CALIFORNIA

CALIFORNIA SCHOOLS VEBA

VEBA Direct

Combined Evidence of Coverage and Disclosure Form (HMO)

January 1, 2024

Welcome to California Schools VEBA – VEBA Direct

California Schools Voluntary Employees Benefits Association (VEBA) – VEBA Direct ("VEBA Direct" or "Health Plan") provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, **see Section 7. Member Eligibility.** As Plan Sponsor for VEBA Direct, VEBA is responsible for contracting with health care providers who provide health care services for VEBA Direct Members. VEBA Direct has contracted with United Healthcare to be the Third-Party Administrator ("TPA" or "the TPA" or "VEBA Direct's TPA").

What is This Document?

This document is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Health Plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 10. Definitions.**

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership. You will learn about important topics like how to choose a Primary Care Physician (PCP) and what to do if you need hospitalization.

This *Combined Evidence of Coverage and Disclosure Form* includes:

- The *Schedule of Benefits*, including the HMO *Schedule of Benefits and Acupuncture Schedule of Benefits, if purchased.*
- The supplements to the *Combined Evidence of Coverage and Disclosure Form* including the *Outpatient Prescription Drug Benefit.*
- *Language Assistance Disclosure Notic*e.

What Else Should I Read to Understand My Benefits?

VEBA Direct has a specifically defined Provider Network. You must receive all Covered Health Care Services through your VEBA Direct Network Medical Group shown on your identification (ID) card, except for the following:

- Emergency Health Care Service provided by an Out-of-Network Provider;
- Urgently Needed Services provided by an Out-of-Network Provider;
- Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician when not Emergency Health Care Services. For these Covered Health Care Services. "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary;
- Air ambulance transport provided by an Out-of-Network Provider;
- Authorized post-stabilization care; or
- Other specific services authorized by your VEBA Direct Network Medical Group, when you are away from the geographic area served by your VEBA Direct Network Medical Group.

In addition to reading this document, be sure to review your *Schedule of Benefits, Provider Directory,* ID card, and any benefit materials. Your *Schedule of Benefits* provides the details of your particular Health Plan, including any Co-payments and Deductibles that you may have to pay when you receive Covered Health Care Services. The *Provider Directory* has detailed information about your specific VEBA Direct Network Medical Groups and other Providers, as well as the Service Area for this Network. If you would like help picking your PCP, please call

the telephone number on your ID card. You can find an online version of the provider directory at **www.myuhc.com**. These documents explain your coverage.

Not all VEBA Direct Network Providers may be part of the defined Network selected by your Employer Group and shown on your ID card. You must choose a PCP from the assigned Network to obtain the group benefits purchased by your employer. If you need a copy or would like help picking your PCP from the defined Network, please call the TPA at the telephone number on your ID card.

For certain Covered Health Care Services, a limit is placed on the total amount you pay for Co-payments and Deductibles, if applicable, during a calendar or plan year. If you reach your out-of-pocket limit, you may not be required to pay additional Co-payments or Deductibles for certain Covered Health Care Services.

You can find your Out-of-Pocket Limit in your *Schedule of Benefits*. If you believe you have met your Deductible or Out-of-Pocket Limit, submit all your health care receipts and a letter of explanation to the TPA, to the address shown below. It is important to send us all health care receipts along with your letter since they confirm that you have reached your annual out-of-pocket limit.

What if I need information about the Plan in my language?

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may be available in some languages at no charge. To get help in your language, please call your Health Plan's TPA1-800-624-8822 / TTY: 711.

What if I Still Need Help?

After you become familiar with your benefits, you may still need help. Please do not hesitate to call VEBA Direct's TPA at 1-800-624-8822 or 711 (TTY).

Note: Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provide the terms and conditions of your coverage with VEBA Direct and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with UnitedHealthcare at the following address:

UnitedHealthcare of California
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

UnitedHealthcare's website is:

www.myuhc.com

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SECTION 1. GETTING STARTED: YOUR PRIMARY CARE PHYSICIAN

What is a PCP?

What is a Subscriber?

What is a VEBA Direct Network Medical Group?

Your *Provider Directory*

Choosing Your PCP

Continuity of Care

One of the first things you do when joining VEBA Direct is to choose a PCP. This is the doctor in charge of overseeing your care through VEBA Direct. This section explains the role of the PCP, as well as how to make your choice. You will also learn about your VEBA Direct Network Medical Group and how to use your *Provider Directory.*

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Introduction

Now that you are a VEBA Direct Member, it is important to become familiar with the details of your coverage. Reading this document will help you understand your coverage and health care benefits. It is written for all our Members receiving this plan, whether you are the Subscriber or an enrolled Family Member.

Please read this *Combined Evidence of Coverage and Disclosure Form* along with any supplements you may have with this coverage. You should also read and become familiar with your *Schedule of Benefits*, which lists the benefits and costs specific to your plan.

What is a PCP?

When you become a Member of VEBA Direct, one of the first things you do is choose a doctor to be your PCP. This is a doctor who is contracted with VEBA Direct and who is mainly responsible for the coordination of your health care services. A PCP is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology. Others may take part in the coordination of your health care services, such as a Hospitalist (Please refer to *Section 2. Seeing Your Doctor or Other Providers and Timely Access To Care* for information on Hospitalist programs).

Unless you need Emergency Health Care Services or Urgently Needed Services, your PCP is your first stop for using these medical benefits. Your PCP will also seek authorization for any referrals, as well as begin any necessary Hospital Services. Either your PCP or a Hospitalist may provide the coordination of any needed Hospital Services.

All Members of VEBA Direct are required to have a PCP. If you do not choose one when you enroll, UnitedHealthcare will choose one for you. Except in an urgent or emergency situation or as described under *Out-of-Area Services* below, if you see another health care Provider without the approval of either your PCP, Network Medical Group or VEBA Direct, the costs for these services will not be covered.

What is the Difference Between a Subscriber and an Enrolled Family Member?

While both are Members of VEBA Direct, there is a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the Employer Group and VEBA Direct. A Subscriber may also contribute toward a portion of the premiums paid to VEBA Direct for his or her health care coverage for him or herself and any enrolled Family Members. An enrolled Family Member is someone such as legal spouse, Domestic Partner, or child whose Dependent status with the Subscriber allows him or her to be a Member of VEBA Direct. Why point out the

difference? Because Subscribers often have special responsibilities, including sharing benefit updates with any enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this document. If you are a Subscriber, please pay attention to any instructions given specifically for you. For a more detailed explanation of any terms, see ***Section 10***: ***Definitions***.

A STATEMENT DESCRIBING VEBA DIRECT TPA'S POLICIES AND PROCEDURES FOR MAINTAINING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE PROVIDED TO YOU UPON REQUEST.

Choosing a PCP

When choosing a PCP, you should always make certain your doctor meets the following criteria:

- Your doctor is chosen from the list of PCPs in VEBA Direct's *Provider Directory*.
- Your doctor is located within 30 miles of either your Primary Residence or Primary Workplace.

You'll find a list of our Network PCPs in the *Provider Directory*. It is also a source for other valuable information. (**Note:** If you are pregnant, please read the section below, "What to do If You Are Pregnant," to learn how to choose a PCP for your newborn.)

What is a Network Medical Group?

When you choose a PCP, you are also choosing a Network Medical Group. This is the group that is affiliated with both your doctor and VEBA Direct. If you need a referral to a Specialist or Non-Physician Health Care Practitioner, you will generally be referred to a doctor, Non-Physician Health Care Practitioner or service within this Network Medical Group. Since Network Medical Groups are independent contractors not employed by VEBA Direct, each has its own specific Network of affiliated Specialists and Providers. Only if a Specialist, Non-Physician Health Care Practitioner or service is unavailable will you be referred to a health care Provider outside your Network Medical Group.

To learn more about a particular Network Medical Group, look in your *Provider Directory* where you will find addresses and phone numbers, and other important information about hospital affiliations or any restrictions on the availability of certain Providers.

Your Provider Directory – Choice of Physicians and Hospitals (Facilities)

Along with listing our Network Physicians, your *Provider Directory* has detailed information about our Network Medical Groups and other Providers. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like help choosing your PCP, please call the TPA at the telephone number on your ID card. You can also find an online version of the Directory at **www.myuhc.com**.

If you receive a Covered Health Care Service from an Out-of-Network Provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network Provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment and applicable Deductible) that would be no greater than if the service had been provided from a Network Provider.

Note: If you are seeing a Network Provider who is not a part of a VEBA Direct Network Medical Group, your doctor will coordinate services directly with the TPA.

Choosing a PCP for Each Enrolled Family Member

Every VEBA Direct Member must have a PCP; however, the Subscriber and any enrolled Family Members do not need to choose the same doctor. Each VEBA Direct Member can choose his or her own PCP, so long as the doctor is chosen from VEBA Direct's list of PCPs and the doctor is located within 30 miles of either the Member's Primary Residence or Primary Workplace.

If a Family Member does not make a selection during enrollment, the TPA will choose the Member's PCP. (**Note:** If an enrolled Family Member is pregnant, please read below to learn how to choose a PCP for the newborn.)

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Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new Member of VEBA Direct, you may be able to continue receiving services from an Out-of-Network Provider to allow for the Completion of Covered Health Care Services provided by an Out-of-Network Provider, if you were receiving services from that Provider at the time your coverage became effective, for one of the Continuity of Care Conditions as limited and described in **Section 10. Definitions**.

This continuity of care help is intended to facilitate the smooth transition in medical care across health care delivery systems for new Members who are undergoing a course of treatment when the Member or the Member's employer changes Health Plans during the Open Enrollment Period.

For a newly enrolled Member to continue receiving care from an Out-of-Network Provider, the following conditions must be met:

1. Your Employer Group did not offer you a PPO plan or other plan that would provide you with an out-of-Network benefit or would allow you to continue to obtain services from your Out-of-Network Provider.
2. A request for continuity of care services from an Out-of-Network Provider must be submitted to UnitedHealthcare within 30 calendar days from your effective date on the Health Plan for review and approval.
3. The requested treatment must be a Covered Health Care Service under this Health Plan.
4. The Out-of-Network Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon VEBA Direct's Network Providers, including location within VEBA Direct's Service Area, payment methodologies and rates of payment.

Covered Health Care Services for the Continuity of Care Condition under treatment by the Out-of-Network Provider will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable; and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Network Provider as determined by a TPA Medical Director in consultation with the Member, the Out-of- Network Provider and, as applicable, the newly enrolled Member's assigned Network Provider.

Continuity of care also applies to those new VEBA Direct Members who are receiving Mental Health Care Services from an Out-of-Network Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of Mental Health Care Services may continue to receive Mental Health Care services from an Out-of-Network Provider for a reasonable period of time to safely transition care to a Mental Health Network Provider. Please refer to Medical Benefits and Exclusions and Limitations in **Section 5. Your Medical Benefits** of the VEBA Direct *Combined Evidence of Coverage and Disclosure Form*, and additional Mental Health Care Services coverage information. For a description of coverage of Mental Health Care Services and Substance-Related and Addictive Disorder Services, please refer to **Section 5. Your Medical Benefits**. An Out- of-Network Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the Network of Providers from whom the Member is entitled to receive Covered Health Care Services.

Complete and return the form to the TPA as soon as possible, but no later than 30 calendar days of the Member's effective date of enrollment. Exceptions to the 30-calendar-day time frame will be considered for good cause. The address is:

UnitedHealthcare
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 30968
Salt Lake City, UT 84130-0968

Questions about your benefits? Call VEBA's Advocacy Team at (888) 276-0250 or UnitedHealthCare's Customer Service Department at 1-800-624-8822 or 711 (TTY)

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Fax: 1-888-361-0514

All continuity of care requests will be reviewed on a case-by-case basis. We will consider the severity of the newly enrolled Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

The TPA will complete a clinical review of your continuity of care request for the Completion of Covered Health Care Services with an Out-of-Network Provider and the decision will be made and communicated in a timely manner appropriate to the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five business days of the TPAs receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States' mail, within two business days of making the decision. If your request for continued care with an Out-of-Network Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of VEBA Direct's continuity of care process, or want to appeal a denial, please call the TPA at the telephone number listed on your ID card.

Please Note: It is not enough to simply prefer receiving treatment from a former Physician or other Out-of-Network Provider. You should not continue care with an Out-of-Network Provider without our formal approval. If you do not receive Prior Authorization from VEBA Direct, payment for routine services performed by an Out-of-Network Provider will be your responsibility.

What to do If you are Pregnant?

Every Member of VEBA Direct needs a PCP, including your newborn. Newborns are assigned to the mother's Network Medical Group from birth until discharge from the Hospital. You may request to reassign your newborn to a different PCP or Network Medical Group following the newborn's discharge by calling the TPA. If a PCP is not chosen for your child, the newborn will remain with the mother's PCP or Network Medical Group. If you call the TPA by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call the TPA on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call the TPA on June 16th, the transfer will be effective August 1st. In order for coverage to continue beyond the first 60 days of life, the Subscriber must submit a request to add the baby to his or her Employer Group prior to the expiration of the 60-day period to continue coverage beyond the first 60 days of life. If you do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth).

If your newborn has not been discharged from the hospital, is being followed by the Case Management or is receiving acute institutional or non-institutional care at the time of your request, a change in your newborn's PCP or Network Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When the TPA's Case Management is involved, the case manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing PCPs in **Section 4. Changing Your Doctor or Medical Group**. For more information on how we may coordinate your newborn's benefits, please see **Section 6. Coordination of Benefits** and for more information about adding a newborn to your coverage, see **Section 7. Member Eligibility.**

Does your Group or Hospital Restrict any Reproductive Services?

Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Health Plan contract and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective

doctor, medical group, independent practice association, or clinic, or call the TPA 1-800-624-8822 or 711 (TTY) to ensure that you can get the health care services that you need.

If you have chosen a Network Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call the TPA.

SECTION 2. SEEING THE DOCTOR OR OTHER PROVIDERS AND TIMELY ACCESS TO CARE

Scheduling Appointments

Referrals to Specialists

OB/GYN and Other Services/ Getting Care Without a Referral

Second Medical Opinions

Prearranging Hospital Stays

24-Hour Support and Information

Timely Access To Care

Now that you have chosen a PCP, you have a doctor for your routine health care.

This section will help you begin taking advantage of your health care coverage. It will also answer common questions about seeing a Specialist and receiving medical services that are not Emergency Health Care Services or Urgently Needed Services. (For information on Emergency Health Care Services or Urgently Needed Services, please turn to **Section 3**.)

Seeing the Doctor: Scheduling Appointments

To visit your PCP, simply make an appointment by calling your doctor's office.

Your PCP is your first stop for accessing routine, non-emergent care. No Physician or other health care services will be covered without an authorized referral from your PCP except for Emergency Health Care Services, Urgently Needed Services, services described under *Out-of-Area Services*, and exceptions found below under "OB/GYN and Other Services/ Getting Care Without a Referral".

When you see your PCP or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Co-payment and Deductible, if applicable. The amount of a Co-payment depends upon the Covered Health Care Service. Your Co-payments and Deductibles are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 6. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

The PCP you have chosen will coordinate your health care needs. If your PCP determines you need to see a Specialist or Non-Physician Health Care Practitioner, he or she will make an appropriate referral with the exception of obstetrical and gynecological (OB/GYN) Physician visits and Mental Health and Substance Related and Addictive Disorder office visits to which you will have direct access.

Your plan may not cover services provided by all Non-Physician Health Care Practitioners. Please refer to the Medical Benefits and Exclusions and Limitations section in this *Combined Evidence of Coverage and Disclosure Form* for further information regarding Non-Physician Health Care Practitioner services excluded from coverage or limited under this Health Plan.

Your PCP will determine the number of Specialist or Non-Physician Health Care Practitioner visits that you require and will provide you with any other special instructions. This referral may also be reviewed by, and may be subject to the approval of, the PCP's Utilization Review Committee. For more information regarding the role of the Utilization Review Committee, please see **Section 10: Definitions for** the definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

Standing Referrals to Specialists

A standing referral is a referral by your PCP that authorizes more than one visit to a network Specialist. A standing referral may be provided if your PCP, in consultation with you, the Specialist and the TPA's medical director, determines that as part of a treatment plan you need continuing care from a Specialist. You may request a standing referral from your PCP or VEBA Direct. **Please Note:** A standing referral and treatment plan is only allowed if approved by your Network Medical Group.

Your PCP will specify how many Specialist visits are authorized. The treatment plan may limit your number of visits to the Specialist and the period for which visits are authorized. It may also require the Specialist to provide your PCP with regular reports on your treatment and condition.

Extended Referral for Care by a Specialist

If you have a life-threatening, degenerative or disabling condition or disease that requires specialized medical care over a prolonged period, you may receive an extended specialty referral. This is a referral to a Specialist or specialty care center so the Specialist can oversee your health care. The Physician or center will have the needed experience and skills for treating the condition or disease.

You may request an extended specialty referral by asking your PCP or VEBA Direct. Your PCP must then determine if it is Medically Necessary. Your PCP will consult with the Specialist or specialty care center, as well as VEBA Direct's medical director.

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your VEBA Direct's medical director. This is done by consulting with your PCP, the Specialist and you.

Once the extended specialty referral begins, the Specialist begins serving as the main coordinator of your care. The Specialist does this in agreement with your treatment plan.

OB/GYN and Other Services/ Getting Care Without a Referral

Women may receive obstetrical and gynecological (OB/GYN) Physician services directly from a Network OB/GYN, family practice Physician, or surgeon shown by your Network Medical Group as providing OB/GYN Physician services. This means you may receive these services without Prior Authorization or a referral from your PCP. In all cases, however, the doctor must be affiliated with your VEBA Direct Network.

Please Remember: if you visit an OB/GYN or family practice Physician not affiliated with your Network Medical Group without Prior Authorization or a referral, you will be financially responsible for these services. All OB/GYN inpatient or Hospital Services, except Emergency Health Care Services or Urgently Needed Services, need to be authorized in advance by VEBA Direct's TPA.

If you would like to receive OB/GYN Physician services, simply do the following:

- Call the telephone number on the front of your Health Plan ID card and request the names and telephone numbers of the OB/GYNs affiliated with your VEBA Direct network;
- Contact your Network OB/GYN to schedule an appointment.

After your appointment, your OB/GYN will contact your PCP about your condition, treatment and any needed follow-up care.

VEBA Direct also covers important wellness services for our Members. For more information, see Health Education Services in **Section 5. Your Medical Benefits**.

Additionally, for reproductive and sexual health care services, prior approval from your PCP or Network Medical Group or the Health Plan is not necessary. Such services include:

- Prevention or treatment of pregnancy.
- Screening, prevention, diagnosis and treatment of an infectious, communicable or sexually transmitted disease, including HIV and HIV testing.
- Abortion
- Rape including the medical care related to the diagnosis or treatment of the condition and the collection of medical evidence and may be provided under Section 3. Emergency Health Care Services.
- Sexual assault including the medical care related to the diagnosis or treatment of the condition and the collection of medical evidence.

VEBA Direct's TPA may establish reasonable provisions governing utilization procedures for obtaining services. Although Prior Authorization is not needed, you may be able to receive these services from your Network Medical Group.

Mental Health Care and Substance Related and Addictive Disorder Services/ Getting Care Without a Referral

You may receive covered Mental Health Care and Substance Related and Addictive Disorder Services directly from a U.S. Behavioral Health Plan, California (USBHPC) Network behavioral health professional. This means you may receive these services without Prior Authorization or a referral from your PCP. In all cases, however, the behavioral health professional must be affiliated with USBHPC's Network with the exception of Emergency Health Care Services and out of area Urgently Needed Services.

Second Medical Opinions

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Provider. This Provider must be either a PCP or a Specialist acting within his or her scope of practice and must possess the clinical background needed for examining the illness or condition related to the request for a second medical opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Either you or your treating Network Provider may submit a request for a second medical opinion. Requests should be submitted to your Network Medical Group; however, in some cases, the request is submitted to the TPA's Medical Director. To find out how you should submit your request, talk to your PCP.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment (including, but not limited to, a serious Chronic Condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Provider is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;

- When you have attempted to follow the treatment plan or consulted with the first Provider and still have serious concerns about the diagnosis or treatment.

The TPA's medical director will approve or deny a request for a second medical opinion. The request will be approved or denied in a timely fashion appropriate to the nature of your condition. For circumstances other than an imminent or serious threat to your health, a second medical opinion request will be approved or denied within five business days after the request is received by the TPA.

When there is an imminent and serious threat to your health, a decision about your second opinion will be made within 72 hours after receipt of the request by the TPA. An imminent and serious threat includes the potential loss of life, limb or other major bodily function, or where a lack of timeliness would be harmful to your ability to regain maximum function.

If you are requesting a second medical opinion about care given by your PCP, the second medical opinion will be provided by an appropriately qualified health care professional of your choice within VEBA Direct's Network. If you request a second medical opinion about care received from a Specialist, the second medical opinion will be provided by any Specialist within the VEBA Direct Provider Network of the same or equivalent specialty.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Network Provider. It will include any recommended procedures or tests that the Provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by VEBA Direct – and the recommendation is determined to be Medically Necessary by the TPA – the treatment, diagnostic test or service will be provided or arranged by the TPA.

Please Note: The fact that an appropriately qualified Provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is Medically Necessary or a Covered Health Care Service. You will also remain responsible for paying any outpatient office Co-payments or Deductibles to the Provider who gives your second medical opinion.

If your request for a second medical opinion is denied, the TPA will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 8. Overseeing Your Health Care**. If you get a second medical opinion without Prior Authorization from VEBA Direct, you will be financially responsible for the cost of the opinion.

To receive a copy of the Second Medical Opinion timeline, you may call or write at:

UnitedHealthcare
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

What is UnitedHealthcare's Case Management Program?

The TPA has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's Network Medical Group, may help arrange care for VEBA Direct Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources. Not every Member will be assigned a case manager.

Prearranging Hospital Stays

Your PCP or Hospitalist will prearrange any Medically Necessary hospital or facility care, inpatient care provided in a subacute/Skilled Nursing Facility. If you have been referred to a Specialist and the Specialist determines you need hospitalization, your PCP or Hospitalist will work with the Specialist to prearrange your hospital stay.

Your hospital costs, including semi-private room, tests and office visits, will be covered, minus any required Co-payments, as well as any Deductibles. Under normal circumstances, your PCP or Hospitalist will coordinate your admission to a local VEBA Direct Network Hospital or Facility; however, if your situation requires it, you could be transported to a regional medical center.

If Medically Necessary, your PCP or Hospitalist may discharge you from the hospital to a subacute/Skilled Nursing Facility. He or she can also arrange for Home Health Care Visits.

Please Note: If a Hospitalist program applies, a Hospitalist may direct your inpatient hospital or facility care in consultation with of your PCP.

24-Hour Support and Information

Call the number on the back of your ID card or log into myuhc.com to get connected with a health professional at any time. Here are some of the ways they can help you:

- Choose appropriate medical care.
- Provide guidance for current symptoms 24/7 (via a clinician).
- Find doctors or hospitals that meet your needs and preferences.
- Locate an urgent care center and other health resources in your area.

To use this convenient service, simply call the telephone number on your ID card or log into myuhc.com.

Note: If you have a medical emergency, call 911 or go to the nearest emergency room.

Timely Access To Care

The purpose of the timely access law is to make sure you get the care you need. Sometimes you need appointments even sooner than the law requires. In this case, your doctor can request that the appointment be sooner.

Sometimes waiting longer for care is not a problem. Your Provider may give you a longer wait time if it would not be harmful to your health. It must be noted in your record that a longer wait time will not be harmful to your health.

If Medically Necessary care from a provider within the Medical Group cannot be arranged timely, your Medical Group will make alternate arrangements for the required care with an available and accessible Out-of-Network Provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you

would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

In-person appointment wait times:

Urgent Appointments	**Wait time**
For services that do not need Prior Authorization	48 hours
For services that do need Prior Authorization	96 hours

Non-Urgent Appointments	**Wait time**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health or substance use Provider (who is not a Physician)	10 business days
Follow-up appointments with a mental health care or substance use Provider (who is not a Physician). This does not limit coverage to once every 10 business days.	10 business days
Appointment for other services to diagnose or treat an injury, illness or other health condition	15 business days

Type of Network Provider	**Maximum Travel Distance or Travel Time**
Hospital	15 miles or 30 minutes
Primary Care Physician	15 miles or 30 minutes
Specialist	30 miles or 60 minutes
Mental Health Care Services and Substance-Related and Addictive Disorders professionals	15 miles or 30 minutes

Telephone wait times:

You can call 24-hours-a-day, 7 days a week to talk to a qualified health professional to decide if your health problem is urgent. If someone needs to call you back, they must call you within 30 minutes. Look for the phone number on your Health Plan membership card.

If you call your Health Plan's Telephone number, someone should answer the phone within 10 minutes during normal business hours.

Important Language Information:

You may be entitled to the right and services below. These rights apply only under California law. These rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the *State Department of Health Care Services*.

You can get an interpreter in any of the top 15 languages spoken by limited-English-proficient individuals at no cost to help you talk with your doctor or Health Plan. To get help in your language, please call VEBA Direct's TPA at:

UnitedHealthcare of California 1-800-624-8822 / TTY: 711

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact VEBA Direct's TPA at 1-800- 624-8822 / TTY: 711.

To request language assistance with any other matters not involving a scheduled appointment, please contact the VEBA Advocacy Team at (888) 276-0250.

If you need more help, call the *DMHC* toll-free telephone number **at 1-888-466-2219**.

CALIFORNIA SCHOOLS VEBA

SECTION 3. EMERGENCY HEALTH CARE SERVICES AND URGENTLY NEEDED SERVICES

What are Emergency Health Care Services?

What to Do When You Require Emergency Health Care Services

What to Do When You Require Urgently Needed Services

Post-stabilization and Follow-up Care

Out-of-Area Services

VEBA Direct provides coverage for Emergency Health Care Services and Urgently Needed Services wherever you are. This section will explain how to get Emergency Health Care Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

IF YOU BELIEVE YOU ARE EXPERIENCING AN EMERGENCY MEDICAL CONDITION, CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM FOR TREATMENT.

What are Emergency Health Care Services?

Emergency Health Care Services are Medically Necessary medical screening, exam and evaluation by a Physician, or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Health Care Services include the care, treatment and/or surgery by a Physician needed to stabilize or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the facility which includes admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment needed to relieve or eliminate a Psychiatric Emergency Medical Condition, if in the opinion of the treating Provider, it would not result in material deterioration of the Member's condition.

What is an Emergency Medical Condition or a Psychiatric Emergency Medical Condition?

The State of California defines an Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Serious impairment to his or her bodily functions;
- A serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would happen:
  - There is not enough time to effect a safe transfer to another hospital prior to delivery; or
  - A transfer poses a threat to the health and safety of the Member or unborn child.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a Mental Health Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or others; or

- Unable to provide for, or utilize, food, shelter or clothing, due to the Mental Health Disorder.

What to Do When You Require Emergency Health Care Services

If you believe you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest hospital emergency room for treatment. You do not need to get Prior Authorization if you reasonably believe Emergency Health Care Services are needed to seek treatment for an Emergency Medical Condition that could cause you harm. Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. VEBA Direct covers all Medically Necessary Emergency Health Care Services provided to Members in order to stabilize an Emergency Medical Condition.

You, or someone else on your behalf, must notify the TPA or your PCP within 24 hours, or as soon as reasonably possible, following your receipt of Emergency Health Care Services so that your PCP can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the Facility and a description of the Emergency Health Care Services that you received.

Post-stabilization and Follow-up Care

Following the stabilization of an Emergency Medical Condition, the treating health care Provider may believe that you require additional Medically Necessary Hospital (health care) Services prior to your being safely discharged. If the hospital is not part of the contracted Network, the Hospital will contact your Network Medical Group, or the TPA, in order to get the timely authorization for these post-stabilization services. If the TPA determines that you may be safely transferred, and you refuse to consent to the transfer, the Hospital must provide you written notice that you will be financially responsible for 100 percent of the cost of services provided to you once your emergency condition is stable. Also, if the Hospital is unable to determine your name and contact information on file with VEBA Direct in order to request Prior Authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, PLEASE CALL VEBA Direct's TPA AT 1-800-624-8822.

Following the stabilization of your Emergency Medical Condition, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your PCP in order to be covered by VEBA Direct. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your PCP or the TPA's Out-of-Area unit to request authorization. *VEBA Direct's TPA's Out-of-Area unit can be reached during regular business hours (8 a.m. – 5 p.m., Pacific Time) at 1-800-542-8789.*

Out-of-Area Services

VEBA Direct arranges for the provision of Covered Health Care Services through its Network Medical Groups and other Network Providers. With the exception of the following, you are not covered for any other medical or Hospital Services out-of-area:

- Emergency Health Care Service provided by an Out-of-Network Provider;
- Urgently Needed Services provided by an Out-of-Network Provider;
- Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician when not Emergency Health Care Services. For these Covered Health Care Services. "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary;
- Air ambulance transport provided by an Out-of-Network Provider;
- Authorized post-stabilization care; or

- Other specific services authorized by your VEBA Direct's Network, when you are away from the geographic area served by your Network Medical Group.

If you do not know the area served by your Network Medical Group, please call your PCP or the Network Medical Group's administrative office to inquire.

The out-of-area services that are not covered include, but are not limited to:

- Routine follow-up care to Emergency Health Care Services or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care or home health care.
- Maintenance therapy and DME, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to help you while traveling outside the geographic area served by your Network Medical Group.
- Medical care for a known or Long Term Condition without acute symptoms as defined under Emergency Health Care Services or Urgently Needed Services.
- Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition in or out of the area.

Your Network Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the *TPA's Out-of-Area unit* during regular business hours (8 a.m. – 5 p.m., Pacific Time) at 1-800-542-8789.

What to Do When You Require Urgently Needed Services

When you are in the geographic area served by VEBA Direct, you should call your PCP or Network Medical Group. The telephone numbers for your PCP and/or Network Medical Group are on the front of your VEBA Direct Health Plan ID card. Help is available 24 hours a day, seven days a week. Identify yourself as a VEBA Direct Member and ask to speak to a Physician. If you are calling during non-business hours, and a Physician is not available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions. If your PCP or Network Medical Group is temporarily unavailable, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify the TPA or your Network Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

Out-of-Area Urgently Needed Services

Urgently Needed Services are Medically Necessary health care services required to prevent the serious deterioration of a Member's health, resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the geographic area served by the Member's VEBA Direct Network Medical Group.

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's VEBA Direct Network Medical Group and the Member experiences a medical condition that, while less serious than an Emergency Medical Condition, could result in the serious deterioration of the Member's health if not treated before the Member returns to the geographic area served by the VEBA Direct Network Medical Group.

When you are temporarily outside the geographic area served by your Network Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your PCP or VEBA Direct Network Medical Group as described above in "What to Do When You Require Urgently Needed Services." The telephone numbers for your PCP and/or VEBA Direct Network Medical Group are on the front of your VEBA Direct Health Plan ID card. Help is available 24 hours a day, seven days a

week. Identify yourself as

a VEBA Direct Member and ask to speak to a Physician. If you are calling during non-business hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

If you are unable to contact your PCP or Network Medical Group, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify the TPA or your VEBA Direct Network Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

International Emergency Health Care Services and Urgently Needed Services

If you are out of the country and require Urgently Needed Services, you should still, if possible, call your PCP or Network Medical Group. Follow the same instructions outlined above. If you are out of the country and experience an Emergency Medical Condition, either use the available emergency response system or go directly to the nearest hospital emergency room. Following receipt of Emergency Health Care Services, please notify your PCP or Network Medical Group within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Note: Under certain circumstances, you may need to initially pay for your Emergency Health Care Services or Urgently Needed Services. Please pay for such services and then contact the TPA at the earliest opportunity. Be sure to keep all credit card statements, bank statements with copies of checks and receipts from Providers and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to VEBA Direct, please refer to **Section 6 Payment Responsibility** in this *Combined Evidence of Coverage and Disclosure Form*.

ALWAYS REMEMBER

Emergency Health Care Services: Following receipt of Emergency Health Care Services, you, or someone else on your behalf, must notify the TPA or your PCP within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Urgently Needed Services: When you require Urgently Needed Services inside of the geographic area served by your medical group, you should, if possible, call (or have someone else call on your behalf) your PCP or Network Medical Group. If you are **outside** of the geographic area served by your medical group you should call or have someone on your behalf call your PCP or Network Medical Group, and if you receive medical or Hospital Services, you must notify the TPA or your PCP within 24 hours, or as soon as reasonably possible of initially receiving these services.

MEMBERS ARE NOT FINANCIALLY RESPONSIBLE FOR PAYMENT OF EMERGENCY HEALTH CARE SERVICES BEYOND THE CO-PAYMENTS AND DEDUCTIBLES.

SECTION 4. CHANGING YOUR DOCTOR OR MEDICAL GROUP

How to Change Your Primary Care Physician or Network Medical Group

When We Change Your Network Medical Group

Continuing Care With a Terminated Provider for Members

This section explains how to change your PCP or Network Medical Group, as well as how we continue your care.

How to Change Your Primary Care Physician or Network Medical Group

Whether you want to change doctors within your Network Medical Group or transfer out of your Network Medical Group entirely, you should call the TPA.

The TPA will approve your request to change doctors within your Network Medical Group if the PCP you have chosen is accepting new patients and meets the other criteria in **Section 1. Getting Started**.

If you call the TPA by the 15th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 15th of the current month, your transfer will be effective the first day of the following month. For example, if you meet the above requirements and you call the TPA on June 12th to request a new doctor, the transfer will be effective on July 1st. If you meet the above requirements and you call The TPA on June 16th, the transfer will be effective August 1st.

If you wish to transfer out of your Network Medical Group entirely, and you are not an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, receiving radiation or chemotherapy or in the third trimester of pregnancy the TPA will approve your request if the PCP within the new Network Medical Group you have chosen is accepting new patients and meets the other criteria in **Section 1. Getting Started**. This includes being located within 30 miles of your Primary Residence or Primary Workplace. The effective date of transfer will be the same as referred to above when requesting a transfer within your Network Medical Group. Some Network Medical Groups only allow new enrollments during the employer's open-enrollment period.

Please Note: VEBA Direct does not advise that you change your PCP if you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution or are undergoing radiation or chemotherapy, as a change may negatively impact your coordination of care. VEBA Direct may make exceptions subject to review.

If you wish to transfer out of your Network Medical Group and you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, the change will not be effective until the first day of the second month following your discharge from the institution.

If you are pregnant and wish to transfer out of your Network Medical Group and your pregnancy has reached the third trimester, to protect your health and the health of your unborn child, VEBA Direct does not permit such change until after delivery of your newborn.

If you change your Network Medical Group, authorizations issued by your previous Network Medical Group will not be accepted by your new group. You should request a new referral from your new PCP within your new Network Medical Group, which may require further review by your new Network Medical Group or the TPA.

Please note that your new Network Medical Group or the TPA may refer you to a different Provider than the Provider shown on your original authorization from your previous group.

If you are changing Network Medical Groups, the TPA may be able to help smooth the transition. When the TPA's Case Management is involved, the case manager is also consulted about the effective date

of your Physician change request. At the time of your request, please let us know if you are currently under the care of a Specialist, receiving home health care services or using DME such as a wheelchair, walker, hospital bed or an oxygen-delivery system.

When We Change Your Network Medical Group

Under special circumstances, VEBA Direct may require that a Member change his or her Network Medical Group. This happens at the request of the Network Medical Group after a material detrimental change in its relationship with a Member. If this happens, we will notify the Member of the effective date of the change, and we will transfer the Member to another Network Medical Group, provided he or she is medically able and there is an alternative Network Medical Group within 30 miles of the Member's Primary Residence or Primary Workplace.

VEBA Direct will also notify the Member in the event that the agreement ends between VEBA Direct and the Member's Network Medical Group. If this happens, VEBA Direct will mail a notice at least 60 days prior to the date of termination. VEBA Direct will also assign the Member a new PCP. If the Member would like to choose a different PCP, he or she may do so by calling Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new PCP.

Please Note: Except for Emergency Health Care Services, Urgently Needed Services and those Covered Health Care Services described under *Out-of-Area Services*, once an effective date with your new Network Medical Group has been established, a Member must use his or her new PCP or Network Medical Group to authorize all services and treatments. Receiving services elsewhere will result in VEBA Direct's denial of benefit coverage.

Continuing Care With a Terminated Provider for Members

Under certain circumstances, you may be eligible to continue receiving care from a terminated Provider to ensure a smooth transition to a new Network Provider and to complete a course of treatment with the same terminated Provider or to maintain the same terminating Provider.

The care must be Medically Necessary, and the cause of termination by VEBA Direct or your Network Medical Group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. Upon receipt of VEBA Direct's notice that a Member is eligible for continued care, a request for continuity of care services from a terminated Provider must be submitted to VEBA Direct within 30 calendar days from the date your Provider is terminated for review and approval;
2. The requested treatment must be a Covered Health Care Service under this Health Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to continuity of care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by VEBA Direct or Network Medical Groups/Independent Practice Associations (NMG/IPA) for current Network Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Health Care Services provided by a terminated Provider to a Member who at the time of the Network Provider's contract Termination was receiving services from that Network Provider for one of the Continuity of Care Conditions will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable, and

2. There are no clinical contraindications that would prevent a medically safe transfer to a Network Provider as determined by the TPA's Medical Director in consultation with the Member, the terminated Network Provider and, as applicable, the Member's receiving Network Provider.

Continuity of care also applies to Members who are receiving Mental Health Care Services from a terminated Mental Health Provider, on the effective termination date. Members eligible for continuity of Mental Health Care Services may continue to receive Mental Health Care Services from the terminated Mental Health Provider for a reasonable period of time to safely transition care to a Network Mental Health Provider. Please refer to Medical Benefits and Exclusions and Limitations in **Section 5. Your Medical Benefits** of the VEBA Direct *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for information.

All continuity of care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 10. Definitions** and believe you qualify for continued care with the terminating Provider, please call UnitedHealthcare and request the form for continuity of care benefits.

Complete and return the form to the TPA as soon as possible, but no later than 30 calendar days of the Provider's effective date of termination. Exceptions to the 30-calendar-day time frame will be considered for good cause. The address is:

UnitedHealthcare
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 30968
Salt Lake City, UT 84130-0968
Fax: 1-888-361-0514

The TPA's Health Care Services department will complete a clinical review of your continuity of care request for Completion of Covered Health Care Services with the terminated Provider and the decision will be made and communicated in a timely manner appropriate for the nature of your medical condition. Decisions for non-urgent requests will be made within five 5 business days of the TPA's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two business days of making the decision. If your request for continued care with a terminated Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of the TPA's continuity of care process, or want to appeal a denial, please contact the TPA.

Please Note: It is not enough to simply prefer receiving treatment from a terminated Physician or other terminated Provider. You should not continue care with a terminated Provider without our formal approval. *If you do not receive Prior Authorization by the TPA or your Network Medical Group, payment for routine services performed from a terminated Provider will be your responsibility.*

In the above section *Continuity of Care* with a terminating Provider, **termination, terminated** or **terminating** references any circumstance which terminates, non-renews or otherwise ends the arrangement by which the Network Provider routinely provides Covered Health Care Services to VEBA Direct Members.

SECTION 5. YOUR MEDICAL BENEFITS

Inpatient Benefits

Outpatient Benefits

Other Behavioral Health Care Services

Exclusions and Limitations of Benefits

This section explains your medical benefits, including what is and is not covered by VEBA Direct. You can find some helpful definitions in the back of this document. For any Co-payments or Deductibles that may be related to a benefit, you should refer to your Schedule of Benefits, a copy of which is included with this document. UnitedHealthcare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at ***www.myuhc.com/VEBA****.*

Inpatient Benefits

THESE BENEFITS ARE PROVIDED WHEN ADMITTED OR AUTHORIZED BY EITHER THE MEMBER'S NETWORK MEDICAL GROUP OR VEBA DIRECT. THE FACT THAT A PHYSICIAN HAS ORDERED A PARTICULAR SERVICE, SUPPLY OR TREATMENT WILL NOT MAKE IT COVERED UNDER THE HEALTH PLAN. A SERVICE, SUPPLY OR TREATMENT MUST BE MEDICALLY NECESSARY, OR OTHERWISE REQUIRED TO BE COVERED UNDER THE LAW, OR AS OTHERWISE DESCRIBED BELOW AND NOT EXCLUDED FROM COVERAGE IN ORDER TO BE A COVERED HEALTH CARE SERVICE.

With the exception of Emergency Health Care Services or Urgently Needed Services, a Member will only be admitted to acute care and Skilled Nursing Care Facilities that are authorized by the Member's Network Medical Group under contract with VEBA Direct.

1. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
2. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a Member and the bone marrow or stem cell services are performed at a Designated Facility. The testing of relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. A Designated Facility center approved by the TPAmust conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.
3. **Clinical Trials** – All routine patient care costs incurred during participation in an approved clinical trial for the treatment of:
    - Cancer or other life-threatening disease or condition. For purpose of this benefit, a life-threatening disease or condition is one from which is likely to cause of death unless the course of the disease or condition is interrupted.
    - Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, a clinical trial meets the approved clinical trial criteria stated below.
    - Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, a clinical trial meets the approved clinical trial criteria stated below.
    - Other diseases or disorders which are not life threatening, for which, the clinical trial meets the approved clinical trial criteria stated below.

A Member is considered a qualified individual if the Member is eligible to take part in the approved clinical trial according to the trial's protocol and either a Network treating Physician has concluded that the Member's participation in the trial would be appropriate because the Member meets the trial protocol; or

the Member self-refers to the trial and has provided medical and scientific information to establish that participation in the trial is consistent with the trial protocol.

For the purposes of this benefit, network treating Physician means a Physician who is treating a Member as a Network Provider according to an authorization or referral from the Member's Network Medical Group or the TPA.

Routine patient care costs for qualifying clinical trials include drugs, items, devices and services provided consistent with coverage under the Agreement for a member who is not enrolled in an approved clinical trial including:

- Drugs, items, devices, and services for which Benefits are typically provided absent a clinical trial.
- Drugs, items, devices, and services required solely for the following:
  - The provision of the Experimental or Investigational drug, item, device or service.
  - The clinically appropriate monitoring of the effects of the Experimental or Investigational drug, item, device, or service.
  - The prevention of complications arising from the provision of the Experimental or Investigational drug, item, device, or service.
- Drugs, items, devices, and services needed for reasonable and necessary care arising from the provision of the Investigational drug, item, device, or service, including the diagnosis and treatment of complications.

For purposes of this benefit, routine patient care costs do not include the costs related to any of the following, which are not covered by VEBA Direct:

- The Experimental or Investigational drug service(s), device or item itself. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses. Certain promising interventions refer to treatment that is likely safe but where limited to and/or conflicting evidence exists regarding its effectiveness.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Drugs, items, devices, and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices and services required to be covered pursuant to applicable law.

- Drugs, items, devices and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or conditions, including involving a drug that is exempt under federal regulations from a new drug application. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, an approved clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH). (Includes* National Cancer Institute (NCI).*)*
  - *Centers for Disease Control and Prevention (CDC);*
  - *Agency for Healthcare Research and Quality (AHRQ);*
  - *Centers for Medicare and Medicaid Services (CMS);*
  - A cooperative group or center of any of the entities described above or the *United States Department of Defense (DOD)* or the *Veterans Affairs (VA)*;
  - A qualified non-governmental research entity shown in the guidelines issued by the *National Institutes of Health* for center support grants.
  - *The Department of Veterans Affairs, the Department of Defense* or *the Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - Ensures unbiased review of the highest scientific standards by qualified persons who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

A clinical trial with endpoints defined exclusively to test toxicity is not an approved clinical trial.

All services must have Prior Authorization from the TPA's medical director or designee. Additionally, services must be provided by a VEBA Direct Network Provider in VEBA Direct's Service Area. In the event a VEBA Direct Network Provider does not offer a clinical trial with the same protocol as the one the Member's Network treating Physician recommended, the Member may choose a Provider performing a clinical trial with that protocol within the State of California. If there is no Provider offering the clinical trial with the same protocol as the one the Member's treating Network Physician recommended in California, the Member may choose a clinical trial outside the State of California but within the United States of America.

VEBA Direct is required to pay for the services covered under this benefit at the rate agreed upon by VEBA Direct and a Network Provider, minus any applicable Co-payment or Deductibles. In the event the Member takes part in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate VEBA Direct negotiates with Network Providers, the Member will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by VEBA Direct with Network Providers, in addition to any applicable Co- payment or Deductibles.

Any additional expenses the Member may have to pay beyond VEBA Direct's negotiated rate due to using an Out-of-Network Provider do not apply to the Member's Annual Co-payment Limit.

4. **Gender Dysphoria -** Prior Authorization of Medically Necessary services must be done by the TPA or delegated Providers as determined by VEBA Direct. For more information regarding this coverage, please refer to the Benefit Interpretation Policy Manual and Medical Management Guidelines Manual available at **www.myuhc.com**.
5. **Hospice Services** – Hospice services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less if the disease follows its natural course. Hospice services are provided as determined by the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's PCP, a registered nurse, a social worker and a spiritual caregiver. Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

   Hospice services include skilled nursing services, certified Home Health Aide Services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and needed for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

   Inpatient Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is needed to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.
6. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Network Medical Group or VEBA Direct are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, or other professionals as authorized under California law, intensive care, operating room, recovery room, laboratory and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.
7. **Inpatient Hospital Mental Health Care Services –** The below listed psychiatric services for the diagnosis, prevention, and treatment of Mental Health Disorders are covered under this health plan and require Prior Authorization:

   - Inpatient Mental Health Care Services - Psychiatric inpatient services rendered by a licensed Inpatient Treatment Center or Residential Treatment Center for the prevention, diagnosis and/or treatment of Mental Health Disorders, Prior Authorization required.

- Inpatient Physician Services - Psychiatric inpatient services rendered by a behavioral health care professional acting within the scope of their license while the Member is admitted to an Inpatient Treatment Center or Residential Treatment Center. Prior Authorization required.
- Inpatient Treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

8. **Inpatient Physician and Specialist Care** – Services from Physicians, including Specialists and other licensed health professionals within, or upon referral from, the Member's Network Medical Group are covered while the Member is hospitalized as an inpatient. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
9. **Inpatient Rehabilitation and Habilitation Care** – Rehabilitation and Habilitative Services that must be provided in an inpatient rehabilitation/habilitation facility are covered. Inpatient rehabilitation/habilitation consists of the combined and coordinated use of physical, occupational, and speech therapy when Medically Necessary and provided by a Network Provider who is a registered physical, speech or occupational therapist, or a healthcare professional under the direct supervision of a licensed physical therapist acting within the scope of his or her license under California law.
10. **Inpatient Substance-Related and Addictive Disorder Services** – Inpatient Substance-Related and Addictive Disorders Services - The below listed inpatient services for the diagnosis, prevention and treatment of Substance-Related and Addictive Disorders are covered under this health plan and require Prior Authorization:

- Inpatient Substance-Related and Addictive Disorders Services – Inpatient services rendered by a licensed Inpatient Treatment Center, Residential Treatment Center or Medical Detoxification facility for the prevention, diagnosis and/or treatment of Substance-Related and Addictive Disorders. Prior Authorization required.
- Inpatient Physician Services – Inpatient services rendered by a health care professional acting within the scope of their license while the Member is admitted to an Inpatient Treatment Center, Residential Treatment Center or Medical Detoxification facility. Prior Authorization required.
- Inpatient Transitional Recovery Services – Transitional Residential Recovery services rendered by a licensed or certified Residential Treatment Center for the prevention of Substance-Related and Addictive Disorders prescribed by a practitioner. Prior Authorization required.
- Inpatient Treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

See your Schedule of Benefits for Substance-Related and Addictive Disorder Services for coverage, and for any amounts you may have to pay.

11. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon, in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is needed to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

12. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage and complications of pregnancy or childbirth. Certain prenatal services are covered as preventive care. Please refer to Preventive Care Services in the outpatient benefits section.

    - Educational courses on childcare and/or prepared childbirth classes are not covered.
    - Alternative birthing center services are covered when provided or arranged by a Network Hospital affiliated with the Member's Network Medical Group.
    - Licensed/Certified nurse midwife services are covered only when available within the Member's Network Medical Group.
    - Elective home deliveries are not covered.

    A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

    Maternal mental health condition including but not limited to prenatal or postpartum screening for maternal mental health conditions by a licensed health care practitioner who provides prenatal or postpartum care for a patient is covered. "Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

13. **Morbid Obesity (Surgical Treatment)** – Bariatric surgical procedures are covered when Medically Necessary and prior authorized. We will use evidence-based criteria to determine coverage of bariatric surgery, such as the most recent *National Institutes of Health (NIH)* guidelines, in determining the Medical Necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* for Co-payment/Deductible information of this benefit or you may call the TPA for additional information.

14. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision and special care nursery. A newborn Co-payment applies in addition to the Co-payment for maternity care, unless the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or within 96 hours of the baby's cesarean delivery. Circumcision is covered for male newborns prior to hospital discharge. See Circumcision under *Outpatient Benefits* for an explanation of coverage after hospital discharge.

15. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member, and the transplant is performed at a Designated Facility. Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities.

    Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, VEBA Direct will only cover costs related to the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the facility where the transplant is performed. The Member will be responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second facility. Covered Health Care Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other non-clinical expenses of

the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for Designated Facility.)

16. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include a cleft palate, cleft lip, or other craniofacial anomalies related with a cleft palate. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Prior Authorization by the Member's Network Medical Group or the TPA in agreement with standards of care as practiced by Physicians specializing in reconstructive surgery.
17. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation Care and Habilitative Services are covered. The Member's Network Medical Group or TPA will determine where the Skilled Nursing Care and Skilled Rehabilitation Care and Habilitative Services will be provided. Refer to your *Schedule of Benefits* for the number of days covered under your Health Plan. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

    Skilled Nursing Facility services will be provided in place of a hospital stay when Medically Necessary, and when authorized by the Member's PCP, or by the Member's Network Medical Group or by TPA. When the Member is transferred from a Skilled Nursing Facility to an acute hospital setting, and then back to a Skilled Nursing Facility, the days spent in the acute hospital are not counted against the benefit limitation as described in your *Schedule of Benefits*.

    A benefit period begins on the date the enrollee is admitted to a Hospital or a Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care Hospital is not required to begin a benefit period.

    Prescription drugs are covered when provided by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care. Services or supplies not included in the written treatment plan and Custodial Care are not covered.

    Outpatient drugs and prescription medications are available as a supplemental benefit. Please refer to "Drugs and Prescription Medication" (Outpatient) listed in Exclusions and Limitations.
18. **Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of coverage.

Outpatient Benefits

The following benefits are available on an outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Network Medical Group or TPA. The fact that a Physician has ordered a particular service, supply or treatment will not make it covered under the Health Plan. A service, supply or treatment must be Medically Necessary, or otherwise required to be covered under the law, or as otherwise described below and not excluded from coverage in order to be a Covered Health Care Service.

1. **Allergy Serum** – Allergy serum, including needles, syringes, and other supplies for the administration of the serum, are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a VEBA Direct Network Physician.

2. **Allergy Testing Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy and serum, are covered according to an established treatment plan.

3. **Ambulance** – The use of an ambulance (land or air) is covered without Prior Authorization when the Member reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access Emergency Health Care Services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Health Care Services is covered only when it is authorized by the Member's Network Medical Group or TPA.

4. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

5. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is covered only when the Member has either of the following:

   a. Craniofacial anomalies in which abnormal or absent ear canals prevent the use of a wearable hearing aid, or

   b. Hearing loss of sufficient severity that it cannot be corrected by a wearable hearing aid.

   Covered Health Care Services are available for a bone anchored hearing aid that is purchased as a result of a written recommendation by a network physician.

   Note: Bone-anchored hearing aid will not be subject to the non-implantable hearing aid limit. There will not be a dollar maximum related to this benefit. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g., inpatient hospital, Physician fees) only for Members who meet the medical criteria shown above. Repairs and/or replacement for the implanted components of a bone-anchored hearing aid are not covered, except for malfunctions.

   Replacement of external hearing aid components for bone-anchored hearing aids is covered under the DME benefit. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.

   Please refer to the Hearing Aid and Hearing Device benefit description in this section for non-implantable hearing aid; the *Schedule of Benefits* for applicable Co-payments/Deductibles and to the Bone-Anchored Hearing Aid exclusion listed in Other Exclusions and Limitations.

6. **Chiropractic Services –** Please refer to your *Chiropractic Schedule of Benefits*, if any.

7. **Clinical Trials** – Please refer to the benefit described above under *Inpatient Clinical Trials*. Outpatient services Co-payments and/or Deductibles apply for any clinical trials services received on an outpatient basis according to the Co-payments for that specific outpatient service. VEBA Direct is required to pay for the services covered under this benefit at the rate agreed upon by VEBA Direct and a Network Provider, minus any applicable Co-payment or Deductibles. In the event the Member takes part in a clinical trial provided by an Out-of-Network Provider that does not agree to perform these services at the rate VEBA Direct negotiates with Network Providers, the Member will be responsible for payment of the difference between the Out-of-Network Provider's billed charges and the rate negotiated by VEBA

Direct with Network Providers, in addition to any applicable Co-payment, or Deductibles.

Any additional expenses the Member may have to pay beyond VEBA Direct's negotiated rate due to using an Out-of-Network Provider do not apply to the Member's Annual Co-payment Limit.

8. **Circumcision** – Circumcision is covered for male newborns prior to hospital discharge. Circumcision is covered after hospital discharge when:
   - Circumcision was delayed by the Network Provider during first hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28-day neonatal period, or
   - Circumcision was determined to be medically inappropriate during first hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Network Provider determines it is medically safe and the circumcision is performed within 90 days from that determination.
   - Circumcision other than noted under the outpatient circumcision benefit will be reviewed for Medical Necessity by the Network Medical Group or the TPA's medical director or designee.
9. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing-impaired persons or prelingual persons who are not benefited from conventional amplification (hearing aids) is covered. Please also refer to *Cochlear Implant Medical and Surgical Services*.
10. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing-impaired or prelingual persons who are not benefited from hearing aids is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Network Provider. (For an explanation of speech therapy benefits, please refer to *Outpatient Medical Rehabilitation and Habilitation Therapy*.)
11. **Dental Treatment Anesthesia** – See *Oral Surgery and Dental Services; Dental Treatment Anesthesia*.
12. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Network Provider.
13. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to help the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes-related complications. Members must have coverage under an *Outpatient Prescription Drug Benefit Supplement* for insulin, glucagon and other diabetic medications.

    Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses or contact lenses. The Member's Network Provider will prescribe insulin syringes and pen delivery systems, lancets and lancet puncture devices, blood glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with VEBA Direct or it's TPA, United Healthcare.
14. **Dialysis** – Acute and chronic hemodialysis and peritoneal dialysis services and supplies are covered. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Network Medical Group or TPA and provided within the Member's Network Medical Group. The fact that the Member is outside the geographic area served by the Network Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

15. **Durable Medical Equipment (DME) (Rental, Purchase or Repair)** – DME is covered when it is designed to help in the treatment of an injury or illness of the Member, and the equipment is mainly for use in the home (or another location used as the enrollee's home). DME is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered DME include wheelchairs, hospital beds, standard oxygen-delivery systems, equipment for the treatment of asthma (nebulizers, masks, tubing and peak flow meters, the equipment and supplies must be prescribed by and are limited to the amount requested by the network physician), standard curved handle or quad cane and replacement supplies, standard or forearm crutches and replacement supplies, dry pressure pad for a mattress, IV pole, enteral pump and supplies, bone stimulator, cervical traction (over the door), phototherapy blankets for treatment of jaundice in newborns, certain dialysis care equipment, brassieres required to hold a breast prosthesis (up to three every 12 months), compression burn garments and lymphedema wraps and garments dialysis equipment and supplies for home hemodialysis and peritoneal dialysis. Outpatient drugs, prescription medications and inhaler spacers for the treatment of asthma are available under the prescription drug benefit if purchased as a supplemental benefit. Please refer to the Pharmacy *Schedule of Benefits*, *Medication Covered By Your Benefit* under *Miscellaneous Prescription Drug Coverage* for coverage.

    Ostomy and urological supplies substantially equal to the following:

    a. Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.
    b. Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.
    c. Incontinence supplies for Hospice patients: disposable incontinence under pads; adult incontinence garments.
    d. Ostomy and urological supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.

    Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Network Medical Group or TPA has the option to repair or replace DME items. Replacement of lost or stolen DME is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accommodate the Member's condition.

    For a detailed listing of covered DME, please contact the TPA at 1-800-624-8822.

    Please refer to *Bone-Anchored Hearing Aid* in the *Outpatient Benefits* section and in the *Other Exclusions and Limitations* section for a description of coverage for external hearing aid components subject to the

DME benefit and limitations.

16. **Enteral Formula** – Benefits are provided for specialized enteral formulas and low protein modified food products, administered either orally or by tube feeding for certain conditions under the direction of a physician.
17. **Family Planning** – Covered Health Care Services include all *Food and Drug Administration (FDA)* approved contraceptive methods including devices, and other products for women, including all FDA-approved contraceptive devices, as prescribed by the Member's Network Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to the devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Contraceptive drugs available by a prescription order or refill and eligible over-the-counter products are provided as described under the *Outpatient Prescription Drug Supplement*.
18. **Fertility Preservation for Iatrogenic Infertility** - Benefits are available for fertility preservation for medical reasons that cause irreversible Infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

    - Collection of sperm.
    - Cryo-preservation of sperm.
    - Ovarian stimulation, retrieval of eggs and fertilization.
    - Oocyte cryo-preservation.
    - Embryo cryo-preservation.

    Benefits for medications related to the treatment of fertility preservation are provided as described under the *Outpatient Prescription Drug Supplement*.

    Benefits are not available for elective fertility preservation.

    Benefits are not available for embryo transfer.

    Benefits are not available for long-term storage costs (greater than one year).
19. **Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and prior authorized by the Member's Network Medical Group or TPA.
20. **Gender Dysphoria -** Prior Authorization of Medically Necessary services must be done by delegated Providers as determined by the TPA. For more information regarding this coverage, please refer to the Benefit Interpretation Policy Manual and Medical Management Guidelines Manual available at **www.myuhc.com**.
21. **Health Education Services** – Includes wellness programs such as a stop smoking or tobacco cessation program available to enrolled Members. The TPA also makes health and wellness information available to Members. For more information about the tobacco cessation program or any other wellness program, contact the TPA at 1-800-624-8822, or at **www.myuhc.com**.

    The Member's Network Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by VEBA Direct and are not covered. Fees charged will not apply to the Member's Co-payment limit.

22. **Hearing Aids and Hearing Devices/ Exams** – Hearing aids required for the correction of a hearing impairment, a reduction in the ability to perceive sound which may range from slight to complete deafness are covered. Hearing aids are electronic amplifying devices designated to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

    Covered Health Care Services are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Covered Health Care Services are provided for the hearing aid and for charges for associated fitting and testing.

    Non-implantable hearing aid benefit will be limited to one hearing aid including repairs and replacements per hearing impaired ear every three years.

    Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

    Benefits for over-the-counter hearing aids do not require any of the following:

    - A medical exam
    - A fitting by an audiologist
    - A written prescription.

    If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

    Please refer to the *Schedule of Benefits* for any applicable Co-payments, and Deductible amounts limit and benefit limitations in the *Hearing Aid and Hearing Device* listed in *Other Exclusions and Limitations*. For implantable hearing aid, refer to *Bone-Anchored Hearing Aid* in this section.

23. **Home Health Care Visits** – A Member is eligible to receive Home Health Care Visits if the Member:

    - is confined to the home (home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities);
    - needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and
    - the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a VEBA Direct Network Provider. “Skilled Nursing Services” means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

    If a Member is eligible for Home Health Care Visits in agreement with the authorized treatment plan, the following Medically Necessary Home Health Care Visits may be included, but are not limited to:

    a. Skilled nursing visits;
    b. Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member’s illness or injury;
    c. Physical, occupational, or speech therapy that is provided on a per visit basis;
    d. Medical supplies, DME;

e. Infusion therapy medications and supplies and laboratory services as prescribed by a Network Provider to the extent such services would be covered by VEBA Direct had the Member remained in the hospital, rehabilitation or Skilled Nursing Facility;

f. Drugs, medications and related pharmaceutical services are covered for those Members enrolled in VEBA Direct's *Outpatient Prescription Benefit*. Outpatient prescription drugs are available as a supplemental benefit through VEBA Direct's Pharmacy Benefit Manager, Express Scripts. Please refer to your *Schedule of Benefits*.

If the Member's Network Medical Group determines that Skilled Nursing Care needs are more extensive than the services described in this benefit, the Member will be transferred to a Skilled Nursing Facility to obtain services. The TPA, in consultation with the Member's Network Medical Group, will determine the appropriate setting for delivery of the Member's Skilled Nursing Services.

Please refer to the *Schedule of Benefits* for any applicable Co-payments/Deductibles and benefit limitations.

24. **Home Test Kits for Sexually Transmitted Diseases**

Benefits for home test kits for sexually transmitted diseases (STDs), including any laboratory costs for processing the kit, that are Medically Necessary or appropriate and ordered directly by a Network provider, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

"Home test kit" means a product used for a test recommended by the federal *Centers for Disease Control and Prevention* guidelines or the *United States Preventive Services Task Force* that has been waived under the federal *Clinical Laboratory Improvement Act* (*CLIA*), *FDA*-cleared or approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

25. **Hospice Services** – Hospice services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided according to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's PCP, a registered nurse, a social worker and a spiritual caregiver.

Hospice services include skilled nursing services, certified Home Health Aide services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

Covered Hospice services are available in the home on a 24-hour basis when Medically Necessary, during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms. inpatient Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is needed to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five consecutive days at a time.

26. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Infertility services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If

the Member's Health Plan includes an Infertility services supplemental benefit, a supplement to the *Combined Evidence of Coverage and Disclosure Form* will be provided to the Member.

27. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** –

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route (includes chemotherapy). Infusion therapy is covered when provided as part of a treatment plan authorized by the Member's PCP, Network Medical Group or the TPA. The infusions must be administered in the Member's home, Network Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living facility, which is not a hospital or institution mainly engaged in providing Skilled Nursing Care or Rehabilitation Services.

    - **Outpatient Injectable Medications** – Outpatient injectable medications (except insulin) include those drugs or preparations which are not usually self-administered, and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as part of a Physician's office visit and when not otherwise limited or excluded (e.g., insulin, certain immunizations, infertility drugs, birth control, or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Network Provider, the Member's Network Medical Group or VEBA Direct-Designated Pharmacy and may require Prior Authorization by the TPA. Please refer to *Preventive Care Services* in the *Outpatient Benefits* in this section for a description of immunizations covered as preventive care.

    - **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by the Subcutaneous route regardless of the frequency of administration, or by the Intramuscular route at a frequency of one or more times per week. Self-injectable medications (except insulin) are covered when prescribed by a Network Provider, as authorized by the Member's Network Medical Group or by the TPA. Self- injectable medications must be obtained through a Network Provider, through the Member's Network Medical Group or VEBA Direct-Designated Pharmacy/specialty injectable vendor and may require Prior Authorization by the TPA. A separate Co-payment applies to all self- injectable medications for a 30-day supply (or for the prescribed course of treatment if shorter), whether self-administered or injected in the Physician's office, and is applied in addition to any office visit Co-payment or Deductible.

28. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.

29. **Maternity Care, Tests and Procedures/Maternal Mental Health –** Physician visits, laboratory services (including the California Prenatal Screening Program), and radiology services are covered for prenatal and postpartum maternity care. Nurse-midwife services are covered when available within, and authorized by, the Member's Network Medical Group.

    Prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available are covered.

    When certain laboratory services are performed as prenatal preventive screening, as defined by the *United Services Preventive Services Task Force (USPSTF)* with an ”A" or "B" recommendation and the *Department of Health and Human Services (HHS)*. Covered Health Care Services are provided under Preventive Care Services in the outpatient benefits section.

    Maternal mental health condition including but not limited to prenatal or postpartum screening for maternal mental health conditions by a licensed health care practitioner who provides prenatal or postpartum care for a patient is covered. "Maternal mental health condition" means a mental health

condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

30. **Medical Supplies and Materials** – Medical supplies and materials needed to treat an illness or injury are covered when used or provided while the Member is treated in the Network Provider's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Network Provider. Examples of items commonly provided in the Network Provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.

31. **Mental Health Care Services** – The below list of outpatient services for the diagnosis, prevention and treatment of Mental Health Disorders are covered under this health plan. Certain Outpatient Mental Health Services require Prior Authorization including outpatient electro-convulsive treatment; Partial Hospitalization/ Day Treatment; Intensive Outpatient Treatment; Behavioral Health Treatment for Autism Spectrum Disorders including Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs; and Psychological and Neuropsychological Testing when necessary to diagnose and evaluate a Mental Health Disorder.

- Outpatient Mental Health Services – Outpatient services for the diagnosis, prevention and treatment of Mental Health Disorders by licensed behavioral health professionals including psychiatric evaluations, individual, family and group psychotherapy and medication management.
- Behavioral Health Treatment for Autism Spectrum Disorder - Prior Authorization required; Professional services and treatment programs including Applied Behavior Analysis and evidence-based behavior intervention programs aimed at helping a covered person diagnosed with Autism Spectrum Disorder attain and/or maintain functioning to the extent practicable, and that meet the criteria required by California law. Please refer to **Section 10. Definitions** for a description of the required coverage criteria.

32. **Medically Necessary Behavioral Health Treatment for Autism Spectrum Disorder will not be denied or unreasonably delayed**:

    - Based on an asserted need for cognitive or intelligence quotient (IQ) testing;
    - On the grounds that the Behavioral Health Treatment is an Experimental or Investigational Services or educational; or
    - On the grounds that Behavioral Health Treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission of Certifying Agencies.
    - Intensive Outpatient treatment programs which require Prior Authorization including:
        - Short-term facility-based intensive outpatient care (Partial Hospitalization/Day Treatment)
        - Short-term multidisciplinary treatment in an intensive outpatient program (IOP)
        - Short-term treatment in a crisis residential program by a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
        - Psychiatric observation for an acute psychiatric crisis

Prescribed medications are covered as described in the *Outpatient Prescription Drug Benefit* supplement to this *Combined Evidence of Coverage and Disclosure Form*.

See your *Schedule of Benefits* for any amounts including Co-payments and Deductibles you may have to pay.

For utilization review criteria, education programs and training materials relating to Mental Health Care Services and Substance Related and Addictive Disorder Services contact us at www.myuhc.com or the telephone number on your ID card.

33. **OB/GYN Physician Care** – See "Physician OB/GYN Care."
34. **Oral Surgery and Dental Services** – Emergency Health Care Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable. Other covered oral surgery and dental services include:

- Oral surgery or dental services, provided by a Physician or dental professional for treatment of primary medical conditions. Examples include, but are not limited to:
  - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
  - Biopsy of gums or soft palate;
  - Oral or dental exam performed on an inpatient or outpatient basis as part of a comprehensive work-up prior to transplantation surgery;
  - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
  - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);
  - Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
  - Reconstructive surgery due to congenital defect such as cleft lip and cleft palate. Refer to *Reconstructive Surgery* in this Section.
  - Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
  - Setting of the jaw or facial bones;
  - Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
  - Treatment of maxillofacial cysts, including extraction and biopsy.

Dental Services beyond emergency treatment to stabilize an acute injury including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, dental services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth are not covered except for services covered by VEBA Direct under this outpatient benefit, Oral Surgery and Dental Services.

35. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and related facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when:

    A. the Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and

    B. one of the following criteria is met:

    - The Member is under seven years of age;
    - The Member is developmentally disabled, regardless of age; or
    - The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

    The Member's dentist must get Prior Authorization from the Member's Network Medical Group or TPA before the dental procedure is provided.

    Dental anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, are not covered except for services covered by VEBA Direct under the outpatient benefit, Oral Surgery and Dental Services.

36. **Outpatient Habilitative Services and Devices –** For purposes of this benefit, Habilitative Services means health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

    Services include:

    - Individual and group outpatient physical, occupational, and speech therapy related to Autism Spectrum Disorder.
    - All other individual and group outpatient physical, occupational, and speech therapy.
    - Cognitive habilitation therapy
    - Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

    Habilitative Services must be performed by a Physician, a licensed therapy Provider, or qualified autism service Provider or other Provider licenses, certified, or otherwise authorized under state law to perform the service, and within the Provider's scope of practice. Benefits under this section include Habilitative Services provided in a Physician's office or on an outpatient basis at a hospital or alternate facility. Habilitative Services provided in a Member's home by a home health agency are provided as described under *Home Health Care Visits*. Habilitative Services provided in a Member's home other than by a home health agency are provided as described under this section.

    Benefits can be discontinued when the treatment goals and objectives are achieved or no longer appropriate.

    Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment (Rental, Purchase or Repair)* and*; Prosthetics and Corrective Appliances/Orthotics.*

Benefits for Habilitative Services provided during an inpatient stay are a medical benefit as described under Skilled Nursing Facility/Subacute Transitional Care and inpatient Rehabilitation and Habilitative Services.

Benefits, terms, and conditions for Behavioral Health Treatment for Autism Spectrum Disorders are described under *Inpatient Mental Health Care Services* and *Outpatient Mental Health Care Services* in this Section.

37. **Outpatient Rehabilitation Services and Devices** - Services include:
    - Individual and group outpatient physical, occupational, and speech therapy related to Autism Spectrum Disorder.
    - All other individual and group outpatient physical, occupational, and speech therapy.
    - Pulmonary rehabilitation therapy
    - Cardiac rehabilitation
    - Post-cochlear implant aural therapy
    - Cognitive Rehabilitation Therapy
    - Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

    Rehabilitation Services must be performed by a Physician, a licensed therapy Provider, or qualified autism service Provider or other Provider licenses, certified, or otherwise authorized under state law to perform the service, and within the Provider's scope of practice. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a hospital or alternate facility. Rehabilitation Services provided in a Member's home by a home health agency are provided as described under *Home Health Care Visits*. Rehabilitation Services provided in a Member's home other than by a home health agency are provided as described under this section.

    Benefits can be discontinued when the treatment goals and objectives are achieved or no longer appropriate.

    Benefits for inpatient rehabilitative services provided during an Inpatient Stay are a medical benefit as described under *Skilled Nursing Facility/Subacute Transitional Care* and *Inpatient Rehabilitation and Habilitation* care in this Section.

    Benefits, terms, and conditions for Behavioral Health Treatment for Autism Spectrum Disorder are described under *Inpatient Mental Health Care Services* and *Outpatient Mental Health Care Services* in this Section.

38. **Outpatient Services** – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to endoscopies, hyperbaric oxygen and wound care.

39. **Outpatient Surgery** – Short-stay, same-day or other similar outpatient surgery facilities and professional Physician/surgeon fees and outpatient visits are covered.

40. **Phenylketonuria (PKU) Testing and Treatment** – Testing for phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a result of PKU enzyme deficiency. PKU includes those formulas and special food products

that are part of a diet prescribed by a network Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who takes part in or is authorized by VEBA Direct, provided that the diet is deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein, but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.

41. **Physician Care (PCP and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's PCP are covered. Services from a Specialist are covered upon referral by Member's Network Medical Group or the TPA. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

42. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN, family practice physician or surgeon (designated by the Member's Network Medical Group as providing OB/GYN services) affiliated with the Member's Network Medical Group.

43. **Preimplantation Genetic Testing (PGT) and Related Services**

    Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after genetic counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
    - Ovulation induction (or controlled ovarian stimulation).
    - Egg retrieval, fertilization and embryo culture.
    - Embryo biopsy.
    - Embryo transfer.
    - Cryo-preservation and short-term embryo storage (less than one year).
    - Benefits are not available for long-term storage costs (greater than one year).

44. **Preventive Care Services** – Preventive Care Services means Covered Health Care Services provided on an outpatient basis at a network physician's office or a network hospital that encompasses medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to be related to beneficial health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the *United States Preventive Services Task Force (USPSTF).*
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration and the Periodicity Schedule of the Bright Futures Recommendations for Pediatric*

Preventive Health Care and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration* including well-woman visits (including routine prenatal obstetrical office visits); gestational diabetes screening; human papillomavirus (HPV) DNA testing for women 30 years and older every 3 years; counseling for sexually transmitted infections; counseling and screening for human immune-deficiency virus (HIV); breastfeeding support and counseling; breast pump purchase of personal pump and supplies; and screening and counseling for interpersonal and domestic violence.

  All *Food and Drug Administration (FDA)* approved contraceptive devices, and other products, including all *FDA*-approved contraceptive devices, and products available over the counter, as prescribed by the Member's Network Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Contraceptive drugs available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider*.

Preventive screening services include but are not limited to the following:

- **Adverse Childhood Experiences Screening** – Routine screening for adverse childhood experiences.
- **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's Network Provider. Mammography for screening or diagnostic purposes is covered as authorized by the Member's Network nurse practitioner, Network nurse midwife or Network Provider.
- **Colorectal Screening –** Routine screening beginning at age 50 for men and women at average risk with interval determined by method. Potential screening options include: home Fecal Occult Blood test (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, or double-contrast barium enema or a colonoscopy for a positive result on a test or procedure, other than a colonoscopy.
- **Hearing Screening** – Routine hearing screening by a Network health professional is covered to determine the need for hearing correction. Hearing screening tests for Members are covered in agreement with American Academy of Pediatrics (Bright Futures) recommendations.
- **Human Immunodeficiency Virus (HIV)** – Services for human immunodeficiency virus (HIV) testing, regardless whether the testing is related to a primary diagnosis.
- **Newborn Testing** – Covered tests include, but are not limited to, phenylketonuria (PKU), Sickle cell disease, and congenital hypothyroidism.
- **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These screenings are provided when consistent with good professional practice.
- **Tobacco Screening** – Routine screening of tobacco use. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

- Four Tobacco cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and
- All *Food and Drug Administration (FDA)*-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment plan when prescribed by a health care Provider without Prior Authorization. Please refer to the *Outpatient Prescription Drug Benefit Supplement* to the *Combined Evidence of Coverage and Disclosure Form* for the covered tobacco cessation drugs (both over-the-counter and prescription).
- Tobacco cessation medications (both over-the-counter and prescription) covered at zero cost share when prescribed and prior authorized. In addition you must take part in tobacco cessation counseling sessions as described above. Please call the TPA for more information.

- **Vision Screening** – Annual routine eye health assessment and screening by a Network Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal exam is covered for Members with diabetes.
- **Well-Baby/Child Adolescent Care** –Preventive health care services are covered (including immunizations) when provided by the child's Network Medical Group.
- **Well-Woman Care** – Medically Necessary obstetrical and gynecological services, including a Pap smear (cytology) and routine prenatal obstetrical office visits are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or family practice Physician or surgeon (designated by the Member's Network Medical Group as providing OB/GYN services) affiliated with Member's Network Medical Group.

45. **Prosthetics and Corrective Appliances/Orthotics** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Network Medical Group or the TPA. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include the first contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue, prostheses to replace all or part of an external facial body part that has been removed or impaired due to disease, injury, or congenital defect.

    Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the enrollee needs a prosthetic or orthotic device.

    Custom-made or custom-fitted corrective appliances/ orthotics are covered when Medically Necessary as determined by the Member's Network Medical Group or TPA. Corrective appliances/orthotics are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Member.

    - Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered.
    - Deluxe upgrades that are not Medically Necessary are not covered.
    - Replacements, repairs and adjustments to both corrective appliances/ orthotics and prosthetics are covered when Medically Necessary. Repair or replacement must be authorized by the Member's Network Medical Group or the TPA.
    - An artificial larynx or electronic speech aid is covered post-laryngectomy or for a Member with permanently inoperative larynx condition.

    Refer to *Footwear in Outpatient Benefits* and *Foot Orthotics/Footwear in Other Exclusions and Limitations*

in this Section.

For a detailed listing of covered DME, and prosthetic and corrective appliances, please call VEBA Direct's TPA at 1-800-624-8822.

46. **Radiation Therapy (Standard and Complex) –**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include but are not limited to brachytherapy (radioactive implants) and conformal photon beam radiation and IMRT. Gamma knife procedures and stereotactic radiosurgery procedures are covered as outpatient surgeries for the purpose of determining Co-payments or Deductibles. (Please refer to your *Schedule of Benefits* for applicable Co-payment/Deductible, if any.)
47. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It includes Medically Necessary dental or orthodontic services that are an important part of the reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies related with cleft palate. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Prior Authorization by the Member's Network Medical Group or the TPAin agreement with standards of care as practiced by Physicians specializing in reconstructive surgery.
48. **Refractions** – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's Health Plan includes a supplemental vision benefit.) Coverage under this benefit also includes 1 pair of eyeglasses when prescribed following cataract surgery with an intraocular lens implant. Eyeglasses must be obtained through Network Medical Group.
49. **Substance-Related and Addictive Disorder Services –** The below list of outpatient services for the diagnosis, prevention and treatment of Substance-Related and Addictive Disorders are covered under this health plan. Certain Outpatient Substance-Related and Addictive Disorders Services require Prior Authorization including Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment and Community-based Medical Detoxification.
    - Outpatient Substance-Related and Addictive Disorders Services - Outpatient services for the diagnosis, prevention and treatment of Substance-Related and Addictive Disorders by licensed behavioral health professionals including evaluations and assessments, individual, family and group psychotherapy, medication management and medication-assisted treatment for opioid use disorder.
    - Intensive Outpatient Treatment Programs which require Prior Authorization including:
        - Short-term facility-based intensive outpatient care (Partial Hospitalization/Day Treatment)
        - Short-term multidisciplinary treatment in an intensive outpatient program (IOP)
        - Community-based Medical Detoxification

    Prescribed medications are covered as described in the *Outpatient Prescription Drug Benefit* supplement to this *Combined Evidence of Coverage and Disclosure Form*.

    See your *Schedule of Benefits* for any amounts you may have to pay.
50. **Standard X-rays** – Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms),

mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasound and DEXA scans). See *Specialized Scanning and Imaging Procedures* in *Outpatient Benefits* for coverage and examples of specialized scanning and imaging procedures.

51. **Specialized Scanning and Imaging Procedures** – Specialized scanning and imaging procedures are covered for the diagnosis and ongoing medical management of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as Standard X-rays (see Standard X-rays, item # 46, in *Outpatient Benefits)*, are digitally processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EMG, and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms, and non-obstetrical ultrasounds.

52. **Telehealth Services** – Benefits are available for applicable Covered Health Care Services received through Telehealth. Benefits are also provided for Remote Physiologic Monitoring. No in-person contact is required between a licensed health care provider and a Covered Person for Covered Health Care Services appropriately provided through Telehealth, subject to all terms and conditions of the Agreement.

    Prior to the delivery of Covered Health Care Services via Telehealth, the health care provider at the originating site shall verbally inform the Covered Person that Telehealth may be used and obtain verbal consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

    We shall not require the use of Telehealth services when the health care provider has determined that it is not appropriate. The appropriate use of Telehealth services is determined by the treating Physician pursuant to his or her agreement with us.

    Telehealth does not replace the in-person diagnosis, consultation or treatment with your Primary Care Physician, treating Specialist or other health care Provider. Telehealth will be covered on the same basis and to the same extent as Covered Health Care Services delivered in-person. Telehealth services will also be subject to the same Deductible and/or Out-of-Pocket Limit as equivalent Covered Health Care Services delivered in person.

53. **Virtual Care Services** – Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

    Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

    Benefits are available for urgent, on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

    Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed. Virtual Care Services will be covered on the same basis and to the same extent as Covered Health Care Services delivered in-person. The Co-insurance or Co-payment for Virtual Care Services received through a Designated Virtual Network Provider will accrue to any applicable Deductible and/or Out-of-Pocket Limit.

Benefits do not include services that occur within medical facilities (CMS defined originating facilities).

You have the ability to receive services on an in-person basis or via Telehealth, if available, from your Primary Care Physician, treating Specialist, or from another Network individual health professional, clinic, or health facility. If you are currently receiving specialty Telehealth services for a mental or behavioral health condition, you may continue receiving that service with a Network individual health professional, clinic, or facility.

Prior to the delivery of Virtual Care Services, the Designated Virtual Network Provider shall verbally inform the Covered Person that Virtual Care Services may be used and obtain verbal consent from the Covered Person for this use. The verbal consent shall be documented in the Covered Person's medical record.

The Covered Person has the right to access his or her medical records, and the record of any Virtual Care.

Services provided by a Designated Virtual Network Provider shall be shared with the Covered Person's Primary Care Physician unless the Covered Person prohibits sharing his or her medical records.

Other Mental Health Care and Substance Related and Addictive Disorder Services

1. **Ambulance –** Use of an ambulance (land or air) for Emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 emergency response system is covered without Prior Authorization when the Member reasonably believes that the Mental Health Care and Substance Related and Addictive Disorder requires Emergency Health Care Services that require ambulance transport services.

   Use of an ambulance or a psychiatric transport service for a non-emergency is covered only when specifically authorized by USBHPC and if:

   - USBHPC or a network practitioner determines the Member's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and
   - The use of other means of transportation would endanger the Member's health.
   - These services are covered only when the vehicle transports the Member to or from covered Mental Health Care and Substance Related and Addictive Disorder.

2. **Laboratory Services** – Diagnostic and therapeutic laboratory services are covered when ordered by a network practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Health Disorder and/or Substance-Related and Addictive Disorder.
3. **Inpatient Prescription Drugs** – Inpatient prescription drugs are covered only when prescribed by a USBHPC network practitioner for treatment of a Mental Health Disorder or Substance-Related and Addictive Disorder while the Member is confined to an Inpatient Treatment Center or Residential Treatment Center.
4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC network practitioner for treatment of a Mental Health Care Disorder.
5. **Psychological and Neuropsychological Testing** – Medically Necessary psychological testing is covered when authorized/prior authorized by USBHPC and provided by a network practitioner who has the appropriate training and experience to administer such tests. Neuropsychological testing does not require Prior Authorization unless required by the Health Plan.

Exclusions and Limitations of Benefits

Unless described as a Covered Health Care Service in **Section 5. Your Medical Benefits**, the following services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*. (Note: Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.)

General Exclusions

1. Services that are provided without authorization from the Member's Network Medical Group or the TPA (except for Emergency Health Care Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, family practice Physician or surgeon designated by the Member's Network Medical Group as providing OB/GYN services) are not covered, except for Emergency Health Care Services and out-of-area Urgently Needed Services.
2. Services obtained from Out-of-Network Providers not affiliated with the Member's Network Medical Group and/or services not authorization and/or covered by VEBA Direct or the Network Medical Group, except for Emergency Health Care Services and out-of-area Urgently Needed Services.
3. Services provided prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. VEBA Direct does not cover the cost of services provided in preparation for a non-Covered Health Care Service where such services would not otherwise be Medically Necessary. Additionally, VEBA Direct does not cover the cost of routine follow-up care for non-Covered Health Care Services (as recognized by the organized medical community in the State of California). VEBA Direct will cover Medically Necessary services directly related to non-Covered Health Care Services when complications exceed routine follow-up care.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for the following:
    - Emergency Health Care Service provided by an Out-of-Network Provider.
    - Urgently Needed Services provided by an Out-of-Network Provider
    - Covered Health Care Services provided at certain Network facilities by an out-of-network Physician when not Emergency Health Care Services. For these Covered Health Care Services. "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.
    - Air ambulance transport provided by an Out-of-Network Provider
    - Authorized post-stabilization care, or
    - Other specific services authorized by your Network Medical Group or the TPA, when you are away from the geographic area served by your Network Medical Group

Other Exclusions and Limitations

1. **Acupuncture and Acupressure** – Acupuncture and acupressure are not covered. (Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer as a

supplemental benefit. If the Member's Health Plan includes acupuncture and acupressure supplemental

benefit, a brochure describing it will be enclosed with these materials.) This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.

3. **Ambulance** – Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a private vehicle or taxi fare are also not covered).

   Please refer to *Ambulance* in the *Outpatient Benefits* section and *Organ Transplants* in the *Other Exclusions and Limitations* section.

4. **Artificial Hearts** – Artificial hearts are considered Experimental and are, therefore, not covered.

   A Member may be entitled to an expedited external, independent review of VEBA Direct's coverage determination regarding Experimental or Investigational therapies as described in **Section 8**.

5. **Bariatric Surgery –** Bariatric surgery will only be covered when Medically Necessary for the treatment of morbid obesity. We will use evidence-based criteria to determine coverage of bariatric surgery, such as the most recent *National Institutes of Health (NIH)* guidelines, in determining the Medical Necessity of requests for surgical treatment for morbid obesity. The TPA's evaluation encourages a multidisciplinary team approach that includes medical, surgical, psychological, and nutritional expertise for those who are seeking surgical weight-loss. After surgery, the Member takes part in a multidisciplinary program of diet, exercise, and behavior modification.

   Surgical treatments for morbid obesity and services related to this surgery are subject to prior approval by the TPA's medical director or designee. Please also see *Weight Alteration Program (Inpatient or Outpatient)*.

6. **Biofeedback** – Biofeedback services are not covered except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Member with organic neuromuscular impairment and part of an authorized treatment plan.

7. **Bloodless Surgery**- Surgical procedures performed without blood transfusions or blood products, including Rho(D) immune globulin for members are covered when Medically Necessary and Prior Authorization is obtained.

8. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is not covered except when either of the following applies:

   a. For Members with craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or

   b. For Members with hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Repairs and/or replacement for the implanted components of a bone-anchored hearing aid for a Member who meets the above coverage criteria are not covered, other than for malfunctions. Replacement of external hearing aid components for bone-anchored hearing aids is covered under the DME benefit. External components for bone-anchored hearing aids are either body-worn or worn behind the ear. Examples of external components include an external abutment and a sound processor. Replacement of external hearing aid components is only covered due to malfunction and when the condition of the device or part requires repairs that exceed the cost of replacement. Deluxe model and upgrades that are not Medically Necessary are not covered.

9. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form* under the caption, "Independent Medical Review Procedures." The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. Unrelated donor searches must be performed at a VEBA Direct-approved transplant center. (See Designated Facility in **Definitions**.)
10. **Breast Pumps** – Covered Health Care Services are limited to one breast pump in conjunction with childbirth. The breast pump must be obtained from a Network Provider as determined by the Member's Network Medical Group or the TPA. If more than one breast pump can meet the Member's needs, Covered Health Care Services are available only for the most cost effective pump that meets the Member's needs. The Member's Network Medical Group or the TPA will determine the following:
    - Which pump is the most cost-effective.
    - Timing of a purchase.
11. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered. (Coverage for chiropractic care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a chiropractic care supplemental benefit, a brochure describing it will be enclosed with these materials.)
12. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered. For a detailed listing of covered DME and prosthetic and corrective appliances, please call VEBA Direct's TPA at 1-800-624-8822.
13. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine are not covered unless purchased by your Group as a supplemental benefit. Religious nonmedical health care is not covered. (See the definition for "Complementary and Alternative Medicine.")
14. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered.
15. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice facility incident to a Member's terminal illness as described in the explanation of Hospice services in the Medical Benefits section of this *Combined Evidence of Coverage and Disclosure Form*. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. This exclusion does not apply to authorized Medically Necessary covered services provided to a Member residing in a Custodial Care facility or for the Medically Necessary treatment of Mental Health Care Services and Substance-Related and Addictive Disorders.
16. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned, Oral Surgery and Dental Services, dental care, dental appliances and orthodontics are not covered. Dental care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for dental care may be available if purchased by the Subscriber's employer as a separate

benefit. If your Health Plan includes a dental care separate benefit, a brochure describing it will be enclosed with these materials.)

17. **Dental Treatment Anesthesia** – Dental treatment anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, are not covered except for services covered by VEBA Direct under the *Outpatient Benefit*, **Section 5. Oral Surgery and Dental Services**.
18. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Network Medical Group. The fact that the Member is outside the geographic area served by the Network Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.
19. **Disabilities Connected to Military Services** – Treatment in a government facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency and to which Member has reasonable access is not covered.
20. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs, infusion therapy, and prescribed contraceptive drugs required by federal law are not considered outpatient drugs for the purposes of this exclusion. Refer to *Injectable Drugs*, *Family Planning* and *Infusion Therapy* in the Outpatient Benefits **Section 5. Your Medical Benefits**. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.
21. **Durable Medical Equipment (DME)** – Replacements, repairs and adjustments to DME are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen DME is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to DME for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to fit the Member's physical condition. For a detailed listing of covered DME, please call VEBA Direct's TPA at 1-800-624-8822.

    Please refer to *Bone-Anchored Hearing Aid* in the *Outpatient Benefits* and in the *Other Exclusions and Limitations* section for a description of coverage for external hearing aid components subject to the DME benefit and limitations.
22. **Educational Services for Developmental Delays and Learning Disabilities** – Non-Clinical educational services for Developmental Delays and Learning Disabilities are not Covered Health Care Services. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade are not covered. The Plan does not cover tutoring, special education/instruction required to help a child to make academic progress: academic coaching, teaching Members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered.

    VEBA Direct's TPA refers to *American Academy of Pediatrics, Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services.

    We do not cover any of the following:

    - Items and services to increase academic knowledge or skills;

- Special education (teaching to meet the educational needs of a person with an Intellectual Disability, Learning Disability, or Developmental Delay). A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and social development. This exclusion does not apply to Covered Health Care Services when they are authorized, part of a Medically Necessary treatment plan, provided under the supervision of a licensed or certified health care professional and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law;
- Teaching and support services to increase academic performance;
- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Network Provider acting within the scope of his or her license under California law that is intended to address speech impairments;
- Teaching how to read, whether or not the Member has dyslexia;
- Educational testing;
- Teaching (or any other items or services related to) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law.

This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

23. **Elective Enhancements** – Procedures, technologies, services, drugs, devices, items, and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation, or genetic manipulation related to hair growth, aging, athletic performance, intelligence, height, weight, or cosmetic appearance.
24. **Enteral Feeding** – Enteral Feedings (food and formula) including phenylketonuria (PKU) and the accessories and supplies are not covered except as shown under Enteral Formula. Food products naturally low in protein are not covered. Pumps and tubing are covered under DME in Outpatient Benefits. Formulas and special food products for phenylketonuria (PKU) are covered as described under the outpatient benefit captioned *Phenylketonuria (PKU) Testing and Treatment*. Pumps and tubing are covered under the *DME* Outpatient Benefits in this section. This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.
25. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.
26. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or Investigational procedures, items and treatments are not covered unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular

treatment is Experimental or Investigational and therefore not a covered benefit are determined by the TPA's medical director, or his or her designee.

For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

- It cannot lawfully be marketed without the approval of the *U.S. Food and Drug Administration (FDA)* and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device application on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official documents issued by the FDA and *Department of Health and Human Services (DHHS)*.
- It is being provided according to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself according to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by the TPA in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Health Plan, include, but are not limited to, the following:

- The Member's medical records;
- The protocol(s) according to which the drug, device, treatment or procedure is to be delivered;
- Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations, e.g., *ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman*;
- Regulations and other official actions and documents issued by agencies such as the *FDA, DHHS and Agency for Health Care Policy and Research (AHCPR)*.

A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of VEBA Direct's coverage determination regarding Experimental or Investigational therapies as described in **Section 8. Overseeing Your Health Care**, *Experimental or Investigational Treatment Decisions*.

27. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for the treatment of keratoconus aphakia and aniridia, as a corneal bandage, and one pair after each cataract extraction). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.)

    Routine screenings for glaucoma are limited to Members who meet the medical criteria.

28. **Family Planning** – Family planning benefits, other than those specifically listed in the *Family Planning* Outpatient Benefits section and in the *Schedule of Benefits* that accompanies this document, are not covered.

29. **Follow-up Care: Emergency Health Care Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Health Care Services or Urgently Needed Services, including, but not limited to, treatments, procedures, x-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care, are not covered without the Network Medical Group's or the TPA's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Network Medical Group will not entitle the Member to coverage.

30. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.

31. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. (Coverage for specialized footwear for foot disfigurement may be available if the Subscriber's employer purchased a footwear supplemental benefit. If your Health Plan includes a footwear supplemental benefit, a brochure describing it will be enclosed with these materials.) Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Network Medical Group or the TPA.

32. **Genetic Testing, Treatment or Counseling** – Non-Medically Necessary screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to begin medical interventions/treatment while a newborn, a child or adolescent. Members who have no clinical evidence or family history of a genetic abnormality.

    Refer to *Preventive Care Services and Maternity Care*, *Tests*, *Procedures, and Genetic Testing* in the Outpatient Benefits section for coverage of amniocentesis and chorionic villus sampling.

33. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law or as noted below:

    Services While Confined or Incarcerated – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined according to federal, state or local law are not covered. However, VEBA Direct will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any Facility, if the services were provided or authorized by your PCP or Network Medical Group in agreement with the terms of this Health Plan or were Emergency Health Care Services or Urgently Needed Services. This exclusion does not restrict VEBA Direct's liability with respect to expenses for Covered Health Care Services solely because the expenses were incurred in a state or county hospital; however, VEBA Direct's liability with respect to expenses for Covered Health Care Services provided in a state

hospital is limited to the rate VEBA Direct would pay for those Covered Health Care Services if provided by a Network Hospital.

34. **Hearing Aids and Hearing Devices** – Hearing aids, including repairs and replacements, are covered up to the limits described in the *Schedule of Benefits*. Replacement of a hearing aid is only covered when the condition of the device or part requires repairs that exceed the cost of a replacement hearing aid. Hearing aids or hearing devices are limited to one hearing aid (including repair or replacement) per hearing impaired ear every three years.
35. **Hospice Services** – Hospice services are not covered for:
    a. Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.
    b. Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a non-certified Hospice program).

    Note: Hospice services provided by an out-of-network Hospice agency are not covered except in certain circumstances in counties in California in which there are no network Hospice agencies and only when prior authorized and arranged by the TPA or the Member's Network Medical Group.
36. **Human Growth Hormone** – Human growth hormone injections for the treatment of idiopathic short stature are covered only when determined Medically Necessary by the TPA's medical director or designee.
37. **Immunizations** – Immunizations and vaccines solely for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered, except as otherwise recommended by the national advisory organizations referenced in the section, *Outpatient Benefits, Preventive Care Services.* Routine boosters and immunizations must be obtained through the Member's Network Medical Group.
38. **Implants** – The following implants and services are not covered:
    - Surgical implantation or removal of breast implants for nonmedical reasons.
    - Replacement of breast implants when the first surgery was done for nonmedical reasons, such as for cosmetic breast augmentation mammoplasty or after cosmetic breast reduction mammoplasty.

    VEBA Direct will cover Medically Necessary services directly related to non-Covered Health Care Services when complications exceed routine follow-up care.
39. **Infertility Reversal** – Reversals of sterilization procedures are not covered.
40. **Infertility Services** – Infertility services are not covered unless purchased by the Subscriber's Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the VEBA Direct Health Plan: ovum transplants, ovum or ovum bank charges, except Medically Necessary iatrogenic infertility preservation, sperm or sperm bank charges and the medical or hospital services incurred by surrogate mothers who are not VEBA Direct Members are not covered. Medical and hospital infertility services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.
41. **Institutional Services and Supplies** – Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies provided by a facility that is mainly a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections titled, *Inpatient Benefits* and *Outpatient Benefits*.) Members residing in

these facilities are eligible for Covered Health Care Services that are determined to be Medically

Necessary by Member's Network Medical Group or the TPA and are provided by Member's PCP or authorized by Member's Network Medical Group or the TPA.

42. **Maternity Care, Tests and Procedures** – Elective home deliveries are not covered. Educational courses or childcare and/or prepared childbirth classes are not covered.

43. **Non-Physician Health Care Practitioners** – This Health Plan may not cover services of all Non-Physician Health Care Practitioners. Network Qualified Autism Service Providers, Network Qualified

    Autism Service Professionals, Network Qualified Autism Service Paraprofessionals are covered when criteria are met as authorized by your Network Medical Group or the TPA. Treatment by other Non-Physician Health Care Practitioners other than as shown in **Section 5: Your Medical Benefits**, *Outpatient Benefits* may be available if purchased as a supplemental benefit. (For coverage of Mental Health Disorder, refer to *Inpatient and Outpatient Benefits, Mental Health Care Services*.) This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

44. **Nurse Midwife Services** – Licensed/Certified nurse-midwife services are covered only when available within the Member's Network Medical Group. Elective home deliveries are not covered.

45. **Nursing Services, Private Duty** – Private-Duty Nursing Services are not covered. Private-Duty Nursing Services include nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

46. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the *Outpatient Benefits* description of *Phenylketonuria (PKU) Testing and Treatment or Enteral and Parenteral Nutrition*.

47. **Off-Label Drug Use** – Off-label drug use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved by the FDA, including off-label self-injectable drugs, is not covered except as follows: If the self-injectable drug is prescribed for off-label use, the drug and its administration is covered only when the following criteria are met:

    The drug is approved by the FDA;

    - The drug is prescribed by a Network Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
        a. *The American Hospital Formulary Service's Drug Information*,
        b. One of the following compendia, if recognized by the federal *Centers for Medicare and Medicaid Services* as part of an anticancer chemotherapeutic regimen:

           (i) *The Elsevier Gold Standard's Clinical Pharmacology*;

           (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*;

           (iii) *The Thomson Micromedex DRUGDEX*, or
        c. two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Nothing in this section shall prohibit VEBA Direct from use of a formulary, Co-payment or Deductible, and or the use of a technology assessment panel or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different than the use for which the drug has been approved for marketing by the FDA. Benefits will also include Medically Necessary Covered Health Care Services related to the administration of a drug subject to the conditions of this *Combined Evidence of Coverage and Disclosure Form* and the supplements of this document.

48. **Oral Surgery and Dental Services** – Dental services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered except for Medically Necessary dental or orthodontic services that are an integral part of the reconstructive surgery for cleft palate procedures. Refer to *Reconstructive Surgery* procedure.
49. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see *Dental Care, Dental Appliances and Orthodontics* and *Dental Treatment Anesthesia*.)
50. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors take place through a registry are covered when the Member is the intended recipient. Donor searches are only covered when performed by a Provider included in the Designated Facility.
51. **Organ Transplants** – All organ transplants must be prior authorized by VEBA Direct and performed in a Designated Facility.
    - Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member's Primary Residence as prior authorized by the TPA. Transportation and other non-clinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for Designated Facility in **Section 10 Definitions**.)
    - Food and housing are not covered unless the Designated Facility is located more than 60 miles from the Member's Primary Residence, in which case food and housing are limited to $125 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as prior authorized by the TPA Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
    - Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, VEBA Direct will only cover the costs related to the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant review incurred at the second facility. (See the definition for Regional Organ Procurement Agency under Designated Facility in **Section 10 Definitions**.)
    - Artificial heart implantation and non-human organ transplantation are considered Experimental and are therefore excluded. Please refer to the exclusions titled, *Experimental and/or Investigational Procedures, Items and Treatment* and to the Independent Medical Review process outlined in **Section 8. Overseeing Your Health Care**.

52. **Pain Management** – Pain management services are covered for the treatment of long term and acute pain only when they are received from a Network Provider and authorized by the TPA or its designee.
53. **Physical or Psychological Examinations** – Physical or psychological exams for court hearings, travel, premarital, pre-adoption, employment or other non-health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation and/or testing are not covered. (For a description of Mental Health Care Services, please refer to **Section 5 Your Medical Benefits.**)
54. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during Inpatient Hospitalization are not covered.
55. **Prosthetics and Corrective Appliances/Non-Foot Orthotics** – Replacement of prosthetics or corrective appliances/ orthotics is covered when determined Medically Necessary by the Member's Network Medical Group or the TPA. Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered. For a detailed listing of covered DME and prosthetics and corrective appliances, please call VEBA Direct's TPA at 1-800-624-8822.
56. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by the TPA's Medical Director or designee.
57. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:
    - When there is another more appropriate surgical procedure that has been offered to the Member; or
    - When only a minimal improvement in the Member's appearance is expected to be achieved.

    Prior Authorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
58. **Recreational, Lifestyle, or Hypnotic Services** – Recreational, lifestyle, or hypnotic services, and related testing are not covered except as provided in this paragraph. Recreational therapy services are only covered when they are authorized, part of a Medically Necessary treatment plan, provided by an authorized provider who is a registered physical, speech or occupational therapist or a health care professional under the supervision of a licensed physical therapist acting within the scope of his or her license or as authorized under California law. See *Inpatient Rehabilitation Care* under *Inpatient Benefits* and *Outpatient Medical Rehabilitation and Habilitation Therapy* under *Outpatient Benefits* for an explanation of coverage of physical, occupational and speech therapy. This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.
59. **Rehabilitation and Habilitative Services and Therapy** – Rehabilitation and Habilitative Services and therapy will be provided only as Medically Necessary and are provided by an authorized provider acting within the scope of his or her license or as authorized under California law and are either limited or not covered as listed below.

    Speech, occupational or physical therapy are not covered when medical or mental health documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.

    Cognitive Habilitative and Rehabilitation Therapy is limited to neuropsychological testing by a Provider acting within the scope of his or her license or as authorized under California law and the Medically Necessary treatment of functional deficits due to a traumatic brain injury or cerebral vascular insult or when provided as part of an authorized autism behavioral health treatment plan. This benefit is limited to

outpatient habilitation and rehabilitation limitation, if any and inpatient only when a Member also meets criteria for inpatient medical rehabilitation and Habilitative Services.

Developmental Testing beyond the first diagnosis is limited to Medically Necessary testing for medical conditions and Autism Spectrum Disorder.

Exercise programs are only covered when they are part of an authorized treatment plan and require the supervision of a licensed physical therapist and are provided by an authorized provider acting within his or her license or as authorized under California law.

Activities that are solely recreational, social or for general fitness, such as gyms and dancing classes, are not covered.

Aquatic/pool therapy is not covered unless it is part of an authorized treatment plan and is provided by a licensed physical therapist who is a Network Provider acting within the scope of his or her license or as authorized under California law.

Massage therapy is not covered except if it is part of a physical therapy treatment plan and covered under *Inpatient Hospital, Outpatient Services, Home Health Care, Hospice Services,* or *Skilled Nursing Care* in this *Evidence of Coverage*.

The following Habilitative and Rehabilitation Services, special evaluations and therapies are not covered:

- Biofeedback (except when Medically Necessary for the treatment of urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.)
- Cognitive Behavioral Therapy, unless Medically Necessary and provided by a Network Provider acting within the scope of his or her license or as authorized under California law.
- Hypnotherapy.
- Psychological and Neuropsychological Testing unless Medically Necessary to diagnose and treat an illness, including Mental Health Disorders or injury.
- Vocational habilitation and rehabilitation.

This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

60. **Reproduction Services** – including, but not limited to sperm preservation in advance of hormone treatment or gender dysphoria surgery, elective fertility preservation, cryopreservation of the fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus.
61. **Respite Care** – Respite care is not covered unless part of an authorized Hospice plan and is needed to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis, not to exceed five consecutive days at a time.
62. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the geographic area served by the Member's Network Medical Group. Although it may be Medically Necessary, out-of-area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Health Care Service.
63. **Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels are not covered.
64. **Sperm preservation in advance of hormone treatment or gender surgery.**

65. **Surgical treatment not prior authorized by the TPA or designee.**

66. **Surrogacy** – Infertility and maternity services for non-Members are not covered.
67. **Third-Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the section, the TPA's *Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses*.
68. **Transportation –** Transportation is not a covered benefit except for ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form*.

    Also see *Organ Transplants* listed in *Other Exclusions and Limitations*. Additionally, you can refer to the Benefit Interpretation Policy Manual as to transportation relating to *Gender Dysphoria at* ***www.myuhc.com***.
69. **Treatment received outside the United States –** Surgery or non-surgical treatment for gender dysphoria performed outside of the United States is not covered.
70. **Vision Care** – See *Eyewear and Corrective Refractive Procedures* listed in *Other Exclusions and Limitations.*
71. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
72. **Visual Aids** – Visual aids are not covered, except as shown under the *Outpatient Benefits* for *Diabetic Self-Management Items*. Electronic and non-electronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit.)
73. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered except as noted in this paragraph. These programs include, but are not limited to, dietary reviews, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are non-authorized weight loss program laboratory tests related to monitoring weight loss or weight gain, except as described under *Inpatient Benefits Morbid Obesity (Surgical Treatment)*. For further information on benefits, please refer to **Section 5: Your Medical Benefits** and to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form* for USBHPC under Mental Health Disorders.

    For all adults, the *United States Preventive Services Task Force* recommends screening for obesity. Providers should offer or refer patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. Services performed in a network physician's office are described under *Preventive Care Services* in **Section 5: Your Medical Benefits**.

    This exclusion does not apply to Medically Necessary treatment for Mental Health Care Services and Substance-Related and Addictive Disorders.

Are Incentives Available to You?

Sometimes we may offer enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non- TPA or VEBA Direct entity. The decision about whether or not to take part in a program is yours alone.
However, we recommend that you discuss taking part in such programs with your Physician. Contact the TPA at www.myuhc.com or the telephone number on your ID card if you have any questions.

SECTION 6. PAYMENT RESPONSIBILITY

What are Premiums and Co-payments

What to Do if You Get a Bill

Coordinating Benefits

Medicare Eligibility

Workers' Compensation Eligibility

Other Benefit Coordination Issues

This section explains these and other health care expenses. It also explains your responsibilities when you are eligible for Medicare or workers' compensation coverage and when the TPA needs to coordinate your benefits with another plan.

What are Premiums?

Premiums are fees an Employer Group pays to cover the basic costs of your health care package. An Employer Group usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know if you are contributing to your Premium payment; if you are not sure, contact your Employer Group's health benefits representative. He or she will know if you are contributing to your Premium, as well as the amount, method and frequency of this contribution.

What are Co-payments?

You may be responsible for paying a charge when you receive a Covered Health Care Service. This charge is called a Co-payment and is outlined in your *Schedule of Benefits*. If you review your *Schedule of Benefits*, you will see that the amount of the Co-payment depends on the service, as well as the Provider from whom you choose to receive your care.

For HSAs only: If you intend to use this Health Plan with a Health Savings Account (HSA), you must open an HSA with a financial institution qualified under applicable federal law and *Internal Revenue Service* Rules. Please seek professional guidance from your tax or financial advisor.

What is a Calendar Year Deductible?

The Calendar Year Deductible is the amount incurred for a Covered Health Care Service that you are responsible for paying each Calendar Year before benefits are payable under the *Combined Evidence of Coverage and Disclosure Form*. The amounts applied towards the Calendar Year Deductible are based upon the Health Plan's contracted rate, or the Recognized Amount when applicable. The Deductible is waived for certain Covered Health Care Services. Please refer to the *Schedule of Benefits* for detailed information on the Deductible amount and Covered Health Care Services subject to the Deductible. If your coverage includes a Deductible, we will not cover certain services until you meet the Deductible each Calendar Year. The Calendar Year Deductible is in addition to any Co-payment responsibility. The Calendar Year Deductible applies to the annual out-of-pocket limit. If you feel you have surpassed your annual Deductible amount, you may submit all of your health care receipts for Covered Health Care Services that are subject to the Deductible to the address provided below along with a letter of explanation.

Individual/Family Deductible

When the amount incurred for Covered Health Care Services for all Family Members accrue to the amount indicated on the *Schedule of Benefits*, no additional Calendar Year Deductible will apply to the other Family Members for the rest of that Calendar Year.

All Health Plans have an embedded individual/family Deductible. The individual Deductible is embedded in the family Deductible. When an individual Member of a family unit satisfies the individual Deductible for the Calendar Year, no further Deductible will be required for that individual Member for the remainder of the Calendar Year.

The remaining family Members will continue to pay full Member charges for services that are subject to the Deductible until the Member satisfies the Individual Deductible or until the family, as a whole, meets the family Deductible.

Annual Co-payment Limit

For certain Covered Health Care Services, there is a limit placed on the total amount you pay for Co-payments during a Calendar Year. This limit is called your Annual Co-payment Limit, and when you reach it, for the remainder of the Calendar Year, you will not pay any additional Co-payments for these Covered Health Care Services. Co-payments paid for certain Covered Health Care Services are not applicable to a Member's Annual Co-payment Limit; these services are shown in the *Schedule of Benefits*.

When an individual Member meets the Annual Co-payment Limit, no further Co-payments are required for the year for that individual.

Note: The calculation of your Annual Co-payment Limit includes VEBA Direct benefits, including behavioral health, pediatric dental, pediatric vision, and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision, chiropractic and infertility, if purchased by your employer, benefit plans that may be offered by your Employer Group.

What If You Get a Bill?

If you are billed for a Covered Health Care Service provided or authorized by your PCP or Network Medical Group or if you receive a bill for Emergency Health Care Services or Urgently Needed Services, you should do the following:

1. Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to the TPA.
2. Give the Provider your VEBA Direct Health Plan information, including your name and VEBA Direct Member number.
3. Forward the bill to the TPA:

   UnitedHealthcare of California
   Claims Department
   P.O. Box 30968
   Salt Lake City, UT 84130-0968

Include your name, your VEBA Direct Health Plan ID number and a brief note that indicates you believe the bill is for a Covered Health Care Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional help, call the TPA.

Please Note: Your Provider will bill you for services that are not covered by VEBA Direct or have not been properly authorized. You may also receive a bill if you have exceeded VEBA Direct's coverage limit for a benefit.

Deductible and Out-of-Pocket-Limit Accrual Balances

Up-to-date Deductible and Out-of-Pocket Limit accrual balances will be provided to you as you use Benefits and will appear on your Explanation of Benefits and/or Health Statement or at any time by visiting www.myuhc.com], or by contacting us at the telephone number on your ID card.

You may choose to receive this information electronically by registering for paperless delivery at www.myuhc.com, or by contacting us at the telephone number on your ID card.

What is a Schedule of Benefits?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Health Care Services unique to your Health Plan. It also includes your Co-payments/Deductibles, as well as the Annual Co-payment Limit and other important information. If you need help understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills From Out-of-Network Providers

If you receive a bill for a Covered Health Care Service from a Physician who is not one of our Network Providers, and the service was prior authorized and you have not exceeded any applicable benefit limits, VEBA Direct will pay for the service, less the applicable Co-payment/Deductible. (Prior Authorization is not required for Emergency Health Care Services and Urgently Needed Services. See **Section 3. Emergency Health Care and Urgently Needed Services**.) Out-of-Network Providers may not send you a bill for Emergency Health Care Services. You are only required to pay the Co-payment/Deductible amount shown in your *Schedule of Benefits*. You may also submit a bill to us if an Out-of-Network Provider has refused payment directly from VEBA Direct.

If you receive Covered Health Care Services in a Network contracting health care facility but from an out-of-network individual health professional, you are only required to pay the Co-payment/Deductible amount specified in your *Schedule of Benefits*. A network "contracting health facility" includes, but not limited to, a licensed hospital; ambulatory surgery center or other outpatient setting, lab, radiology or imaging center. You should not be billed more than the amounts shown on your *Schedule of Benefits*.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to the TPA:

UnitedHealthcare of California
Claims Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

Include your name, VEBA Direct Health Plan ID number and a brief note that indicates your belief that you have been billed for a Covered Health Care Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

The TPA will make a determination within 30 working days from the date the TPA receives a claim containing all information reasonably needed to decide the claim. VEBA Direct will not pay any claim that is filed more than 180 calendar days from the date the services or supplies were provided. VEBA Direct also will not pay for excluded services or supplies unless authorized by your PCP, your Network Medical Group or directly by the TPA.

Any payment assumes you have not exceeded your benefit limits. If you have reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How Do You Avoid Unnecessary Bills?

Always obtain your care under our direction, your Network Medical Group, or your PCP. By doing this, you only will be responsible for paying any related Co-payments and for charges in excess of your benefit limitations. Except for Emergency Health Care Services or Urgently Needed Services, if you receive services not authorized by the TPA your Network Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by VEBA Direct. (Services not covered by VEBA Direct are included in **Section 5. Your Medical Benefits**.)

Your Billing Protection

All our Members have rights that protect them from being charged for Covered Health Care Services in the event a Network Medical Group does not pay a Provider, a Provider becomes insolvent, or a Provider breaches its contract with VEBA Direct. In none of these instances may the Network Provider send you a bill, charge you, or have any other recourse against you for a Covered Health Care Service. However, this provision does not prohibit the collection of Co-payment/Deductible amounts as outlined in the *Schedule of Benefits*.

In the event of a Provider's insolvency, VEBA Direct will continue to arrange for your benefits. If for any reason VEBA Direct is unable to pay for a Covered Health Care Service on your behalf (for instance, in the unlikely event of VEBA Direct's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your VEBA Direct Network Provider. You may, however, be responsible for any properly authorized Covered Health Care Services from an Out-of-Network Provider or Emergency Health Care Services or Urgently Needed Services from an Out-of-Network Provider.

Note: If you receive a bill because an Out-of-Network Provider refused to accept payment from VEBA Direct, you may not be billed for authorized services for anything except your Co- payments/Deductibles. Please call Customer Services for assistance or submit a claim for reimbursement. See above: Bills From Out-of-Network Providers.

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. "Plan" is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group Health Plans that provide coverage to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group Health Plan provides benefits in the form of services rather than cash payments.

VEBA Direct's COB activities will not interfere with your medical care.

The order of benefit determination rules below determine which Health Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense. Allowable Expense is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a Plan as defined here; however, the TPA does coordinate benefits with Medicare. Please refer to **Section 6**, Important Rules for Medicare and Medicare-Eligible Members.
2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) above is a separate Plan. However, if the same carrier provides coverage to Members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense** means a health care service or expense, including Deductibles and Co-payments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is Medically Necessary) is not an Allowable Expense.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among VEBA Direct and other applicable group Health Plans be establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-Network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent, for example as an Eligible Employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled

the child in u and provided the Plan with a copy of the court order as required in the

"Eligibility" section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

   - The Plan of the Custodial Parent;
   - The Plan of the legal spouse or Domestic Partner of the Custodial Parent;
   - The Plan of the non-Custodial Parent; and then
   - The Plan of the legal spouse of the non-Custodial Parent.

3. **Active or Inactive Eligible Employee.** The Plan that covers a person as an Eligible Employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid-off or retired Eligible Employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working legal spouse or Domestic Partner will be determined under the rule labeled D(1).
4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA (Cal-COBRA)) also is covered under another Plan, the Plan covering the person as an Eligible Employee, Member, Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order of payment, the Plan that covered the person as an Eligible Employee, Member, Subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

- When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.
- If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

The TPA may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give the TPA any facts it needs to apply those rules and determine benefits payable. The TPA may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations,

including, but not limited to, diagnoses payment of health care services provided, billing, claims management or other administrative functions of VEBA Direct, without obtaining the Member's consent, in agreement with state and federal law.

VEBA Direct's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, VEBA Direct may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. VEBA Direct will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made includes providing benefits in the form of services, in which case, payment made means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by VEBA Direct is more than it should have paid under this COB provision, VEBA Direct may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

Important Rules for Medicare and Medicare-Eligible Members

You must let VEBA Direct know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage).

You can become entitled to Medicare three different ways: because of age, disability, or end stage renal disease (ESRD).

If you have group health insurance through a plan that either you or your legal spouse received through an Employer Group that you are actively working at, and you are enrolled in Medicare, the group health insurance is primary over Medicare. However, there are three exceptions to this rule:

1. Employer Group with less than 20 Eligible Employees;
2. Disabled individual and enrolled in a Health Plan with less than 100 Eligible Employees; or
3. Members who are entitled to Medicare due to End Stage Renal Disease (ESRD) after the mandated 18-month period.

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

VEBA Direct will not provide or arrange for benefits, services or supplies required due to a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers' Compensation Act, occupational disease laws, employer's liability or federal, state or municipal law, to recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers' Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers' Compensation Appeals Board.

If for any reason VEBA Direct provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse VEBA Direct for the benefits, services or supplies provided or arranged for, at Prevailing Rates, after receiving a monetary award, whether by settlement

or judgment. The Member must also hold any settlement or judgment collected due to a

workers' compensation action in trust for VEBA Direct. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits provided to him or her or on his or her behalf by VEBA Direct for each incident. If the Member receives a settlement from workers' compensation coverage that includes payment of future medical costs, the Member must reimburse VEBA Direct for any future medical expenses related to this judgment if VEBA Direct covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, VEBA Direct will provide or arrange for benefits until such dispute is resolved, if the Member signs an agreement to reimburse VEBA Direct for 100 percent of the benefits provided.

VEBA Direct will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions of law under the Workers' Compensation Act. Benefits will not be denied to a Member whose employer has not complied with the laws and regulations governing workers' compensation insurance, provided that such Member has sought and received Medically Necessary Covered Health Care Services under this Health Plan.

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, VEBA Direct will pay for the arrangement or provision of health care services for a Member that would have been Covered Health Care Services except that they were required due to a liable third party, in exchange for the agreement as expressly described in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned, VEBA Direct's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses.

VEBA Direct's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, VEBA Direct will pay for the arrangement or provision of health care services for a Member that would have been Covered Health Care Services except that they were required due to a liable third party, in exchange for the following agreement:

If a Member is injured by a liable third party, the Member agrees to give VEBA Direct, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to VEBA Direct, which debt shall include the cost of arranging or providing otherwise Covered Health Care Services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to VEBA Direct, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement

relating to the arrangement or provision of the Member's health care services for injuries caused by a liable third party.

Non-Duplication of Benefits With Automobile, Accident or Liability Coverage

If you are receiving benefits as a result of automobile, accident or liability coverage, VEBA Direct will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected and to notify the TPA of such coverage when available. VEBA Direct will provide Covered Health Care Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

SECTION 7. MEMBER ELIGIBILITY

Who is a VEBA Direct Member?

Adding Family Members

Late Enrollment

Updating Your Enrollment Information

Termination and Rescission of Coverage

Coverage Options Following Termination

This section describes how you become a VEBA Direct Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your VEBA Direct coverage when it would otherwise terminate.

Who is a VEBA Direct Member?

There are two kinds of VEBA Direct Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefits plan. The Employer Group, in turn, has signed a Group Agreement with VEBA Direct.

The following Family Members are eligible to enroll in VEBA Direct:

1. The Subscriber's legal spouse or Domestic Partner,
2. The biological children of the Subscriber or the Subscriber's legal spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see **Definitions**);
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's legal spouse or the Domestic Partner who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to VEBA Direct upon request; and
5. Children for whom the Subscriber, the Subscriber's legal spouse or Domestic Partner is required to provide health insurance coverage pursuant to a qualified medical child support order assignment order, or medical support order, in this section.
6. Any child for whom the Subscriber has assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by the Subscriber, as certified by the Subscriber at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. The term child does not include foster children as determined eligible by the Employer Group.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a federal income tax return;
- Does not reside with the Subscriber or within the VEBA Direct Service Area.

Who is Eligible for Coverage?

All Members must meet all eligibility requirements established by the Employer Group and VEBA Direct. VEBA

Direct's eligibility requirements are:

- Have a Primary Residence within California;

- Have a Primary Residence or Primary Workplace within the Health Plan's Service Area;
- Choose a PCP within 30 miles of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a qualified medical child support order);
- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an Eligible Employee can enroll in VEBA Direct. Employers will also establish the "Limiting Age," the age limit for providing coverage to children.

Eligible Family Members must enroll in VEBA Direct at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to VEBA Direct all applications, medical review questionnaires or other forms or statements that VEBA Direct may reasonably request.

Enrollment is the completion of a VEBA Direct enrollment form (or a nonstandard enrollment form approved by VEBA Direct) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by VEBA Direct, the existence of a valid Employer Group Agreement, and the timely payment of applicable Health Plan Premiums. VEBA Direct may in its discretion and subject to specific protocols accept enrollment data through an electronic submission.

Effective Date of Coverage for New Subscribers and Family Members to Be Added Outside Open Enrollment Period

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the Employer Group or under the terms of the signed Group Agreement provided we receive the completed enrollment form and any required Health Plan Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Health Plan.

The effective date of enrollment when adding Family Members outside of the initial or Open Enrollment Period is explained below. (**Please Note:** VEBA Direct enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

What is a Service Area?

Please call the TPA's Customer Service department for information about VEBA Direct's Service Area.

Open Enrollment

Most Members enroll in VEBA Direct during the "Open Enrollment Period" established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefits plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the employer and VEBA Direct.

Adding Family Members to Your Coverage

The Subscriber's legal spouse or Domestic Partner and eligible children may apply for coverage with VEBA Direct during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your legal spouse or Domestic Partner) because of other Health Plan insurance or group Health Plan coverage, you may be able to enroll yourself and your Dependents in VEBA Direct if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer Group stops contributing toward your or your Dependents' other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents during a special enrollment

period. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period. To obtain more information, contact our Customer Service department.

1. **Getting Married.** When a new legal spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a legal spouse or child eligible as a result of marriage within 30 days of the marriage.
2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered from the moment of birth for the first 60 days of life. In order for coverage to continue beyond the first 60 days of life, an application or Change Request Form must be submitted to VEBA Direct within 60 days to add the newborn child. If you do not enroll the newborn child during the special enrollment period, the newborn is covered for only 60 days (including the date of birth).
4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Subscriber, Subscriber's legal spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's legal spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's legal spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to VEBA Direct along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber, Subscriber's legal spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in VEBA Direct) may enroll a child who is eligible to enroll in VEBA Direct upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a VEBA Direct Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling VEBA Direct's Customer Service department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the Health Plan ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney.
Coverage will begin on the date of the court or administrative order provided we receive the completed enrollment form with the court or administrative order attached and any required Health Plan Premium.

Except for Emergency Health Care Services and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the VEBA Direct Service Area by the designated Network Medical Group, as selected by the custodial parent or person having legal custody.

Continuing Coverage for Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Health Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

A Dependent residing outside of the Service Area must maintain a permanent address inside the Service Area and must select a Network Medical Group within 30 miles of that address. All health care coverage must be provided or arranged for in the Service Area by the designated Network Medical Group, except for Emergency Health Care Services and Urgently Needed Services. A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents who attain the Limiting Age may continue enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The unmarried Dependent is chiefly Dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, VEBA Direct will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age unless proof of such incapacity and dependency is provided to VEBA Direct by the Member within 60 days of receipt of notice. VEBA Direct shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until VEBA Direct makes a determination.

VEBA Direct may require ongoing proof of a Dependent's incapacity and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self- sustaining employment by reason of physical or mental disabling injury, illness or condition.

If you are enrolling a disabled child for new coverage, VEBA Direct may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide VEBA Direct with the requested information within 60 days of receipt of the request. The child must have been covered as a Dependent of the Subscriber or legal spouse under a previous health plan at the time the child reached the age limit.

Late Enrollment

In addition to a special enrollment period due to the addition of a new legal spouse, Domestic Partner or child, there are certain circumstances when employees and their eligible Family Members may enroll outside of the employer's Open Enrollment Period. These circumstances include:

1. The Eligible Employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in VEBA Direct when they were first eligible because they had other health care coverage; and
2. VEBA Direct cannot produce a written statement from the Employer Group or Eligible Employee stating that prior to declining coverage, the Eligible Employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and signed, acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with VEBA Direct during the initial enrollment period permits the Company to impose, beginning on the date the Eligible Employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Health Plan, an exclusion of coverage under

the Health Plan for a period of 12 months unless the Eligible Employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.

3. The other health care coverage is no longer available due to:
    a. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
    b. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
    c. The termination of the other Health Plan coverage; or
    d. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
    e. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered;
    f. The loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage; or
    g. The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or
    h. The employee or eligible Family Member previously declined coverage under the Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP), or the AIM Program. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date of the determination of subsidy eligibility; or
    i. The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP), the AIM Program, or the Medi-Cal program. Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.
4. The Court has ordered health care coverage be provided for your legal spouse or minor child.

If the employee or an eligible Family Member meets these conditions, the employee must request enrollment with VEBA Direct no later than 30 days following the termination of the other Health Plan coverage.
VEBA Direct may require proof of loss of the other coverage, except for Dependent child special enrollment period. Enrollment will be effective on the date agreed to by the Employer Group under the terms of the signed Group Agreement or the first day of the month following receipt by VEBA Direct of a completed request for enrollment. This paragraph does not apply to the Dependent Child Special Enrollment Period.

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or VEBA Direct do not require the consent of a Member. VEBA Direct may amend or modify the Health Plan, including the applicable Premiums, at any time after sending written notice to the Employer Group 60 days prior to the effective date of any amendment or modification. Your Employer Group may also change your Health

Plan benefits during the contract year. In accordance with VEBA Direct's Group Agreement, the Employer Group is obliged to notify employees who are VEBA Direct Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer and VEBA Direct of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see "Adding Family Members to Your Coverage." If you wish to change your PCP or Network Medical Group, you may contact VEBA Direct's TPA's Customer Service department at 1-800-624-8822 or 711 (TTY).

About Your VEBA Direct Health Plan ID Card

Your VEBA Direct Health Plan ID card is important for identifying you as a Member of VEBA Direct. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a PCP or upon referral, any other Network Provider.

Important Note: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her ID card by any other person, VEBA Direct may immediately terminate that Member's membership.

Termination of Benefits

Usually, your enrollment in VEBA Direct terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefits plan. In most instances, your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Health Plan is subject to the terms and conditions of the employer's Group Agreement with VEBA Direct.

When the Group Agreement between the Employer Group and VEBA Direct is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by VEBA Direct for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated at the end of the 30-day grace period. The grace period begins after the last day of paid coverage. VEBA Direct will continue to provide coverage during the grace period. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. In that circumstance, VEBA Direct will notify you directly of such termination.

Termination and Rescission of Coverage

VEBA Direct has the right to terminate your coverage under this Health Plan in the following situations:

For Nonpayment of Premiums. Your coverage may be terminated if the Employer Group failed to pay the required Premiums. VEBA Direct will mail your Employer a notice at least 30 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 30 days of the date the notice was mailed.

If payment is not received from your employer within 30 days of the date the Prospective Notice of Cancellation is mailed, VEBA Direct will cancel the Group contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group contract has been cancelled for nonpayment of Premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date the Plan mails you the Notice Confirming Termination of Coverage.

Reinstatement of the Contract after Cancellation due to Nonpayment of Premiums

If the Group contract is cancelled for the group's nonpayment of Premiums, the Plan will permit reinstatement of the Group contract once during any 12-month period if the group pays the amounts owed within 30 days of the date of the Notice Confirming Termination.

For Fraud or Intentional Misrepresentation of a Material Fact by Member. Your coverage may be rescinded if you intentionally misrepresent a material fact on your enrollment form or commit fraud which may include, but not be limited to, deception in use of services or facilities of VEBA Direct, its Network Medical Group or other health care Providers or intentionally allow another person to do the same or alter a prescription. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. VEBA Direct will send the Employer Group and you a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.

For Fraud or Intentional Misrepresentation of a Material Fact by Employer Group. Your coverage may be terminated, if your Employer Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of the Group Agreement (including any omissions, misrepresentations, or inaccuracies in the application form) or to the provision of coverage under the Group Agreement. Also, VEBA Direct has the right to rescind the Group Agreement back to either: (1) the date of the Group Agreement; or (2) the date of the act, practice or omission, if later. Rescinding coverage means that the Group Agreement and *Combined Evidence of Coverage and Disclosure Form* are void and that no coverage existed at any time. VEBA Direct will send the Employer Group and the Subscriber a written notice via certified mail at least 30 days prior to the effective date of rescission explaining the reasons for the intended rescission and information on how to file an appeal of the decision with the California Department of Managed Health Care.

For Violation of Employer Group's Contribution or Group Participation Requirements. Your coverage may be terminated if your Employer Group fails to meet the Group Contribution or Group Participation requirements as described in the Group Agreement.

For Discontinuance of this Health Plan. Your coverage may be terminated if VEBA Direct decides to cease offering the Health Plan described in this *Combined Evidence of Coverage and Disclosure Form* upon 90

days written notice to the Director of the Department of Managed Health Care, the Employer Group and all Members covered under this Health Plan. If this Health Plan is discontinued, VEBA Direct will make all other health plans offered to new group business available to your Employer Group.

Other Reasons for Termination of Coverage Related to Loss of Eligibility

In addition to terminating the Group Agreement, VEBA Direct may terminate a Member's coverage for any of the following reasons related to loss of eligibility:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or VEBA Direct.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the State of California.
- The Member no longer meets the eligibility requirements under the Health Plan because the Member establishes his or her Primary Residence outside the VEBA Direct Service Area and does not work inside the VEBA Direct Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Customer Service department.

Note: If a Group Agreement is terminated by VEBA Direct, reinstatement with VEBA Direct is subject to all terms and conditions of the Group Agreement between VEBA Direct and the employer.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there's a divorce, the legal spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they reach the Limiting Age established by the employer and do not qualify for extended coverage as a Dependent or as a disabled Dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a Dependent child reaches the Limiting Age.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, VEBA Direct will continue to provide benefits to the

Subscriber or any enrolled Family Member for Covered Health Care Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by VEBA Direct at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination (Individual Continuation of Benefits)

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Health Plan at group rates, plus an administration fee, in certain instances where your coverage under the Health Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your legal spouse and your Dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable Premiums.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

Your hours of employment are reduced to less than the number of hours required for eligibility, or

Your employment ends for any reason other than gross misconduct on your part.

If you are the legal spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Health Plan because any of the following qualifying events happens:

- Your legal spouse dies;
- Your legal spouse's hours of employment are reduced to less than the number of hours required for eligibility;
- Your legal spouse's employment ends (for reasons other than his or her gross misconduct);
- Your legal spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your legal spouse.

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage if group health coverage under this Health Plan is lost because any of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;

3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscriber becomes divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

When is COBRA Coverage Available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, legal spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Health Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event occurs. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

How is COBRA coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. the date coverage ends due to a qualifying event; or
2. the date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Health Plan may elect COBRA continuation coverage on behalf of their legal spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child losing eligibility as a Dependent child under this Health Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his legal spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the legal spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the legal spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the legal spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not occurred.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Maximum Coverage Period Ends

Under COBRA, the continuation coverage may terminate before the maximum coverage period if any of the following events occur:

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA Premium

Under the law, you may have to pay all of the Premium for your continuation coverage. Premium for COBRA continuation coverage is generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to VEBA Direct.

If You Have Questions About COBRA

If you have any questions about your COBRA continuation coverage rights, please contact your Employer Group.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA

benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at

110 percent of the Premium charged for similarly situated Eligible Employees currently working at your former employment. A notice will be provided to you by VEBA Direct at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify VEBA Direct within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from VEBA Direct. If you do not notify VEBA Direct within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to VEBA Direct by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by VEBA Direct. You must pay your initial Premiums to VEBA Direct within 45 days from the date VEBA Direct mails your enrollment package after you notified VEBA Direct of your intent to enroll. Your first Premium must equal the full amount billed by VEBA Direct. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to VEBA Direct by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2024, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll in VEBA Direct on or after January 1, 2024. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or do not make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for VEBA Direct coverage, such as moving outside the VEBA Direct Service Area; or
5. The contract for health care services between your employer and VEBA Direct is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to VEBA Direct within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with VEBA Direct coverage, you may continue the remaining balance of your unused coverage with

VEBA Direct, but only if you enroll with and pay Premiums to VEBA Direct within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and VEBA Direct terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must choose a Network Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Network Medical Group, except for Emergency Health Care Services and Urgently Needed Services.

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other VEBA Direct Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to VEBA Direct along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible for maintaining accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for VEBA Direct to administer this continuation benefit.

California Military Families Financial Relief Act

Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Member Service for information on how to apply for reinstatement of coverage following active duty as a reservist.

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SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

How VEBA Direct Makes Important Decisions?

What to Do if You Have a Problem?

Filing a Grievance

The Appeals Process

Independent Medical Reviews

This section explains how VEBA Direct authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your health plan, including how to appeal a health care decision by VEBA Direct, the TPA or one of our Network Providers. You'll learn the process that is available for filing a formal Grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How VEBA Direct Makes Important Health Care Decisions?

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted by the TPA, or in many situations, by a Network Medical Group. Processes are used to review, approve, modify or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

Medical Necessity refers to an intervention as defined in **Section 10: Definitions**. A service or item will be covered under the VEBA Direct Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

The reviewer may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used to modify or deny requested health care services in specific cases will be provided free of charge to the Provider, the Member and the public upon request.

Decisions to deny or modify requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed Physicians or other appropriately licensed health care professionals.

The reviewer makes these decisions within at least the following time frame required by state law:

- Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five business days from the TPA's, or in many situations, the Network Medical Group's receipt of the information reasonably necessary and requested to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, but not later than 72 hours after the TPA's or in many situations, the Network Medical Group's receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because (i) the TPA, or in many situations the Network Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii consultation by an expert reviewer is required, or (iii) the reviewer has asked that an additional examination or test be

performed upon the Member, provided the examination or test is reasonable and consistent with good

medical practice, the reviewer will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as the TPA or the Network Medical Group becomes aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by the TPA, or in many situations the Network Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

The reviewer will notify requesting Providers initially by fax or telephone of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services, in writing, within two business days of the decision. The written decision to the Member will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with the TPA. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. VEBA Direct's Appeals Process is outlined in this section.

VEBA Direct's Utilization Management Policy

VEBA Direct contracts with its Network Providers, Members and employees and requires utilization management to be conducted in accordance with national, State, and industry standards. VEBA Direct also requires that Network Providers and staff who make utilization decisions, and those who supervise them, are bound by these contracts. The standards require that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. VEBA Direct does not specifically reward Network Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Health Care Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of the TPA's Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidence-based medical literature and documents related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

VEBA Direct's TPA regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Co-payments, or other payment contributions.

In determining whether to cover a service, the TPA uses proprietary technology guidelines to review new devices, procedures and drugs, for the treatment of medical conditions and mental health and substance-related and addictive disorders. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a TPA Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

When a Provider or Member requests Prior Authorization of a procedure/service requiring Prior Authorization, an appropriately qualified licensed health professional reviews the request. The qualified licensed health professional applies the applicable criteria, including, but not limited to:

- Nationally published guidelines for utilization management (Specific guideline information available upon request.
- HCIA-Sachs Length of Stay© Guidelines (average length of Hospital stays by medical or surgical diagnoses).
- The TPA Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP). (*UnitedHealthcare's Medical Management Guideline Manual* and *Commercial HMO Benefit Interpretation Policy Manual* are available at **www.myuhc.com**.)

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Network Medical Group's Medical Director or a TPA Medical Director.

Denial, delay or modification of health care services based on Medical Necessity must be made by an appropriately qualified licensed Physician or a qualified licensed health professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for reasons other than Medical Necessity that include, but are not limited to, the fact that the patient is not a VEBA Direct Member or that the service being requested is not a benefit provided by the Member's plan.

Prior Authorization determinations are made once the TPA or Member's Network Medical Group Medical Director or designee receives all reasonably necessary medical information. The TPA makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and federal requirements.

What to Do if You Have a Problem?

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We will assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor or Other Providers and Timely Access to Care**.

If you feel that your problem is not resolved or that your situation requires additional action, you may also submit a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following section: "Appealing a Health Care Decision or Requesting a Quality of Care Review."

Filing a Grievance

You or Your Covered Dependent may file an appeal or grievance with VEBA Direct in response to any Adverse Benefit Determination You or Your Covered Dependent receive notifying you that a claim has been denied.

You may also file an appeal to address any grievance You or Your Covered Dependent have regarding access to, or services received from, the Health Plan or any of its contracted medical or behavioral health service providers. For this purpose, a grievance is any dissatisfaction or disagreement You or Your Covered Dependent have with access to, or services provided by, the Health Plan but only when You or Your Covered Dependent submit the nature of this dissatisfaction or disagreement in writing to the Office of the Ombudsperson.

There are three steps (also referred to as levels of review) in filing an appeal or pursuing a grievance. At each step/level you will receive a written decision from the Health Plan, or its representatives, letting you know if your

appeal or grievance was denied, or it was upheld (which means the Health Plan agrees with you and rendered a decision in your favor).

If your appeal or grievance is denied, the notice of the decision must provide you with enough information for you to understand the basis of the denial, and provide you with an understanding of any additional information you may submit to the Health Plan to perfect your appeal or grievance so that it can be upheld during any of the steps described below. The notice of the decision shall include:

- A citation to any internal rule(s), guideline(s), protocol(s), or other similar criterion relied upon in making the adverse determination, and;
- Whether the decision to deny the claim or grievance is based upon a determination of medical necessity, involved experimental treatment, or any similar exclusion or limit described in the Health Plan's governing documents;
- An explanation of any scientific or clinical judgment used in the determination as applied to the medical circumstances;
- Any determination made by any medical or vocational expert whose advice was obtained on behalf of the Health Plan in order to render a decision, and if the Health Plan disagreed with a determination made by a medical or vocational expert, it must include a statement as to why the Health Plan disagreed with or did not follow that determination;
- A statement of the right You or Your Covered Dependent have to request copies of any documents or materials reviewed by the third-party administrator when deciding your Claim.

First-Level Appeal or Grievance

Filing Deadline:	180 days after receive of the Adverse Benefit Determination, or after the date of occurrence of the events giving rise to a grievance.
Decision Due: **Non-Urgent Claims:** **Urgent Care Claims:**	 30 days after receipt of the first-level appeal request. 72 hours after receipt of the first-level appeal request.
Submit to:	You may call VEBA Direct's TPA Customer Service department at 1-800-624-8822, or at www.myuhc.com. A Customer Service representative will document your oral Grievance. You may also file a Grievance using the Online Grievance form at www.myuhc.com or write to the Appeals Department at: Appeals & Grievances UnitedHealthcare P.O. Box 6107 Mail Stop CA124-0160 Cypress, CA 90630-9972

The first step in obtaining a resolution is to file a first-step/level appeal with VEBA Direct's TPA no more than 180 days after you receive an Adverse Benefit Determination, or from the date you first learn of the grievance you have with the Health Plan. When you contact VEBA Direct's TPA, a representative will be assigned to assist you.

The Grievance Process:

To begin a quality-of-care review or other type of Grievance, or for other questions relating to filing a Grievance, including but not limited to those involving discrimination, call VEBA Direct's TPA's Customer Service department at 1-800-624-8822, or at www.myuhc.com. A Customer Service representative will document your oral Grievance. You may also file a Grievance using the Online Grievance form at www.myuhc.com or write to the Appeals Department at:

Appeals & Grievances

UnitedHealthcare

P.O. Box 6107

Mail Stop CA124-0160 Cypress, CA 90630-9972

This request will begin the Grievance Review Process except in the case of "expedited reviews," as discussed below. You may submit written comments, documents, records and any other information relating to your Grievance regardless of whether this information was submitted or considered in the initial determination.

After receipt of your Grievance:

- We will provide for a written acknowledgment within five calendar days of the receipt of your Grievance. The acknowledgment shall provide you with the following information:
  - That the Grievance has been received.
  - The date of receipt
  - The name of the Health Plan representative and the telephone number and email address of the Health Plan representative who may be contacted about the Grievance.

You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

All quality of clinical care and quality of service complaints are investigated by VEBA Direct's TPA's Health Services Department. VEBA Direct's TPA conducts this quality review by investigating the complaint and consulting with your Network Medical Group, treating Providers and other VEBA Direct TPA internal departments. Medical records are requested and reviewed as necessary, and as such, you may need to sign an authorization to release your medical records. We will respond to your complaint in a manner, appropriate to the clinical urgency of your situation. You will also receive written notification regarding the disposition of your quality of clinical care and/or quality of service review complaint within 30 calendar days of VEBA Direct's TPA's receipt of your complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

The Appeals Process:

You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through VEBA Direct's TPA's Appeals Department. VEBA Direct's TPA's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of VEBA Direct's TPA's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, VEBA Direct's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Health Care Services, the response will specify the provisions in the Combined Evidence of Coverage

Statement and Disclosure Form that exclude that coverage.

To begin an appeal, call VEBA Direct's TPA's Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at www.myuhc.com or write to the Appeals department at:

Appeals & Grievances

UnitedHealthcare

P.O. Box 6107

Mailstop CA124-0160 Cypress, CA 90630-9972

This first-level appeal must be filed with VEBA Direct's TPA within 180 days of the date the events occurred giving rise to any grievance, or after receiving the Adverse Benefit Determination. The Health Plan will assume You or Your Covered Dependent received the Adverse Benefit Determination form seven (7) days after the third-party administrator mailed it to you.

A written decision notifying you as to whether your appeal or grievance has been denied or upheld will be made within thirty (30) days after the written appeal is received by VEBA Direct's TPA. If a written decision is not provided to You or Your Covered Dependent by this deadline, the Health Plan will consider the appeal or grievance to have been denied.

Special Note Regarding Expedited Review Appeals Process:

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to VEBA Direct's TPA's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, VEBA Direct's TPA will immediately inform you of your review status.

Second-Level Appeal

Filing Deadline:	60 days after receipt of the first-step/level appeal denial notice.
Decision Due:	20 days after receipt of the second-level appeal request.
Submit to:	Ombudsperson, California Schools VEBA Phone: 1-888-276-0250 Email: appeals@vebaonline.com Mailing Address: California Schools VEBA c/o Office of the Ombudsperson (VEBA Direct) 1843 Hotel Circle South, Suite 300 San Diego, California 92108

If the grievance or appeal is denied at the first-level, You or Your Covered Dependent have the right to file a written appeal of the denial within sixty (60) calendar days following receipt of the denial of the first level/step appeal. To do this, you must contact the Office of the Ombudsperson using the preceding contact information. When you contact the Office of the Ombudsperson, a representative will be assigned to assist you.

If your first-level appeal or grievance was denied because it involved a benefit that was deemed to be medically unnecessary or not medically appropriate. The VEBA Direct Ombudsperson will submit your second-step/level appeal to a review conducted by an independent medical reviewer who is external to the Health Plan (that is,

this person is not employed by the Health Plan or any of its contracted medical or behavioral health provider groups). This is called "External Review" and will be available to you if you received a medical necessity denial.

The review undertaken by the Independent Medical Reviewer will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the review of the original claim, or as part of the first-step/level benefit decision.

The second-level appeal will be reviewed, and a written decision will be made within twenty (20) days after it has been received by either the Ombudsperson or by the External Reviewer. If a written decision is not provided to You or Your Covered Dependent by this deadline, the claim will be deemed denied, and You or Your Covered Dependent will have the right to submit your appeal or grievance to review by the California Department of Managed Health Care.

Third-Level Appeal

Filing Deadline:	90 days after receipt of the second-step/level appeal denial notice.
Decision Due:	As determined by the California Department of Managed Health Care.
Submit to:	California Department of Managed Health Care – Help Center Phone: 1-888-466-2219 Fax: 1-916-255-5241 Online: https://www.dmhc.ca.gov/FileaComplaint.aspx Mailing Address: Help Center Department of Managed Health Care 980 9th Street, Suite 500 Sacramento, California 95814

If You or Your Covered Dependent disagree with the second-level appeal determination, You or Your Covered Dependent have the right to file a complaint within ninety (90) calendar days following receipt of the denial of the first-level/step appeal to the Director of the California Department of Managed Health Care. The designated representative from the Office of the Ombudsperson assigned to your appeal or grievance will assist You or Your Covered Dependent with filing this complaint. If you do not submit a complaint to the Director of the California Department of Managed Healthcare within the required timeframes, the denial of the second level/step appeal shall be upheld and the denied services will be excluded from coverage.

The review provided by the Director of the California Department of Managed Health Care is final and binding upon you and upon the Health Plan. The review will be conducted using the procedures set forth at Section 1368 of the California Health and Safety Code.

Patient Protection and Affordable Care Act (PPACA) – Changes provided for under the PPACA may impact how appeals are handled and are applicable to your Health Plan.

- An Adverse Benefit Determination includes a decision to rescind coverage. You may submit an appeal for a rescission of coverage determination or a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.
- You may submit an appeal for any Adverse Benefit Determination as defined in **Section 10. Definitions**.
- If any new or additional evidence is relied upon or generated by the TPA or the Network Medical Group

during the determination of an appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

Voluntary Mediation

In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to VEBA Direct. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Binding Arbitration

All disputes of any kind, including, but not limited to, claims relating to the delivery of services under the plan and claims for medical malpractice between the Member (including any heirs, successors or assigns of Member) and VEBA Direct, except for claims subject to ERISA, will be submitted to Binding Arbitration. Medical malpractice includes any issues or allegations that medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. This means that disputes between the Member and VEBA Direct will not be resolved by a lawsuit or by pursuing other court processes and remedies, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Under this provision, neither the Court nor any arbitrator may delay arbitration of disputes or refuse to order disputes to arbitration. The intent of this arbitration provision, and the parties, is to put litigation on hold so that issues can be resolved through the Binding Arbitration process. Any disputes about the scope of arbitration, about the arbitration itself or about whether an issue falls under this arbitration provision will be resolved by the arbitrator to avoid ambiguities and litigation costs.

The Member and VEBA Direct understand and agree that they are giving up their constitutional rights to have disputes decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator. The arbitration will be performed by JAMS or another arbitration service as the parties may agree in writing. The arbitration will be conducted under the JAMS Comprehensive Arbitration Rules and Procedures. The parties will attempt in good faith to agree to the appointment of an arbitrator, but if agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator will be chosen using the appointment procedures set out in the JAMS Comprehensive Arbitration Rules and Procedures. These rules may be viewed by the Member at the JAMS website, **www.jamsadr.com**. If the Member does not have access to the Internet, the Member may request a copy of the rules from VEBA Direct, and arrangements will be made for the Member to obtain a hard copy of the rules and procedures.

Arbitration hearings will be held in San Diego, California or at a location agreed to in writing by the Member and VEBA Direct. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and VEBA Direct. Each party will be responsible for any expenses related to discovery conducted by them and their own attorney fees. In cases of extreme hardship, VEBA Direct may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and JAMS approves the application. The approval or denial of the hardship application will be determined solely by JAMS. The Member will remain responsible for their own attorney fees, unless an award of attorney fees is allowable under the law and the arbitrator makes an award of attorney fees to the Member.
Following the arbitration, the arbitrator will prepare a written award that includes the legal and factual reasons for the decision.

Nothing in this Binding Arbitration provision is intended to prevent the Member or VEBA Direct from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court. However, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, will be subject to this Binding Arbitration provision. Any claim for permanent injunctive relief will

be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, will apply to the arbitration.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED IN COURT BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

Complaints Against Network Medical Groups, Providers, Physicians and Hospitals

Claims against a Network Medical Group, the group's Physicians, or Providers, Physicians or Hospitals – other than claims for benefits under your coverage – are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Network Medical Group (or one of its Network Providers) for claims not involving benefits, VEBA Direct agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The Grievance will not be subject to Binding Arbitration except upon agreement between the parties. Should the parties fail to resolve the Grievance, you or the Network Medical Group (or its Network Provider) may seek any appropriate legal action deemed necessary. Member claims against VEBA Direct will be handled as discussed above under "Appealing a Health Care Decision or Requesting a Quality Review."

SECTION 9. GENERAL INFORMATION

How to Replace Your Card
Translation Assistance
Speech-and Hearing-Impaired Assistance
Coverage in Extraordinary Situations
Compensation for Providers
Organ and Tissue Donation
Public Policy Participation
Nondiscrimination Notice
Important Language Information

This section provides answers to some common and uncommon questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service department. If you have special needs, this document may be available in other formats.

What Should I do if I Lose or Misplace My Membership Card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does VEBA Direct Offer a Translation Service?

The TPA uses a telephone translation service for almost 140 languages and dialects. In addition to Customer Service representatives who are fluent in Spanish, translated Member materials are available upon request. Interpretation services are available at no charge to the member in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services. To get help in your language, please call your health plan's TPA1-800-624- 8822 / TTY: 711.

Does VEBA Direct Offer Hearing-and Speech-Impaired Telephone Lines?

The TPA has a dedicated telephone number for the hearing and speech-impaired. This phone number is 711.

How is My Coverage Provided Under Extraordinary Circumstances?

In the event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Network Medical Groups and Hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Health Care Services. VEBA Direct will provide appropriate reimbursement.

Nondiscrimination Notice

VEBA Direct does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by VEBA Direct directly or through a Network Medical Group or any other entity with which VEBA Direct arranges to carry out Covered Health Care Services under any of its Health Plans.

This statement is in agreement with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued according to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

If you think you were discriminated against, you may file a Grievance with the plan and, if not resolved, you can file a Grievance with the Department of Managed Healthcare ("DMHC"). For filing a Grievance, please refer to Filing a Grievance under Section 8.

If you think you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can file a complaint with the U.S. Department of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

Important Language Information:

You can get translated written materials and an interpreter at no cost. These rights apply only under California law. These rights shall be available in the top 15 languages spoken by limited English-proficient individuals in California as determined by the State Department of Health Care Services.

You can get an interpreter in any of the top 15 languages spoken by limited English-proficient individuals at no cost to help you talk with your doctor or Health Plan. To get help in your language, please call your Health Plan's TPA at:

UnitedHealthcare of California 1-800-624-8822 / TTY: 711

Language services and the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, will be at no charge and provided in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities. For further assistance, please contact your Health Plan's TPA at 1-800- 624-8822 / TTY: 711.

How Does VEBA Direct Compensate Its Network Providers?

VEBA Direct itself is not a Provider of health care. VEBA Direct typically contracts with independent medical groups to provide medical services to its Members, and with hospitals to provide Hospital Services. Once they are contracted, they become VEBA Direct Network Providers.

Network Medical Groups in turn employ or contract with individual Physicians. None of the Network Medical Groups or Network Hospitals, or their Physicians or employees, are employees or agents of VEBA Direct. Likewise, neither VEBA Direct nor any employee of VEBA Direct is an employee or agent of any Network Medical Group, Network Hospital or any other Network Provider.

Most of our Network Medical Groups receive an agreed-upon monthly payment from VEBA Direct to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly Premium received by VEBA Direct. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Network Medical Group.

Some of VEBA Direct's Network Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Network Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, VEBA Direct and its Network Medical Groups agree on a budget for the cost of services for all VEBA Direct Members assigned to the Network Medical Group. At the end of the year, the

actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Network Medical Group shares in the savings.

The Network Hospital and Network Medical Group typically participate in programs for Hospital Services similar to what is described above.

Stop-loss insurance protects Network Medical Groups and Network Hospitals from large financial expenses for health care services. In most circumstances, Network Hospitals and Network Medical Groups, obtain stop-loss insurance directly from stop-loss insurance carriers.

VEBA Direct arranges with additional Providers or their representatives for the provision of Covered Health Care Services that cannot be performed by your assigned Network Medical Group or Network Hospital. Such services include authorized Covered Health Care Services that require a Specialist not available through your Network Medical Group or Network Hospital or Emergency Health Care Services and Urgently Needed Services. VEBA Direct or your Network Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Health Care Services received from these Providers is limited to payment of applicable Co-payments/Deductibles. (For more about Co-payments, see **Section 6. Payment Responsibility**.) You may get additional information on VEBA Direct's compensation arrangements by contacting VEBA Direct or your Network Medical Group.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants according to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other Providers in our Network through our provider website. Network Physicians and Providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, Out-of-Network Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your Out-of-Network Physician or Provider by contacting **www.myuhc.com** or the telephone number on your ID card.

We may apply a reimbursement methodology established by OptumInsight and/or a third-party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

If you receive a bill for a Covered Health Care Service from a Physician who is not one of our Network Providers, and the service was prior authorized and you have not exceeded any applicable benefit limits, VEBA Direct will pay for the service, less the applicable Co-payment/Deductible. (Prior Authorization is not required for Emergency Health Care Services and Urgently Needed Services. See **Section 3. Emergency Health Care and Urgently Needed Services**.) Out-of-Network Providers may not send you a bill for Emergency Health Care Services. You are only required to pay the Co-payment/Deductible amount shown in your *Schedule of Benefits*. You may also submit a bill to us if an Out-of-Network Provider has refused payment directly from VEBA Direct.

If you receive Covered Health Care Services in a Network contracting health care facility but from an Out-of-Network individual health professional, you are only required to pay the Co-payment/Deductible amount specified in your Schedule of Benefits. A Network "contracting health facility" includes, but not limited to, a licensed hospital; ambulatory surgery center or other outpatient setting, lab, radiology or imaging center. You should not be billed more than the amounts shown on your Schedule of Benefits.

How Do I Become an Organ and Tissue Donor?

Transplantation has helped thousands of people suffering from organ failure or in need of corneas, skin, bone or other tissue. The need for donated organs and tissues continues to outpace the supply. At any given time, nearly 50,000 Americans may be waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others.

Almost anyone can be a donor. There is no age limit and the number of donors age 50 or older has increased. If you have questions or concerns about organ donation, speak with your family, doctor or clergy. There are many resources that can provide the information you need to make a responsible decision.

If you do decide to become a donor, be sure to share your decision. Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a Family Member gives consent at the time of your death even if you have signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How Can I Learn More About Being an Organ and Tissue Donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (**www.transweb.org)**
- Department of Health and Human Services (**www.organdonor.gov**)

Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

Keep in mind that even if you have signed a donor card, you must tell your family so they can act on your wishes.

SECTION 10. DEFINITIONS

This Section will help you understand the meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form,* as well as the *Schedule of Benefits.*

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Adverse Benefit Determination – Means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including the following:

- a determination of a Member's eligibility to take part in the Health Plan (including rescission);
- a determination that services are not covered based on certain exclusions or limitations on otherwise Covered Health Care Services; and
- a determination that benefits are Experimental or Investigational or not Medically Necessary or appropriate.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.

As reported by generally recognized professionals or publications.

As used for Medicare.

As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency Health Care Services;
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care and Substance-Relates and Addictive Disorder Services on an outpatient or inpatient basis.

Ancillary Services - items and services provided by out-of-network physicians at a network facility that are any of the following:

Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

Provided by assistant surgeons, hospitalists, and intensivists;

Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;

Provided by such other specialty practitioners as determined by the Secretary; and

Provided by an out-of-network physician when no other Network physician is available.

Annual Co-payment Limit – The limit amount of Co-payments a Member is required to pay for certain Covered Health Care Services in a Calendar Year. (Please refer to your *Schedule of Benefits*.)

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Behavioral Health Treatment for Autism Spectrum Disorder- Professional services and treatment programs, including *Applied Behavior Analysis* and evidence-based behavior intervention programs, that develop or restore, to the limit extent practicable, the functioning of a Member with Autism Spectrum Disorder, and meet all of the following criteria:

The treatment is prescribed by a licensed Physician and surgeon of the *California Business and Professions Code* or developed by a licensed Network psychologist according to the *California Business and Professions Code* or as authorized under California law.

The treatment is provided under a treatment plan prescribed by a Network Qualified Autism Service Provider and is administered by one of the following:

- A Network Qualified Autism Service Provider.
- A Network Qualified Autism Service Professional supervised by the Network Autism Service Provider.
- A Network Qualified Autism Service Paraprofessional supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Network Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Network Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with *Section 4686.2 of the California Welfare and Institutions Code* pursuant to which the Network Qualified Autism Service Provider does all of the following:

- Describes the Member's behavioral health impairments or developmental challenges that are to be treated.
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorder.
- Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for Network in the treatment program. The treatment plan shall be made available to us upon request.

For a description of coverage of Mental Health Care Services for the diagnosis and treatment of Mental Health Disorders, please refer to **Section 5. Your Medical Benefits**.

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued

a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can use voluntary control over the functions, and thereby reduce an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Calendar Year – January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A Calendar Year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy – Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits due to traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher-level cognitive ability. This therapy is direct, one-on-one, patient contact.

Complementary and Alternative Medicine – Defined by the *National Center for Complementary and Alternative Medicine* as the broad range of healing philosophies, approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in hospitals. These types of therapies used alone are often referred to as alternative. When used in combination with other alternative therapies, or in addition to conventional therapies, these therapies are often referred to as complementary.

Completion of Covered Health Care Services – Covered Health Care Services for the Continuity of Care Condition under treatment by the terminated Provider or Out-of-Network Provider will be considered complete, when:

- The Member's Continuity of Care Condition under treatment is medically/clinically stable, and
- There are no clinical contraindications that would prevent a medically/clinically safe transfer to a Network Provider as determined by the TPA's Medical Director in consultation with the Member, the terminated Provider or Out-of-Network Provider, and as applicable, the Member's assigned Network Provider.

Continuity of Care Condition(s) – The Completion of Covered Health Care Services will be provided by: (i) a terminated Provider to a Member who, at the time of the Network Provider's contract termination, was receiving Covered Health Care Services from that Network Provider, or (i) Out-of-Network Provider for newly enrolled Member who, at the time of his or her coverage became effective with VEBA Direct, was receiving Covered Health Care Services from the Out-of-Network Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – A medical condition, including medical and Mental Health Care Services 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 Health Care Services will be provided for the duration of the acute condition.

2. **A Serious Chronic Condition** – A medical condition due to disease, illness, or other medical or mental health problem or medical or mental health 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 Health Care Services will be provided for the period of time needed to complete the active course of treatment and to arrange for a clinically safe transfer to a Network Provider, as determined by the TPA's medical director in consultation with the Member, and either (i) the terminated Provider or (ii) the Out-of-Network Provider and as consistent with good professional practice. Completion of Covered Health Care Services for this condition will not exceed 12 months from the agreement's termination date or 12 months from the effective date of coverage for a newly enrolled Member.

USBHPC will coordinate continuity of care for Members requesting continued care with a terminated or Out-of-Network Provider for Mental Health Care and Substance-Related and Addictive Disorder Services.

3. **A pregnancy -** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Health Care Services will be provided for the duration of the pregnancy. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

   Maternal Mental Health Condition. A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. The member's current Provider shall provide written documentation of a Maternal Mental Health Condition diagnosis from the member's treating health care Provider. Completion of covered services will be provided not to exceed 12 months from the diagnosis of the Maternal Mental Health Condition, or from the end of pregnancy, whichever occurs later, and to arrange for a safe transfer to a provider. The transfer shall be determined by the TPA in consultation with the member and the terminated provider and consistent with good medical practice.

4. **A Terminal Illness** – An incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Health Care Services will be provided for the duration of the terminal illness.

5. **The Care of a Newborn** – Services provided to a child between birth and age 36 months. Completion of Covered Health Care Services will not exceed 12 months from the: (i) Provider agreement termination date, or (ii) the newly enrolled Member's effective date of coverage with VEBA Direct, or (iii) extend beyond the child's third (3rd) birthday.

6. **Surgery or Other Procedure –** Performance of a surgery or other procedure that has been authorized by the TPA or the Member's assigned Network Provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating Provider to occur within 180 calendar days of the agreement's termination date, or (ii) Out-of-Network Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with VEBA Direct. This includes nonelective surgery from a provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

7. **Inpatient or institutional care. -** Unless otherwise specific above, continuity of care will continue until the earlier of:

   90 days from the date of notice of the right to continuation of care; or

   The date the Member is no longer a continued care patient with respect to such provider or facility.

Conventional Medicine – Defined by the *National Center for Complementary and Alternative Medicine* as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for Conventional Medicine are allopathic, Western, regular and mainstream medicine.

Co-payments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Health Care Service. Co-payments may be a specific dollar amount or a percentage of the Allowed Amount, or percentage of the Recognized Amount as applicable, for Covered Health Care Services. Co-payments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

For Co-payments that are specific dollar amount, you are responsible for paying the lesser of the following:

- The Co-payment.
- The negotiated amount, or the Recognized Amount, when applicable.

For Co-payments that are percentage, you are responsible for paying the percentage of the Allowed Amount, or the percentage of Recognized Amount, when applicable.

Covered Health Care Services – Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that help an individual in the activities of daily living. Examples include: help in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care, or extended care not requiring skilled nursing.

Day Treatment Center- A network facility which provides a specific mental health or substance-related and addictive disorder treatment program on a full- or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a USBHPC network practitioner and which is also licensed, certified or approved to provide such services by the appropriate state agency.

Deductible – The Deductible is the total of the Allowed Amount or the Recognized Amount when applicable, for certain Covered Health Care Service that you are responsible for paying each Calendar Year before benefits are payable under the *Combined Evidence of Coverage and Disclosure Form*. Please refer to the *Schedule of Benefits* for detailed information on the Deductible amount and Covered Health Care Services subject to the Deductible.

Dependent – A Member of a Subscriber's family who is enrolled with VEBA Direct after meeting all of the eligibility requirements of the Subscriber's Employer Group and VEBA Direct and for whom applicable Health Plan Premiums have been received by VEBA Direct.

Designated Facility – A facility that has entered into an agreement with VEBA Direct, or with an organization contracting on VEBA Direct's behalf, to render Covered Health Care Services for the treatment of specified diseases or conditions. The fact that a hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Virtual Network Provider - A Provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services via interactive audio and video modalities

Developmental Delay – Is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and/or social development.

Domestic Partner - A person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is 18 years of age or older. An exception is provided to Subscribers and/or Dependents less than 18 years of age who have, in accordance with California law, obtained:
  - Written consent from the underage person's parents or legal guardian and a court order granting permission to the underage person to establish a domestic partnership.
  - A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent or legal guardian capable of consenting to the domestic partnership.
  - Is mentally competent to consent to contract.
- Is unmarried or not a Member of another domestic partnership.
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Eligible Employee - Is an Eligible Employee who meets the eligibility requirement established by the Employer Group and VEBA Direct. (**Please Note:** If you are a Member of a guaranteed association you must abide by the eligibility requirement of the association.)

Emergency Health Care Services – An appropriate medical screening, examination and evaluation by a Physician or other personnel – to the extent provided by law– to determine if an Emergency Medical Condition or Psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Health Care Services include the care, treatment and/or surgery by a Physician necessary to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided) and relieve or eliminate the Emergency Medical Condition or Psychiatric Emergency Medical Condition within the capabilities of the facility, which includes and Independent Freestanding Emergency Department, and an admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital for the purpose of providing care and treatment necessary to relieve or eliminate a Psychiatric Emergency Medical Condition. For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3)),* (For a detailed explanation of Emergency Health Care Services, see **Section 3. Emergency Health Care Services and Urgently Needed Services**.)

Emergency Health Care Services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an inpatient stay or outpatient stay that is connected to the original emergency, unless each of the following conditions are met:

a) The attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
e) Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
    1. there is inadequate time to effect safe transfer to another hospital prior to delivery or
    2. a transfer poses a threat to the health and safety of the Member or unborn child.

An Emergency Medical Condition also includes a Psychiatric Emergency Medical Condition which is a Mental Health Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or others; or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the Mental Health Disorder.

Employer Group – The single employer, labor union, trust, organization or association through which you enrolled for coverage.

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity, or pump.

ERISA – The *Employee Retirement Income Security Act (ERISA)* of 1974 is a federal law designated to protect the rights of participants and beneficiaries of employee welfare benefits plans. Please contact your employer's benefit administrator to determine whether your employer is subject to ERISA.

Experimental or Investigational – Defined in **Section 5** under the *Exclusions and Limitations of Benefits* section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member – The Subscriber's legal spouse or Domestic Partner and any person related to the Subscriber or legal spouse or Domestic Partner by blood, marriage, adoption, assumption of a parent-child relationship or guardianship. An enrolled Family Member is a Family Member who is enrolled with VEBA Direct, meets all the eligibility requirements of the Subscriber's Employer Group and VEBA Direct, and for whom Premiums have been received by VEBA Direct. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and VEBA Direct.

Gender Identity Disorder and Gender Dysphoria - A disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another Mental Disorder or a chromosomal abnormality.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

Group Agreement – The Medical and Hospital Group Subscriber Agreement entered into between VEBA Direct and the employer, labor union, trust, organization or association through which you enroll for coverage.

Habilitative Services – Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings, or both. Habilitative Services shall be covered under the same terms and conditions applied to Rehabilitation Services under the Plan contract.

Health care practitioner - means a physician and surgeon, naturopathic doctor, nurse practitioner, physician assistant, nurse midwife, or a midwife licensed pursuant to *Division 2 (commencing with Section 500)* of the *Business and Professions Code* or an initiative act referred to in that division and who is acting within his or her scope of practice.

Health Plan – Means VEBA Direct, which is your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and supplemental benefit materials.

Health Plan Premiums (or Premiums) – Amounts established by VEBA Direct to be paid to VEBA Direct by employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise help and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients' health services in a hospital setting.

Hospital Services – Services and supplies performed or supplied by a licensed hospital on an inpatient or outpatient basis.

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Iatrogenic Infertility – an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Independent Freestanding Emergency Department - a health care facility that Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and provides Emergency Health Care Services.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Network Provider as a cause of Infertility.

Inpatient Treatment Center - An acute care Network Facility which provides Mental Health and Substance-Related and Addictive Disorder Services in an acute, inpatient setting, pursuant to a written mental health treatment plan approved and monitored by a USBHPC network practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

Intellectual Disability – An individual is determined to have intellectual disability based on the following three criteria: Intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An Eligible Employee or Eligible Employee's Dependent who declined enrollment in the VEBA Direct Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age.

Limiting Age – The age established by VEBA Direct when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage. The Limiting Age is at least 26 years of age as established by federal law.

Long Term Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Manipulative Treatment - The therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medical Detoxification - The medical treatment of withdrawal from alcohol, drug or other substance addiction is covered.

Medically Necessary (or Medical Necessity) - Refers to an intervention, if, as recommended by the treating Physician and determined by the TPA's medical director or the Network Medical Group, it is all of the following:

a. A health intervention for the purpose of treating a medical condition;

b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. cost-effective does not necessarily mean lowest price.

A service or item will be covered under the VEBA Direct Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, if it is Medically Necessary or otherwise

required to be covered under the law or otherwise described in **Section 5** of this *Combined Evidence of Coverage*. An intervention may be medically indicated yet not be a covered benefit if it is not Medically Necessary or otherwise required to be covered under the law or otherwise set forth in **Section 5** of this *Combined Evidence of Coverage*.

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

a. In accordance with the generally accepted standards of mental health and substance-related and addictive disorder care.

b. Clinically appropriate in terms of type, frequency, extent, site and duration.

c. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

i. "Treating Physician" means a Physician who has personally evaluated the patient.

ii. "Health Intervention" is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A "medical condition" is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.

iii. "Effective" means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

iv. "Health outcomes" are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. "Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A "new intervention" is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the

basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered "cost-effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Medicare (Original Medicare) – The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under *Title XVIII of the Social Security Act*, as amended.

Medicare Eligible – Those Members who meet eligibility requirements under *Title XVIII of the Social Security Act*, as amended.

Member – The Subscriber or any Dependent who is eligible, enrolled and covered by VEBA Direct.

Mental Health Care Services - Medically Necessary services for the prevention, diagnosis and treatment of a mental health disorder.

Mental Health Care Services and Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders.

Mental Health Disorder – a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*. Changes in terminology, organization, or classification of mental health in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health disorder by health care providers practicing in relevant clinical specialties.

Network Hospital – Any general acute care hospital licensed by the State of California that has entered into a written agreement with VEBA Direct to provide Hospital Services to VEBA Direct's Members. Network Hospitals are independent contractors and are not employees of VEBA Direct.

Network Medical Group – An Independent Practice Association (IPA) or medical group of Physicians that has entered into a written agreement with VEBA Direct to provide Physician services to VEBA Direct's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations. Network Medical Groups are independent contractors and are not employees of VEBA Direct.

Network Provider – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor who has entered into a written agreement with the network of Providers from whom the Member is entitled to receive Covered Health Care Services. Network Providers are independent contractors and are not employees of VEBA Direct.

Network Qualified Autism Service Provider – either of the following:

A person that is certified by a national entity, such as the *Behavior Analyst Certification Board*, with a certification that is accredited by the *National Commission for Certifying Agencies*, and who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the person who is nationally certified.

A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to *Division 2 (commencing with Section 500)* of the *California Business and Professions Code* who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the licensee.

For a description of coverage of inpatient and outpatient Mental Health Care Services for the prevention, diagnosis and treatment of Mental Health Disorder, please refer to **Section 5. Your Medical Benefits.**

Network Qualified Autism Service Paraprofessional – an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is supervised by a Network Qualified Autism Service Provider or Network Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Network Qualified Autism Service Provider.
- Meets the education and training qualifications described in *Section 54342 Title 17 of the California Code of Regulations*.
- Has adequate education, training, and experience, as certified by a Network Qualified Autism Service Provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

For a description of coverage of inpatient and outpatient mental health care services for the diagnosis and treatment of Mental Health Disorder, please refer to **Section 5. Your Medical Benefits.**

Network Qualified Autism Service Professional – an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- Is supervised by a Network Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Network Qualified Autism Service Provider.
- Is a behavioral service Provider who meets the education and experience qualifications described in *Section 54342 of Title 17 of California Code of Regulations* for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program.
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to *Division 4.5 (commencing with Section 4500)* of the *California Welfare and Institutions Code* or *Title 14 (commencing with Section 95000)* of the *California Government Code.*
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

For a description of coverage of inpatient and outpatient Mental Health Care Services for the diagnosis and treatment of Mental Health Disorder, please refer to **Section 5. Your Medical Benefits.**

Non-Physician Health Care Practitioners – Include but are not limited to Network Qualified Autism Service Provider, Network Qualified Autism Service Professional, Network Qualified Autism Service Paraprofessional, acupuncturists, optometrists, podiatrists, chiropractors and nurse midwives.

Open Enrollment Period – The time period determined by VEBA Direct and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in VEBA Direct.

Out-of-Network Mental Health Providers - A psychiatrist, psychologist or other allied behavioral health professional that is licensed, certified or as authorized under California law that has not entered into a written agreement to provide Covered Health Care Services to VEBA Direct's Members.

Out-of-Network Providers – A Hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Health Care Services to VEBA Direct's Members.

Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment – A structured ambulatory prgram that may be a free-standing or Hospital-based program and that provides Mental Health or Substance Use Disorder Services for at least 20 hours per week.

Pharmacy Benefit Manager – a third party administrator for prescription drug programs for health plans.

Physician – Any licensed allopathic or osteopathic Physician. It includes a licensed acupuncturist.

Preimplantation Genetic Testing (PGT) – a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Prevailing Rates – As determined by VEBA Direct, the usual, customary and reasonable rates for a particular health care service in the Service Area.

Primary Care Physician (PCP) – A Network Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services. PCPs are independent contractors and are not employees of VEBA Direct.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

Primary Workplace – The Facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

Prior Authorization – VEBA Direct's review process that decides whether a service is Medically Necessary and not otherwise excluded prior to the Member receiving the service.

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the Hospital or Skilled Nursing Facility.

Provider – A person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental

benefit materials.

Psychiatric Emergency Medical Condition – A Mental Health Disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for use, food, shelter or clothing due to the Mental Health Disorder.

Psychological and Neuropsychological Testing – Psychological and Neuropsychological Testing includes the administration, interpretation and scoring of tests such as *WAIS-R, Rorschach, MMPI* and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis.

Recognized Amount - the amount which Co-payment and applicable Deductible, is based on for the below Covered Health Care Services when provided by Out-of-Network Providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An All Payer Model Agreement if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Regional Organ Procurement Agency – An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The individual or combined and coordinated use of medical, physical, occupational and speech therapy for developing or retraining to the maximum extent practical the functioning of individuals.

Remote Physiologic Monitoring - the collection and electronic transmission of biometric data that are analyzed and used to develop, manage, and update a treatment plan related to a chronic and/or acute health illness or condition. Remote Physiologic Monitoring services must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship.

Residential Treatment - treatment in a facility established and operated as required by law, which provides health care services for the diagnosis and treatment of Mental Health Care Services or Substance-Related and Addictive Disorders.

Schedule of Benefits – An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Co-payment information.

Secretary - as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

Service Area – A geographic region in the State of California where VEBA Direct is authorized by the California Department of Managed Health Care to provide Covered Health Care Services to Members.

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation facility or a specially designed unit within a Hospital licensed by the State of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care – The care provided directly by a Network Provider or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialist, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive licensed Skilled Nursing Care than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

Subscriber – The individual enrolled in the Health Plan for whom the appropriate Health Plan Premiums have been received by VEBA Direct and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Substance-Related and Addictive Disorder Services – Medically Necessary treatment for the prevention, diagnosis and treatment of a substance-related and addictive disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.* Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Substance-Related and Addictive Disorder Inpatient Treatment Program - A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Substance-Related and Addictive Disorder.

Telehealth – The mode of delivering Covered Health Services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the licensed health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes real-time interactions and the transmission of a patient's medical information from an originating site to the licensed health care provider at a distant site without the presence of the patient. The originating site and the distant-site are licensed to provide Telehealth according applicable law.

Third-Party Administrator: One or more entities who will be under contract with the Applicant on or before January 1, 2022, to provide daily operational services to these pilot programs including, but not limited to, fee-for-service claims processing (where applicable) and financial administration.

Totally Disabled or Total Disability – For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from

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an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental

impairment resulting from an injury or illness. Determination of Total Disability will be made by a Network Medical Group Physician on the basis of a medical examination of the Member and upon concurrence by the TPA's medical director.

Transitional Residential Recovery Services - Substance-Related and Addictive Disorder or chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

VEBA Direct-Designated Pharmacy – VEBA Direct Network pharmacy designated to dispense injectable medications. A VEBA Direct-Designated Pharmacy may include *Prescription Solutions*® Mail Service Pharmacy or alternative specialty injectable vendor as determined by VEBA Direct.

Urgently Needed Services – Covered Health Care Services that are provided when the Member's Network Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Network Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which VEBA Direct is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by *Medical Data Research (MDR)* for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

Utilization Review Committee – A committee used by the TPA or a Network Medical Group to promote the efficient use of resources and maintain the quality of health care. If needed, this committee will review and determine whether particular services are Covered Health Care Services.

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation, when needed, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* PROVIDES A DESCRIPTION OF THE BENEFITS AVAILABLE TO YOU UNDER YOUR VEBA DIRECT HEALTH PLAN. THE AGREEMENT BETWEEN VEBA DIRECT AND YOUR EMPLOYER CONTAINS ADDITIONAL TERMS SUCH AS PREMIUMS, LENGTH OF CONTRACT, AND GROUP TERMINATION. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT VEBA DIRECT AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.