



CALIFORNIA'S
VALUED TRUST

Healthcare Benefits for the Education Community

October 1, 2023

***MEDICARE SUPPLEMENTAL
PLAN 1***

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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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

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 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

This plan is intended only for *members* who have *Medicare* Part A and Part B coverage. The benefits described in this booklet are payable only for covered services to supplement *Medicare* benefits, except as specifically stated in HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, BENEFITS BEYOND MEDICARE and BENEFITS OUTSIDE THE UNITED STATES.

The benefits of this *plan* are provided only for services that *Medicare* determines to be allowable and *medically necessary*, except as specifically stated in this booklet. For covered services for which *Medicare* does not provide coverage (as described in HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, BENEFITS BEYOND MEDICARE and BENEFITS OUTSIDE THE UNITED STATES), the benefits of this *plan* are provided only for services that the *claims administrator* determines to be *medically necessary*. The fact that a *physician* prescribes or orders a service does not, in itself, mean that the service is *medically necessary* or that the service is a covered expense. Consult this booklet or telephone the Member Services 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”) that are defined in the DEFINITIONS section. When reading through this booklet, consult the DEFINITIONS section to be sure that you understand the meanings of these italicized words.

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*.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this <i>plan</i> are subject to the SUBROGATION AND REIMBURSEMENT section.
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BENEFITS TO SUPPLEMENT MEDICARE

In the following benefit sections, a summary of what you pay, what *Medicare* pays, and what the *plan* pays is provided. However, for complete information about *Medicare*, you should contact your local Social Security office or the Health Care Finance Administration, or refer to its publications.

HOSPITAL INPATIENT BENEFITS (PART A)

Part A refers to the portion of the *Medicare* program which provides benefits for inpatient *hospital* services and *skilled nursing facility* care.

The *plan* will provide payment for its portion of the Part A benefits whether or not a *hospital stay* has been approved by *Medicare* or services were received in a *hospital* participating in the *Medicare* program. However, SERVICES MUST BE *MEDICALLY NECESSARY* AS DETERMINED BY THE CLAIMS ADMINISTRATOR, AND ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS OF THIS PLAN.

The following paragraphs describe what you pay, what *Medicare* pays and what the *plan* pays:

HOSPITAL INPATIENT BENEFITS FOR CONDITIONS OTHER THAN MENTAL OR NERVOUS DISORDERS

You Pay:

- Any amounts in excess of *Medicare's* allowable charge amount for the first three pints of unreplaced whole blood.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE* PART A DEDUCTIBLE and the first three pints of unreplaced blood.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE* CO-PAYMENT.
- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE* CO-PAYMENT. *MEDICARE* DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY.

The Plan Pays:

- The *Medicare* Part A deductible.
- Benefits (UP TO *MEDICARE'S* ALLOWABLE CHARGE AMOUNT) for the first three pints of **unreplaced** whole blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part B.
- The *Medicare co-payment* for *hospital stays* from the 61st through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day. See HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED for inpatient *hospital* benefits after the 150th day.

HOSPITAL INPATIENT BENEFITS FOR MENTAL OR NERVOUS DISORDERS**You Pay:**

- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid either (a) the first 90 days of coverage during any one *benefit period*, provided you have no additional lifetime reserve days remaining; or (b) the first 150 days of coverage during any one *benefit period*, provided you have all of your lifetime reserve days remaining and choose to use them. If you have fewer than 60 lifetime reserve days available, or choose to use fewer than the number you have available, your payment responsibility increases accordingly.
- Any additional inpatient *mental or nervous disorder* services you receive after *Medicare* has paid the 190 day lifetime maximum for these services.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE PART A DEDUCTIBLE*.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

MEDICARE DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY OF EACH BENEFIT PERIOD OR BEYOND THE LIFETIME MAXIMUM OF 190 DAYS.

The Plan Pays:

- The *Medicare Part A deductible*.
- The *Medicare co-payment* for *hospital stays* from the 61st day through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

HOSPITAL INPATIENT BENEFITS FOR SUBSTANCE ABUSE

You Pay:

- Any additional inpatient substance abuse services you receive after *Medicare* has paid either (a) the first 90 days of coverage during any one *benefit period*, provided you have no additional lifetime reserve days remaining; or (b) the first 150 days of coverage during any one *benefit period*, provided you have all of your lifetime reserve days remaining and choose to use them. If you have fewer than 60 lifetime reserve days available, or choose to use fewer than the number you have available, your payment responsibility increases accordingly.
- Any additional inpatient substance abuse services you receive after *Medicare* has paid the 190 day lifetime maximum for these services.

Medicare Pays:

- Covered inpatient *hospital* services received for the first 60 days of each *benefit period* during an approved *stay*, EXCEPT FOR THE *MEDICARE PART A DEDUCTIBLE*.
- Covered inpatient *hospital* services received for the 61st through 90th day of each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

- If you exercise your option to use the 60 day lifetime reserve, covered inpatient *hospital* services received for the 91st through 150th day, EXCEPT FOR THE *MEDICARE CO-PAYMENT*.

MEDICARE DOES NOT PAY ANY BENEFITS AFTER THE 150TH DAY OF EACH BENEFIT PERIOD OR BEYOND THE LIFETIME MAXIMUM OF 190 DAYS.

The Plan Pays:

- The *Medicare Part A deductible*.
- The *Medicare co-payment* for *hospital stays* from the 61st day through 90th day.
- If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

SKILLED NURSING FACILITY BENEFITS

You Pay:

- Any additional *skilled nursing facility* services you receive after *Medicare* has paid the 100 day maximum allowance during a *benefit period* for these services.

Medicare Pays:

- When you are admitted within 30 days of a covered inpatient *hospital stay* of three or more consecutive days, covered Part A services for up to 100 days for each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT* FROM THE 21ST TO THE 100TH DAY. *MEDICARE DOES NOT PAY FOR SERVICES BEYOND THE 100TH DAY DURING A BENEFIT PERIOD.*

The Plan Pays:

- The *Medicare Part A co-payment* for *skilled nursing facility* services received from the 21st to the 100th day per *benefit period*.

MEDICAL BENEFITS (PART B)

Part B refers to the portion of the *Medicare* Program which provides benefits for *physician* services, outpatient *hospital* care, outpatient X-rays and laboratory procedures, local ground ambulance and other specified health services and supplies.

After you have met the *Medicare* Part B deductible each *year*, the *plan* pays **100%** of the difference between *Medicare's* Allowable Charge(s) and the amount *Medicare* pays for *medically necessary* Part B services and supplies, SUBJECT TO ANY MAXIMUMS STATED BELOW. The *plan* will also pay benefits (up to *Medicare's* Allowable Charge amount) for the first three pints of unreplaced blood, packaged red blood cells or any other blood derivative received during each *year* unless already paid for under Part A.

The *plan* will provide payment for its portion of the Part B benefits only when services are allowed by *Medicare* and *Medicare* has provided benefits for the same services.

The following paragraphs describe what you pay, what *Medicare* pays and what the *plan* pays:

HOSPITAL OUTPATIENT BENEFITS

You Pay:

- The *Medicare* Part B deductible.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge amount for covered *hospital* outpatient services listed below.

The Plan Pays:

- **20%** of *Medicare's* Allowable Charge amount for the covered *hospital* outpatient services listed below, after you have met the *Medicare* Part B deductible.

Covered Services:

- Outpatient medical care.
- Outpatient surgical treatment.
- Radiation therapy, chemotherapy and hemodialysis treatment.

PROFESSIONAL SERVICES AND SUPPLIES

You Pay:

- The *Medicare* Part B deductible.
- Any amounts in excess of *Medicare's* Allowable Charge amount.
- Any amounts in excess of the *plan's* yearly maximum benefits for certain services, as stated in the section entitled COVERED SERVICES.

Medicare Pays:

- **80%** of *Medicare's* Allowable Charge amount for covered professional services and supplies.

The Plan Pays:

- **20%** of *Medicare's* allowable charge amount for covered professional services and supplies listed below, subject to any stated maximums, after you have met the *Medicare* Part B deductible.

Covered Services:

- *Physicians'* services for surgery and surgical assistance.
- Anesthesia during surgery.
- Consultations requested by the attending *physician*.
- Visits of a *physician* during a covered *hospital stay*, including a *hospital stay* for *mental or nervous disorders* or substance abuse.
- Radiation therapy and chemotherapy.
- A *physician's* services for outpatient *emergency* care.
- A *physician's* services for home or office visits.
- Diagnostic radiology and laboratory services.
- Routine and diagnostic mammograms, mastectomy, complications from a mastectomy, reconstructive surgery following mastectomy, and breast prostheses following mastectomy.
- Medical supplies, rental or purchase of durable medical equipment, including therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications

- Contraceptive services and supplies, limited to injectable drugs and implants for birth control, IUDs and diaphragms dispensed by a *physician*, and the services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your *physician* determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and prescribed by your *physician*.

- Diabetes instruction program which: (1) 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; (2) 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 (3) is supervised by a *physician*.
- Ground and air ambulance services of a licensed ambulance company to or from the nearest *hospital* or *skilled nursing facility*. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

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.

- Blood and blood plasma beginning with the fourth pint during any *year*.
- The first pair of contact lenses or the first pair of eyeglasses following eye surgery.
- Physical therapy and occupational therapy.
- Chiropractic services.
- Speech therapy.
- Outpatient care for *mental* or *nervous disorders* and substance abuse.
- **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement, limited to **\$300** per *calendar year*.

HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED

When you have used all of your *Medicare* Part A benefit days during a *benefit period* and all of your *Medicare* lifetime reserve days are exhausted, the *plan* will provide additional *hospital* benefits for the remainder of that *benefit period*.

1. Days Covered

THE COVERED SERVICES LISTED BELOW ARE LIMITED TO A LIFETIME MAXIMUM OF 365 DAYS.

2. Payment

The *plan* provides payment for **100%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You will pay only covered expenses in excess of *reasonable charges*.

3. Covered Services

The following services of a *hospital* are covered:

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that *hospital* if a private room is used.
- Services in *special care units*.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical therapy, radiation therapy, chemotherapy, and hemodialysis treatment.
- Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- Services must be those which are regularly provided and billed by a *hospital*.
- Services are provided only for the number of days required to treat your illness, injury or condition.

BENEFITS BEYOND MEDICARE

In addition to the *Medicare* benefits shown above (as described in HOSPITAL INPATIENT BENEFITS (PART A), MEDICAL BENEFIT (PART B) and HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED), the *plan* will provide additional benefits as described below.

1. Payment

The *plan* provides payment for **100%** of billed *reasonable charges*, up to any applicable maximums, for *medically necessary* services listed below. You will pay only covered expenses in excess of *reasonable charges*.

2. Covered Services

The following services are covered:

- Inpatient *hospital* services for the treatment of substance abuse. The *plan* will pay up to 515 days during your lifetime.
- Services provided by a *home health agency* when skilled nursing care is no longer needed. The *plan* will pay up to \$40.00 per visits and for up to \$1,600.00 during a calendar year for eight additional weeks of at-home help.

BENEFITS OUTSIDE THE UNITED STATES

When you require medical care outside the *United States*, before the *plan* pays for the benefits listed below, you are required to pay a separate \$250.00 deductible. The *plan* provides benefits for 60 days for each trip and will pay up to a maximum of \$50,000.00 during your lifetime. These benefits are subject to all provisions of the *plan*, which may limit benefits or result in benefits not being payable.

Special Instructions for Foreign Claims Submission

When you submit a claim to the *claims administrator* for medical care services rendered outside the *United States*, you must include any canceled checks, receipts or other documents you receive in connection with those services along with your properly completed claim form.

If you receive drugs or medicines during an inpatient or outpatient hospital admission outside the *United States*, you should ask the provider of service to include the chemical or generic name of the drug on your bill.

INPATIENT HOSPITAL SERVICES

Your *hospital* care must be rendered in a facility which is properly licensed and accredited as a *hospital* in the country where services are rendered. The *plan* provides benefits for services of a *hospital* as follows:

1. Days Covered

THE COVERED SERVICES LISTED BELOW ARE LIMITED TO A TOTAL OF 90 DAYS FOR EACH *HOSPITAL STAY*. IF THERE ARE FEWER THAN 60 DAYS BETWEEN *HOSPITAL STAYS*, THAT ENTIRE PERIOD WILL BE CONSIDERED TO BE ONE *HOSPITAL STAY*.

2. Payment

- You pay your \$250.00 deductible and **20%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You will also be responsible for any charges in excess of *reasonable charges*.
- The *plan* provides payment for **80%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*.

3. Covered Services

The following services of a *hospital* are covered:

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that *hospital* if a private room is used.
- Services in *special care units*.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- Services must be those which are regularly provided and billed by a *hospital*.
- Services are provided only for the number of days required to treat your illness, injury or condition.

OUTPATIENT HOSPITAL SERVICES

1. Payment

- You pay your \$250.00 deductible and **20%** of billed *reasonable charges* for *medically necessary* outpatient services listed below when provided by a *hospital*. You will also be responsible for any charges in excess of *reasonable charges*.
- The *plan* provides payment for **80%** of billed *reasonable charges* for *medically necessary* outpatient services listed below when provided by a *hospital*.

2. Covered Services

- *Emergency* room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.

- Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.

3. **Conditions of Service**

- Services must be those which are regularly provided and billed by a *hospital*.
- *Emergency* room care must be for the first treatment of an *emergency*.

PROFESSIONAL MEDICAL BENEFITS

Your professional medical care must be rendered by a provider who is properly licensed and accredited as a *physician* in the country where services are provided. The *plan* provides benefits for professional medical services as follows:

1. **Payment**

- You pay your \$250.00 deductible and **20%** of billed *reasonable charges* for *medically necessary* services listed below. You will also be responsible for any charges in excess of *reasonable charges*.
- The *plan* provides payment for **80%** of billed *reasonable charges* for *medically necessary* services listed below.

2. **Covered Services**

- Surgery and surgical assistance.
- Anesthesia during surgery.
- Visits during a covered *hospital stay* (except those relating to surgery), limited to one per day unless additional visits are needed due to your medical condition.

EXCLUSIONS AND LIMITATIONS

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, 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 dermatoses or acupuncture points.

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

Chronic Pain. Inpatient room and board charges in connection with a *hospital stay* primarily for treatment of chronic pain.

Clinical Trials. Services and supplies provided in connection with a clinical trial except for routine costs associated with a clinical trial for which *Medicare* provides benefits.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated under "Covered Services" in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B).

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

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

Custodial Care and Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures. 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 under in the "Skilled Nursing Facility" provision of HOSPITAL INPATIENT BENEFITS (PART A).

Dental Services or Supplies. Cosmetic dental surgery or other dental services for beautification. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except for surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a *physician*.

This exclusion also does not apply to general anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or ambulatory surgical center. This applies only if you are developmentally disabled or your health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

Education or Counseling. Educational services, nutritional counseling or food supplements.

Excess Amounts. Any amounts in excess of:

1. Allowable Charges as determined by *Medicare*, for benefits provided under the sections entitled HOSPITAL INPATIENT BENEFITS (PART A) and MEDICAL BENEFITS (PART B); and
2. *Reasonable charges*, as the *claims administrator* determines, for benefits provided under the sections entitled HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED, BENEFITS BEYOND MEDICARE and BENEFITS OUTSIDE THE UNITED STATES; and
3. Any maximum payments and benefits stated in this booklet.

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

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Hearing Aids or Tests. Hearing aids and routine hearing tests.

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.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Medicare Part B Deductible. Any charges you incur that are applied toward your *Medicare* Part B deductible.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* and substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Hospital Inpatient Benefits for Mental or Nervous Disorders" provision of HOSPITAL INPATIENT BENEFITS (PART A), in the "Professional Services and Supplies" provision of MEDICAL BENEFITS (PART B) and "Covered Services" provision of BENEFITS BEYOND MEDICARE.

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

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 us.

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.

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

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity as determined by the *claims administrator* if they authorize the treatment in advance as *medically necessary* and appropriate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Orthodontia. Braces and other orthodontic appliances or services.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

Outpatient Physical and Occupational Therapy. Outpatient physical and occupational therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B) and “Covered Services” provision of BENEFITS BEYOND MEDICARE.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

Outpatient Speech Therapy. Outpatient speech therapy, except as specifically stated in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

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. Inpatient or outpatient services of a private duty nurse.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated under “Covered Services” in the “Professional Services and Supplies” provision of MEDICAL BENEFITS (PART B).

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

Services outside the United States. Services and supplies provided outside the *United States*, except as specifically stated in the section entitled BENEFITS OUTSIDE THE UNITED STATES.

Sterilization Reversal. Reversal of sterilization.

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

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

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

Work Related. Work related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in SUBROGATION AND REIMBURSEMENT.

SUBROGATION AND REIMBURSEMENT

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

SUBROGATION

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

1. CVT has first priority from any Recovery for the full amount of benefits they have paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
2. You and your legal representative must do whatever is necessary to enable CVT to exercise their rights and do nothing to prejudice those rights.
3. In the event that you or your legal representative fail to do whatever is necessary to enable CVT to exercise their subrogation rights, CVT shall be entitled to deduct the amount CVT paid from any future benefits under the *plan*.
4. CVT has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the *plan*.
5. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full CVT's subrogation claim and any claim held by you, CVT's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
6. CVT is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without CVT's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the *plan*.

REIMBURSEMENT

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

1. You must reimburse CVT from any Recovery to the extent of benefits the *plan* paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
2. Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, CVT shall have a right of full recovery, in first priority, against any Recovery. Further, CVT's rights will not be reduced due to your negligence.
3. You and your legal representative must hold in trust for CVT the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to CVT immediately upon your receipt of the Recovery. You 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 *plan* 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 trustee 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. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a *subscriber* 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 a plan which covers you as a *subscriber*.

For example: You are covered as a retired *subscriber* under this *plan* and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired *subscriber* will pay last, after Medicare.

3. 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 employees, provision 5 applies.
4. 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.

5. 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.

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.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscriber.** The persons described in the *participation agreement* are eligible to enroll as a *subscriber* if he or she is a *retired employee* who is actively enrolled under both Part A and Part B of *Medicare*.
2. **Family Members.** The *subscriber's spouse* or *domestic partner* is eligible to be enrolled as a *family member*, provided that the *spouse* or *domestic partner* is actively enrolled under both Part A and Part B of *Medicare*.
 - a. **Spouse of Employee:** A spouse of an enrolled employee is eligible for coverage. **(Marriage Certificate is required for enrollment.)**
 - b. **State Registered Domestic Partner:** A state registered (same sex or over 62 opposite sex) domestic partner is eligible for coverage. **(State Registration Certificate is required for enrollment.)**

<p>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.</p>

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 Retiree Guidelines.

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

- **New Spouse:** A new spouse is eligible to enroll for coverage within 31 days of the date of the marriage to the employee. An enrollment form for the new spouse 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 is required.)**
- **New Domestic Partner:** A domestic partner is 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. 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 is required.)**

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 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 person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either a *subscriber* enrolled *spouse*. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including a *spouse* acquired during the COBRA continuation period. 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 the Spouse:

- 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 the Spouse. Cancellation or a substantial reduction of benefits under the *plan* for retired employees and the *spouse* 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 the Spouse:

- a. The death of the *subscriber*; or
- b. The *spouse's* divorce from the *subscriber*.

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or enrolled *spouse* 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 *spouse* 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 Event 3(a) above, a *spouse* will be notified of the COBRA continuation right.
3. You must inform the *participating employer* within 60 days of Qualifying Event 3(b) 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 both *family members*, or for the *subscriber* only, or for the *spouse* only.

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* acquired during the COBRA continuation period is eligible to be enrolled, provided that the *spouse* meets the eligibility requirements specified in HOW COVERAGE BEGINS.. 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 a *spouse* whose COBRA continuation began due to divorce or death of the *subscriber*.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *member*, who is a Qualified Beneficiary, 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 *spouse* 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 *spouse* 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 a *spouse* 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*, or divorce.*
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 coverage, the *member* first becomes covered under any other group health plan.

*For a *member* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*.

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 *spouse* may continue coverage for 36 months after the *subscriber's* death. But coverage could terminate prior to such time for either the *subscriber* or *spouse* in accordance with items 3, 4 or 5 above.

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, 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.

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

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

An enrolled *domestic partner* 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 a *domestic partner*. 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* 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 covered under any other group health plan.
6. The date the maximum benefits of this *plan* are paid.
7. The end of the period for which required monthly contributions are last paid on the *member's* behalf.

8. 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*.

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*.

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

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

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

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

Payment to Providers. Benefits of this *plan* will be paid directly to *contracting hospitals* and medical transportation providers. Also, pay *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill CVT's obligation to you for those covered services.

Care Coordination. We pay *participating providers* in various ways to provide covered services to you. For example, sometimes we may pay *participating providers* a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay *participating providers* 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 us because they did not meet certain standards. You do not share in any payments made by *participating providers* to us under these programs.

Right of Recovery. When the amount paid exceeds CVT's liability under this *plan*, CVT has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

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

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

Entitlement to Medicare Benefits. CVT has the right to require that you furnish information concerning your entitlement to *Medicare* benefits. CVT may need this information to determine your eligibility under the *plan*.

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*.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, the *plan* will provide benefits 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 *claims administrator* terminates the provider's contract (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

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 *claims administrator* is not required to continue the provider's services beyond the contract termination date.

The *plan* will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. 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.

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*.

The *claims administrator* will notify you 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 *claims administrator* will request that the terminated provider 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, the *claims administrator* is not required to continue that provider's services. If you disagree with the *claims administrator's* determination regarding continuity of care, you may file a complaint as described in the COMPLAINT NOTICE.

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](https://www.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 services that *Medicare* determines to be allowable and are considered *medically necessary* and satisfy all other terms and conditions of this *plan*. The fact that a *physician* prescribes or orders a service does not, in itself, mean that the service is *medically necessary* or that the service is a covered expense. Consult this *benefit booklet* or telephone the *claims administrator* at the number shown on your identification card if you have any questions regarding whether services are covered.

The *claims administrator* has responsibility for determining whether services are *medically necessary*. That determination will be made during claims review, unless *Medicare* has determined that the services are allowable.

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 requested over the telephone or 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 may 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. By calling Customer Service or in writing, and
2. Within 60 days of receiving the original denial when the request is for reconsideration, or
3. Within 30 days of receiving the reconsidered determination when the request is for an appeal.

Requests must include the following:

1. Any medical information that supports the medical necessity of the services for which payment was denied, and any other information you or your *physician* feels should be considered, and
2. A copy of the original denial.

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

BINDING ARBITRATION

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

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

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

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

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

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

NOTE: If you wish to appeal a decision made by *Medicare* and not by CVT, you must initiate the appeal process by contacting your local Social Security Administration office.

DEFINITIONS

The meanings of key terms used in this 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 booklet, you should refer to this section.

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

Benefit period, as defined by *Medicare* for inpatient *hospital* and *skilled nursing facility* services (Part A), begins when you first enter a *hospital* after your *Medicare* insurance begins. In no event will a new benefit period start until you have been discharged and have remained out of the *hospital* or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), Benefit period is defined as a calendar *year*.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan*.

Contracting hospital is a hospital which has a Standard Hospital Contract with the *claims administrator* to provide care to you.

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.

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

CVT is the California's Valued Trust.

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 a medical or psychiatric *emergency*.

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

Family member means the *subscriber's* enrolled *spouse* or *domestic partner*.

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).

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* or *nervous disorder* or substance abuse), and (2) *residential treatment centers*.

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

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

Medically necessary services, procedures, equipment or supplies are those which are:

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 the convenience of your *physician* or another provider;
6. Not more costly than an equivalent service 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.

NOTE: The *plan* will accept *Medicare's* determination of medical necessity.

Medicare is the name commonly used to describe "Health Insurance Benefits for the Aged and Disabled" provided under Public Law 89-97 and its amendments.

Medicare co-payment is that portion of the Medicare approved amount not paid by Medicare for covered inpatient *hospital* days, lifetime reserve days, *skilled nursing facility* days and Professional (Part B) services, not including amounts applied to the Part A or Part B deductibles. Medicare may increase the co-payment amounts for certain services.

Member is the *subscriber* or covered *spouse* or *domestic partner* of the *subscriber*.

Mental or nervous disorders, including substance abuse, for the purposes of this *plan*, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental or nervous disorders include severe mental disorders as defined in this plan (see definition of “severe 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.

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

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

Physician means:

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

- o. A nurse midwife
- p. Any agency licensed by the state to provide services for the treatment of *mental or nervous disorders* or substance abuse, when required by law to cover those services.
- q. 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

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

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.

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.

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.

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

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

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

Retired employee is a former full-time employee who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

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

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

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

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.

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

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

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

Totally disabled family member is a *family member* who is unable to perform all activities usual for persons of that age.

Totally disabled retired employee is a *retired employee* who is unable to perform all activities usual for persons of that age.

United States means all the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Northern Mariana Islands, Guam and American Samoa.

Year or calendar year is a 12 month period starting each 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*.

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 www.anthem.com/resources.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health 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.

Oral interpretation services are available in additional 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.

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 مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك
(TTY/TDD: 711) للمساعدة

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 मुफ्त 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

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ
និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើកាត ID
របស់អ្នកដើម្បីទទួលបានជំនួយ។(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 information written in other 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 Anthem Blue Cross' Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a complaint with CVT in writing to Kymberly Gilpin, 520 E Herndon Ave., Fresno, CA 93720.