically equivalent" means *drugs* that for most *members*, will give you similar results for a disease or condition. If you have questions about whether a certain *drug* is covered and which *drugs* fall into this group, please call the number on the back of your ID card, or visit the *claims administrator's* website at www.anthem.com.

  If you or your *physician* believes you need to use a different *prescription drug*, please have your *physician* or pharmacist get in touch with us. We will cover the other *prescription drug* only if we agree that it is *medically necessary* and appropriate over the clinically equivalent *drug*. We will review benefits for the *prescription drug* from time to time to make sure the *drug* is still *medically necessary***.**

- **Drugs Contrary to Approved Medical and Professional Standards.** *Drugs* given to you or prescribed in a way that is against approved medical and professional standards of practice.

- **Drugs Over Quantity or Age Limits.** *Drugs* which are over any quantity or age limits set by the *plan* or us.

- **Drugs Over the Quantity Prescribed or Refills After One Year.** *Drugs* in amounts over the quantity prescribed or for any refill given more than one year after the date of the original *prescription*.

- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** *Prescription drugs* prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

- **Drugs That Do Not Need a Prescription.** *Drugs* that do not need a *prescription* by federal law (including *drugs* that need a *prescription* by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter *drugs* that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a *physician*.

- **Lost or Stolen Drugs.** Refills of lost or stolen *drugs*.

- **Non-Approved Drugs.** *Drugs* not approved by the FDA.

Educational or vocational testing. Services for educational or vocational testing or training.

Excess Amounts. Any amounts in excess of *maximum allowed amounts*, except for *surprise billing claims* as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet, or any Medical Benefit Maximum.

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 that the denial be reviewed.

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

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.

Family Members. Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.

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.

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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.

Growth Hormone Treatment. Any treatment, device, *drug*, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as specifically stated in the "Scalp hair prostheses" 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.

Hearing Aids or Tests. Hearing aids, including bone-anchored hearing aids. Routine hearing tests, except as specifically provided under the "Preventive Care Services" provisions of MEDICAL CARE THAT IS COVERED.

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

Hospital Services Billed Separately. Services rendered by *hospital* resident *physicians* or interns that are billed separately. This includes separately billed charges for services rendered by employees of *hospitals*, labs or other institutions, and charges included in other duplicate billings.

Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Member's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required.

This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Illegal drugs or medications. Services, supplies, care or treatment to a Member for Injury or Sickness resulting from that Member's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Members other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence.

Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

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.

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.

In-vitro Fertilization. Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

Medical Equipment, Devices and Supplies. This *plan* does not cover the following:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

- Enhancements to standard equipment and devices that is not *medically necessary*.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in your situation.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered under the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

This exclusion does not apply to the *medically necessary* treatment of specifically stated in "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

Mental Health or Substance Use Disorder. Academic or educational testing, counseling, and remediation. Any treatment of *mental health* or substance use disorder, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental Health or Substance Use Disorder" provision 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*.

Mobile/Wearable Devices. Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

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

Non-Approved Facility. Services from a *physician* that does not meet the definition of facility.

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

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

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*. This exclusion does not apply to the *medically necessary* treatment of autism spectrum disorders, to the extent stated in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

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

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

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

This exclusion does not apply to services that are mandated by federal law or listed as covered under "YOUR MEDICAL BENEFITS", "Prescription Drugs Obtained from or Administered by a Medical Provider" and/or "Your Prescription Drug Benefits".

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

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

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

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 or for lymphatic drainage therapy for oncology follow up care.

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.

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

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.

Private Duty Nursing. Private duty nursing services given in a *hospital* or *skilled nursing facility*. Private duty nursing services are a covered service only when given as part of the "Home Health Care" benefit..

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice*, *skilled nursing facility* or *residential treatment center*.

This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, *custodial care* center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

Routine Physicals. Physical exams required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care Services" provision of MEDICAL CARE THAT IS COVERED.

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

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

Services Received Outside of the United States Services rendered by providers located outside the United States, unless the services are for an *emergency,* emergency ambulance or *urgent care*.

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**.

Sterilization Reversal. Reversal of an elective sterilization.

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).

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

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as defined as a Covered Charge.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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 nongovernmental 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.

Waived Cost-Shares Non-Participating Provider. For any service for which you are responsible under the terms of this *plan* to pay a co-payment or deductible, and the co-payment or deductible is waived by a *nonparticipating provider*.

War. Any loss that is due to a declared or undeclared act of war.

Wilderness. Wilderness or other outdoor camps and/or programs.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If the *plan* provides benefits for such injuries, conditions or diseases the *claims administrator* shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law.

BENEFITS FOR AUTISM SPECTRUM DISORDERS

This *plan* provides coverage for behavioral health treatment for autism spectrum disorders. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this *plan* are subject to the same deductibles, co-payments and co-insurance that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under *plan* benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a facility, such as the outpatient department of a *hospital*, will be covered under *plan* benefits that apply to such facilities. See also the section BENEFITS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER.

You must obtain pre-service review for all behavioral health treatment services for the treatment of autism spectrum disorders in order for these services to be covered by this *plan* (see UTILIZATION REVIEW PROGRAM for details).

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

DEFINITIONS

Autism Spectrum Disorders means one or more of disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the

National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for autism spectrum disorders, provided the services are within the experience and competence of the licensee.

The *claims administrator's* network of *participating providers* may be limited to licensed Qualified Autism Service Providers who contract with the *claims administrator* or a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California, and
- Has training and experience in providing services for autism spectrum disorders pursuant to applicable state law.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,

- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

The behavioral health treatment services covered by this *plan* for the treatment of autism spectrum disorders are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorders and that meet all of the following requirements:

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
    - ♦ Describes the patient's behavioral health impairments to be treated,
    - ♦ Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
    - ♦ Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorders,

- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to the *claims administrator* upon request.

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 it has 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 its 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 its 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 and your legal representative acknowledge that the portion of the Recovery to which the *plan's* equitable lien applies is a *plan* asset.

4. Any Recovery you obtain must not be dissipated or disbursed until such time as the p*lan* has been repaid in accordance with these provisions.

5. 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*.

6. 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.

7. 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*.

8. 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.

9. 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 promptly notify the *plan* 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 and any other information requested by the *plan*.

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.

6. You must immediately notify the *plan* if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case

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* and per *calendar year*. 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 any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.

2. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

3. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.

4. If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.

5. The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.

6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

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 first of the following rules which applies will 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 entitled to Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first, Medicare will pay second, and the plan which covers you as a retired employee would pay last.

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

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

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

b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

   i. The plan which covers that *child* as a dependent of the parent with custody.

   ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

   iii. The plan which covers that *child* as a dependent of the parent without custody.

   iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

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

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

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

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

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

OUR RIGHTS UNDER THIS PROVISION

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

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

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Their Family Members

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

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

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

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

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

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

For Retired Employees and Their Spouses

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

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

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

2. If you are 65 years of age or older and not eligible for Medicare Part A, CVT requires you still be enrolled for Medicare Part B benefits.

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

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

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

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

   This method of payment will be applied when you are under the age of 65, retired and actually enrolled in Medicare Part A and Part B.

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

UTILIZATION REVIEW PROGRAM

Your *plan* includes the process of utilization review to decide when services are *medically necessary* or *experimental* / *investigative* as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be *medically necessary* to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be *medically necessary* if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not *medically necessary* for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered *medically necessary*. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a *hospital* but may be approvable if provided on an outpatient basis at a *hospital*.
- A service may be denied on an outpatient basis at a *hospital* but may be approvable at a free standing imaging center, infusion center, ambulatory surgery center, or in a *physician's* office.
- A service may be denied at a *skilled nursing facility* but may be approvable in a home setting.

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not *medically necessary* if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means treatments that for most *members*, will give you similar results for a disease or condition.

If you have any questions about the utilization review process, the medical policies or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;

2. The service or supply must be a covered service under your *plan*;

3. The service cannot be subject to an exclusion under your *plan* (please see MEDICAL CARE THAT IS NOT COVERED for more information); and

4. You must not have exceeded any applicable limits under your *plan*.

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.

  - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is *experimental* / *investigative* as those terms are defined in this booklet.

    For admissions following an *emergency*, you, your authorized representative or *physician* must tell the *claims administrator* within 24 hours of the admission or as soon as possible within a reasonable period of time.

    For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

    For inpatient *hospital* stays for mastectomy surgery, including the length of *hospital* stays associated with mastectomy, precertification is not needed.

- **Continued Stay / Concurrent Review –** A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

  - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any *physician* with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided.

Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the *plan* has a related clinical coverage guideline and are typically initiated by the *claims administrator*.

Services for which precertification is required (i.e., services that need to be reviewed by the *claims administrator* to determine whether they are *medically necessary*) include, but are not limited to, the following:

- Scheduled, non-emergency inpatient *hospital stays* and *residential treatment center* admissions, including detoxification and rehabilitation.

  Exceptions: Pre-service review is not required for inpatient *hospital stays* for the following services:

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

- Specific, *non-emergency* outpatient services, including diagnostic treatment, genetic tests and other services.
- Surgical procedures, wherever performed.
- Transplant services including transplant travel expense. The following criteria must be met for certain transplants, as follows:

  a. For bone, skin or cornea transplants, if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.

  b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* facility.

- Air ambulance in a *non-emergency*.
- Home infusion therapy if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.
- Admissions to a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

- 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. A specified number of additional visits may be authorized. While there is no limit on the number of covered visits for *medically necessary* physical therapy and physical medicine, additional visits in excess of the stated number of visits must be authorized in advance.

- Home health care. The following criteria must be met:

  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*.

- Speech therapy services. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for medically necessary speech therapy, visits must be authorized in advance.

- 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.

- Hip, knee replacement or spine surgical services, including hip, knee replacement or spine surgery travel expense, if:

  ♦ The services are to be performed for hip, knee replacement or spine surgery;

  ♦ The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

  ♦ The hip, knee replacement or spine surgical procedure will be performed at a *Blue Distinction+ (BD+)* facility.

- Bariatric surgical services such as gastric bypass and other surgical procedures for weight loss, including bariatric travel expense if:

  a. The services are to be performed for the treatment of morbid obesity;

b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and

c. The bariatric surgical procedure will be performed at a *CME* facility.

- Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. You may call the toll-free Member Services telephone number on your identification card to find out if an imaging procedure requires pre-service review.

  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.

- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.

- *Prescription drugs* that require prior authorization as described under the "Prescription Drugs Obtained from or Administered by a Medical Provider" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

- Behavioral health treatment for autism spectrum disorders, as specified in the section BENEFITS FOR AUTISM SPECTRUM DISORDERS.

- Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).

- Transgender services, as specified under the "Transgender Services" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a *physician*.

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Typically, *participating providers* know which services need precertification and will get any precertification when needed. Your *physician* and other *participating providers* have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, *hospital* or attending *physician* ("requesting provider") will get in touch with the *claims administrator* to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request.

The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	**Responsibility to Get Precertification**	**Comments**
Participating Providers	Provider	• The provider must get precertification when required.
Non-Participating Providers	*Member*	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be *medically necessary*.

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	*Member* **(Except for Inpatient Admissions)**	• *Member* must get precertification when required. (Call Member Services.) • *Member* may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be *medically necessary*. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an *emergency* admission, precertification is not required. However, you, your authorized representative or *physician* must notify the *claims administrator* within 24 hours of the admission or as soon as possible within a reasonable period of time.		

HOW DECISIONS ARE MADE

The *claims administrator* uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make medical necessity decisions. This includes decisions about *prescription drugs* as detailed in the section "Prescription Drugs Obtained From Or Administered By a Medical Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The *claims administrator* reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the precertification phone number on the back of your identification card.

If you are not satisfied with our decision under this section of your benefits, you may call the Member Services phone number on the back of your Identification Card to find out what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

The *claims administrator* will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the *plan* will follow state laws. If you live in and/or get services in a state other than the state where your *plan* was issued, other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	**Timeframe Requirement for Decision**
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	15 business days from the receipt of the request
Urgent Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request. We may request additional information within the first 24 hours and then extend to 72 hours
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	15 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the *claims administrator* will tell the requesting *physician* of the specific information needed to finish the review. If the *plan* does not get the specific information it needs by the required timeframe identified in the written notice, the *claims administrator* will make a decision based upon the information received.

The *claims administrator* will notify you and your *physician* of the *plan's* decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

For a copy of the medical necessity review process, please contact Member Services at the telephone number on the back of your Identification Card.

Revoking or modifying a Precertification Review decision. The *claims administrator* will determine **in advance** whether certain services (including procedures and admissions) are *medically necessary* and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *plan administrator* terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under the *plan* change so that the service is no longer covered or is covered in a different way.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables the *claims administrator* to assist you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, the *claims administrator* will discuss possible options for an alternative plan of treatment which may include services not covered under this *plan*. It is not your right to receive individual case management, nor does the *claims administrator* have an obligation to provide it.

HOW HEALTH PLAN INDIVIDUAL CASE MANAGEMENT WORKS

The health plan individual case management program (Case Management) helps coordinate services for *members* with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate *members* who agree to take part in the Case Management program to help meet their health-related needs.

The Case Management programs are confidential and voluntary, and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.

If you meet program criteria and agree to take part, then *claims administrator* will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

In addition, the *claims administrator* may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, the *plan* may provide benefits for alternate care that is not listed as a covered service. The *claims administrator* may also extend services beyond the benefit maximums of this *plan*. A decision will be made on a case-by-case basis by the *claims administrator* if it determines that the alternate or extended benefit is in the best interest for you and the *plan* and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. The *claims administrator* reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the *claims administrator* will notify you or your authorized representative in writing.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, the *claims administrator* may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if such a change furthers the provision of cost effective, value based and quality services. In addition, the *claims administrator* may select certain qualifying health care providers to participate in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The *claims administrator* may also exempt claims from medical review if certain conditions apply.

If the *claims administrator* exempts a process, health care provider, or claim from the standards that would otherwise apply, the *claims administrator* is in no way obligated to do so in the future, or to do so for any other health care provider, claim, or *member*. The *claims administrator* may stop or modify any such exemption with or without advance notice.

The *claims administrator* also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then the *claims administrator* may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this ***plan's*** *members*.

You may determine whether a health care provider participates in certain programs by checking the *claims administrator's* online provider directory on the website at www.anthemcom/ca or by calling the Member Services telephone number listed on your ID card.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

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

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

Definition of Family Member

1. **Spouse of Employee:** A spouse of an enrolled employee is eligible for coverage. **(Marriage Certificate is required for enrollment.)**

2. **State Registered Domestic Partner:** A state registered domestic partner is eligible for coverage. **(State Registration Certificate is required for enrollment.)**

3. **Child:**

   Child of an enrolled employee, spouse or *domestic partner* under 26 years of age:

   - Natural child – **(Birth Certificate is required for enrollment)**
   - Adopted child – **(Final Adoption Papers are required for enrollment)**
   - Step child – **(Birth Certificate is required for enrollment)**
   - Child of an eligible, covered *domestic partner* – **(Birth Certificate is required for enrollment)**
   - Unmarried child under legal guardianship – A dependent child under a court ordered legal guardianship of the *employee* is eligible for coverage, provided they meet all other eligibility requirements. Please note: eligibility ends on the date of expiration of the court awarded guardianship or upon the 18th birthday of the child, whichever comes first. **(Legal Guardianship Papers are required for enrollment)**

   Permanently disabled child: A permanently disabled child who is presently covered with CVT as a dependent may continue as a dependent regardless of age provided the disabling condition existed before the child attained the age of 26, the disability renders the child incapable of self-sustaining employment.

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

A permanently disabled dependent who is married will lose their coverage at age 26; a permanently disabled dependent who is single will continue to be covered past age 26 until he or she marries, is no longer certified as permanently disabled. **(Disabled Dependent Certification required for enrollment.)**

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 CVT's Active Eligibility Policy and Retiree Guidelines.

2. **Family Member's Effective Date**

   - **New Spouse and Eligible Dependent(s):** A new spouse and an eligible dependent(s) of the new spouse are eligible to enroll for coverage within 31 days of the date of the marriage to the employee. An enrollment form for the new spouse and eligible dependent(s) must be submitted to request coverage within 31 days of the date of the marriage.

Coverage will commence on the first day of the month following the date of the marriage and receipt of a timely request for enrollment. **(Copies of Marriage Certificate and Birth Certificates for children under age 26 are required.)**

- **New Domestic Partner and Eligible Dependent(s) of Domestic Partner:** A domestic partner and his or her eligible dependent(s) are eligible to be enrolled by an employee when the requirements for eligible domestic partners (see "Who is Eligible For Coverage – Domestic Partner") have been met. An employee has 31 days from the date of first meeting the requirements of domestic partnership to enroll his or her domestic partner and eligible dependent(s). Coverage will commence on the first day of the month following the date of first meeting the requirements and receipt of a timely request for enrollment. **(Copies of the State Registration Certificate and Birth Certificates for children under age 26 are required.)**

- **Newborn Child:** 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.

- **Adopted Child:** 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.

- **Guardianship:** Children under the legal guardianship of the employee are eligible to be enrolled for coverage on the date the guardianship is awarded by the court. A copy of the "court ordered custody documents" is required before the child will be added to the coverage as a dependent of the employee. An employee must submit an enrollment request within 90 days of the date the guardianship is awarded to the employee by the court. Coverage will commence on the first day of the month following the court awarded guardianship and receipt of a timely request for enrollment. **If a request for enrollment is not received within 90 days of the date the guardianship is awarded by the court the child is not eligible to be enrolled for coverage until the annual open enrollment period or until the employee experiences a qualifying event.**

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

Contact CVT Member Services Department at (800) 288-9870 for complete Active Eligibility Policy and Retiree Guideline criteria.

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. Loss of coverage under an employer's health plan due to 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.

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.

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.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a ***spouse's*** plan) through the conditions listed under the SPECIAL ENROLLMENT PERIODS provision. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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.
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.

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. A *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 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.
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.

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*.

Inter-Plan Arrangements

Out-of-Area Services

Overview. The *claims administrator* has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the State of California, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of California, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not

included are *prescription drugs* that you obtain from a *pharmacy* and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, the *claims administrator* will still fulfill the plan's contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem Blue Cross Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem Blue Cross may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem Blue Cross by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem Blue Cross through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the group on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the *claims administrator* will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Non-participating Providers Outside California

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of California by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network *emergency* services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within California, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

Member Services is also available to assist you in determining your allowed amount for a particular service from a non-participating provider. In order for Anthem to assist you, you will need to obtain from the non-participating provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this information, the final allowed amount for your claim will be based on the actual claim submitted by the provider. You may call Member Services toll free at the telephone number on the back of your Identification Card for their assistance.

F. BlueCross BlueShield Global Core® Program

If you plan to travel outside the United States, call Member Services for information about your BlueCross BlueShield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

When you are traveling abroad and need medical care, you can call the BlueCross BlueShield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is **(800) 810-BLUE (2583)**. Or you can call them collect at **(804) 673-1177**.

If you need inpatient hospital care, you or someone on your behalf, should contact the *claims administrator* for preauthorization. Keep in mind, if you need *emergency* medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for *emergency* or non-emergency care.

How Claims are Paid with BlueCross BlueShield Global Core

In most cases, when you arrange inpatient hospital care with BlueCross BlueShield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any co-payment or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- *Physician* services;
- Inpatient hospital care not arranged through BlueCross BlueShield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front. When you need BlueCross BlueShield Global Core claim forms you can get international claims forms in the following ways:

- Call the BlueCross BlueShield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com

You will find the address for mailing the claim on the form.

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. After you get covered services, we must receive written notice of your claim in order for benefits to be paid.

- *Participating providers* will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

- *Non-participating provider* claims can be submitted by the *physician* if the *physician* is willing to file on your behalf. However, if the *physician* is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

    - Name of patient.

    - Patient's relationship with the *member*.

    - Identification number.

- Date, type, and place of service.
- Your signature and the *physician's* signature.

Non-participating provider claims must be submitted within 180 days after the date of service. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your *plan*.

Claims submitted by a public (government operated) hospital or clinic will be paid by us directly, as long as you have not already received benefit under that claim. We will pay all claims within 30 days after we receive proof of loss. If you are dissatisfied with our denial or amount of payment, you may request that we review the claim a second time, and you may submit any additional relevant information.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation. You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits. You authorize the *claims administrator*, in its own discretion and on behalf of the employer, to make payments directly to providers for covered services. In no event, however, shall the *plan's* right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the *plan*. The *claims administrator* also reserves the right, in its own discretion, to make payments directly to you as opposed to any provider for covered service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the *non-participating provider*. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a *subscriber* who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the employer's *plan*), or that person's custodial parent or designated representative. Any payments made by the claims administrator (whether

to any provider for covered service or you) will discharge the employer's obligation to pay for covered services. You cannot assign your right to receive payment to anyone.

Once a provider performs a covered service, the *claims administrator* will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the *plan* are not assignable by any *member* without the written consent of the *plan*, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the *plan* and/or law, sue or otherwise begin legal action, or request *plan* documents. Any assignment made without written consent from the *plan* will be void and unenforceable.

Care Coordination. The *plan* pays *participating providers* in various ways to provide covered services to you. For example, sometimes payment to *participating providers* may be a separate amount for each covered service they provide. The *plan* may also pay them one amount for all covered services related to treatment of a medical condition. Other times, the payment may be a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, *participating provider* payments may be financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate *participating providers* for coordination of your care. In some instances, *participating providers* may be required to make payment to the *plan* because they did not meet certain standards. You do not share in any payments made by *participating providers* to the *plan* under these programs.

Right of Recovery. Whenever payment has been made in error, the *claims administrator* will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the *claims administrator* recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the *claims administrator* will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. The *claims administrator* reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if the *claims administrator* pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the *claims administrator* may collect such amounts directly from you. You agree that the *claims administrator* has the right to recover such amounts from you.

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

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

The *claims administrator* reserves the right to deduct or offset, including cross plan offsetting on *participating provider* claims and on *non-participating providers* claims where the *non-participating providers* agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

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*.

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

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

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

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. For purposes of an individual who presents written documentation of being diagnosed with a *maternal mental health condition* from the individual's treating health care provider, completion of covered services for the *maternal mental health condition* shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

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 Member Services 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). If your *physician* leaves our network for any reason other than termination of cause, and you are in active treatment, you may be able to continue seeing that provider for a limited period of time and still get the *participating provider* benefits.

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. For purposes of an individual who presents written documentation of being diagnosed with a *maternal mental health condition* from the individual's treating health care provider, completion of covered services for the *maternal mental health condition* shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later. A maternal mental health condition is a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

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 Member Services 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.

Discount Programs. The *claims administrator* may offer health or fitness related programs to its *members*, through which they may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not covered services under the *plan* but are in addition to *plan* benefits. As such, program features are not guaranteed under this health *plan* contract and could be discontinued at any time. The *claims administrator* does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Voluntary Clinical Quality Programs. The *claims administrator* may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your plan. These programs are not guaranteed and could be discontinued at any time. The *claims administrator* will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Policies and Procedures. The Claims Administrator are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Service Agreement with your Employer, the Claims Administrator has the authority, in its discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. The Claim's Administrator reserves the right to discontinue a pilot or test program at any time.

New Program Incentives. The *plan administrator* may offer incentives from time to time in order to introduce you to new programs and services available under this *plan*. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards and health-related merchandise. Acceptance of these incentives is voluntary as long as the *plan* offers the incentives program. The *plan administrator* may discontinue an incentive for a particular new service or program at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, please consult your tax advisor.

Protecting Your Privacy - Where to find our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at https://www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Member Services using the contact information on your identification card.

CLAIMS REVIEW

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

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

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

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

Reconsiderations

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

Appeals

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

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

How to Initiate Requests for Reconsideration or Appeals

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

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

You must include Your Member Identification Number when submitting an appeal.

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.

You have the right to review all documents that are part of your requests for reconsideration or appeals and to present evidence and testimony as part of the reconsideration or appeals process.

Voluntary Second Level Appeals

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

External Review

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

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

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

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

- 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
CVT Member Services Unit
P. O. Box 60007
Los Angeles, CA 90060-0007

You must include Your Member Identification Number when submitting an appeal.

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 taking action

No legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the *claims administrator's* final decision on the claim or other request for benefits. If the *claims administrator* decides an appeal is untimely, the *claims administrator's* latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the *plan*'s internal Appeals Procedure but not including any voluntary level of appeal, before taking legal action of any kind.

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

BINDING ARBITRATION

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

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

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

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

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

The arbitration is begun by the *member* making written demand on CVT. The arbitration will be conducted by Judicial Arbitration and 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 (TJC) or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a *non-participating provider,* or require special services or facilities not available at a *contracting hospital*, but only when the referral has been authorized by the *plan administrator* before services are rendered and when the following conditions are met:

1. there is no *participating provider* who practices in the appropriate specialty, or there is no *contracting hospital* which provides the required services or has the necessary facilities; and

2. that meets the adequacy and accessibility requirements of state or federal law.

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

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

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

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

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

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

Chiropractic services means *medically necessary* care by means of adjustment of the spine (to correct a subluxation) performed by a legally licensed chiropractor pursuant to the terms of their license. (Subluxation is a term used in the chiropractic field to describe what happens when one of the vertebrae in your spine moves out of position.)

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.*

Consolidated Appropriations Act of 2021 is a federal law described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details.

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

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

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

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

CVT is the California's Valued Trust.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental health* or *substance use disorder* 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 or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or unborn child.

An *emergency medical condition* includes a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

Experimental is any medical, surgical and/or other procedures, services, products, *drugs* or devices including implants used for research except as specifically stated under the "Clinical Trials" provision from the section MEDICAL CARE THAT IS COVERED.

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

Generally Accepted Standards of Mental Health and Substance Use Disorder Care are standards of care and clinical practice that are generally recognized by health care *providers* practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to state law. Valid, evidence-based sources establishing *generally accepted standards of mental health and substance use disorder care* include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care *provider* professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

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 (TJC).

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 (TJC).

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 (TJC).

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

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

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a *mental health* or substance use disorder, put the *members* and others at risk of harm.

Intensive Outpatient Program is a structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

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

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

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and

7. 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.

For purposes of treatment of *mental health* and *substance use disorder*, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care,

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration, and

(iii) Not primarily for the economic benefit of the Claims Administrator and the Member or for the convenience of the patient, treating Physician, or other health care Provider.

Member is the *subscriber* or *family member*.

Mental health and substance use disorder include conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders.

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-emergency means an illness, injury or condition that is considered *non-emergency*. Final determination as to whether services rendered were considered as *non-emergency* will rest solely with the *claims administrator*.

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:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- A *hospice*
- A *retail health clinic*
- An *urgent care center*

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

Other health care provider is one of the following providers:

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

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

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

Partial Hospitalization Program is a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

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:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A *home infusion therapy provider*
- A *hospice*
- A *retail health clinic*
- An *urgent care center*

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

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

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this *benefit booklet*, and when benefits would be payable if the services were provided by a physician as defined above:

    - A dentist (D.D.S. or D.M.D.)
    - An optometrist (O.D.)
    - A dispensing optician
    - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    - A licensed clinical psychologist

- A licensed educational psychologist or other provider permitted by law to provide behavioral health treatment services for the treatment of autism spectrum disorders only
- A clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A *psychiatric mental health nurse* (R.N.)*
- A nurse midwife**
- A nurse practitioner
- A physician assistant
- A chiropractor (D.C.)
- A licensed acupuncturist (A.C.)
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the BENEFITS FOR AUTISM SPECTRUM DISORDERS section.

***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 Member Services 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 Member Services 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.

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

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

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

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

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

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by The Joint Commission (TJC); 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.

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

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

Retail Health Clinic - A facility that provides limited basic medical care services to *members* on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores.

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.

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

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.

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.

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.

Specialist is a *physician* who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has added training in a specific area of health care.

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.

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.

Surprise Billing Claim is described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this booklet for details.

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

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.

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

Urgent care center is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call the Member Services number listed on your ID card or you can also search online using the "Find a Doctor" function on the website at **www.anthem.com/ca**. Please call the *urgent care center* directly for hours of operation and to verify that the center can help with the specific care that is needed.

Virtual Visits (Telemedicine / Telehealth Visits) 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.

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

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

FOR YOUR INFORMATION

Your Rights and Responsibilities as a Member of this Plan

As *member* of this Plan, you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care providers and the information you need to make the best decisions for your health. As a *member* of this Plan you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your healthcare professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services
    - Our network of health care providers
    - Your rights and responsibilities
    - The rules of your health plan
    - The way your health plan works
- Make a complaint or file an appeal about:
    - Your health plan and any care you receive
    - Any covered service or benefit decision that your health plan makes
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your doctor to tell you how that may affect your health now and in the future.

- Get the most up-to-date information from a health care provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose any primary care physician , also called a PCP, who is in our network if your health plan requires it.
- Treat all doctors, health care providers, and staff with respect.
- Keep all scheduled appointments. Call your health care provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care providers to make a treatment plan that you all agree on.
- Inform your health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care providers.
- Give us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Let our Member Services department know if you have any changes to your name, address or family members covered under your plan.

For details about your coverage and benefits, please read your Benefit Booklet.

If you would like more information, have comments, or would like to contact us, please go to **www.anthem.com/ca** and select “Customer Support>Contact Us”, or you may call the Member Services number on your ID card.

We want to provide high quality benefits and Member Services to our *insured persons*. Benefits and coverage for services given under the plan are governed by the Certificate and not by this Member Rights and Responsibilities statement.

WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross’s web site to access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card. Simply log on to **www.anthem.com/ca**, select “Member”, and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. The privacy statement can also be viewed on this website.

IDENTITY PROTECTION SERVICES

The *claims administrator* has made identity protection services available to *members*. To learn more about these services, please visit https://anthemcares.allclearid.com/**.**

LANGUAGE ASSISTANCE PROGRAM

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *members* with limited English proficiency.

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

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by state law.

Oral interpretation services are available in these languages.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Anthem Blue Cross does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

For information on how to file a complaint, please see How to Make a Complaint. To file a discrimination complaint, please see "Get Help in Your Language" at the end of this certificate.

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

For more information about the Language Assistance Program visit www.anthem.com/ca.

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

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

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

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

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

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك
للمساعدة(TTY/TDD: 711).

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

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

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

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

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

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

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ
និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID
របស់អ្នកដើម្បីទទួលជំនួយ។(TTY/TDD: 711)

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

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

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

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

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html