October 1, 2014

TO: Santa Clara County Board of Education

FROM: Philip Gordillo
Chief Human Resources Officer

VIA: Jon R. Gundry
County Superintendent of Schools

SUBJECT: Request Approval of Contract Exceeding $250,000

Goal

Goal 3: Be a Premier Employer

Background

Effective November 1, 2014, Valley Health Plan will be available to all eligible employees and their families. We have estimated the premiums to be as noted below based on open enrollment calculations as of September 24, 2014.

Board Policy 3312(a) states that all contractual agreements estimated to exceed $250,000 shall be placed on the agenda of regular County Board meetings as a Study Action items. The following contract is, therefore, being submitted for Board approval:

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<tr>
<th>Fund</th>
<th>Vendor</th>
<th>Description</th>
<th>Amount Requested</th>
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<tbody>
<tr>
<td>800</td>
<td>Valley Health Plan</td>
<td>Health care plan for SCCOE employees</td>
<td>$2,620,031</td>
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Fiscal Implications

Funding has been incorporated into the FY 2014-15 budget to cover this expense.

Requested Action

Approve contract for Valley Health Plan.
GROUP
MEDICAL AND HOSPITAL
SERVICE AGREEMENT
VALLEY HEALTH PLAN
&
SANTA CLARA COUNTY
OFFICE OF EDUCATION
# VALLEY HEALTH PLAN
## GROUP SERVICE AGREEMENT
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GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

THIS AGREEMENT (the "Agreement") is made and entered into effective November 1, 2014 (the "Effective Date of Coverage") by and between the County of Santa Clara, doing business as Valley Health Plan ("Plan") and Santa Clara County Office of Education ("Group").

RECITALS

WHEREAS, Plan is a prepaid health care service plan, which arranges for the provision of health care services for Members, subject to the licensing requirements and operational regulatory standards of the Knox-Keene Health Care Service Plan Act of 1975, as amended;

WHEREAS, Group wishes to participate in said program;

NOW THEREFORE, Group engages Plan to arrange for the provision of Medically Necessary Covered Services to Members in accordance with the following Declarations and all terms and conditions hereinafter provided.

DECLARATIONS

1. The initial term of this Agreement is November 1, 2014, through October 31, 2015. Thereafter, this Agreement will automatically renew from year to year for up to four additional years, unless terminated as provided herein.

2. As of the effective date, this Agreement supersedes and replaces any previous Group Service Agreement between the parties.

3. The Premiums for Plan membership are specified in the Rate Schedule to this Agreement. Subject to changes in rates or other terms as provided in Section 4 (Fees and Charges), the rates shall remain in effect for the Initial Term of this Agreement. Thereafter, the rate schedule is subject to change on the anniversary date as provided herein.

4. This Agreement is made in reliance upon the information provided by Group in its application; upon the statements of each Subscriber in his or her application for Coverage and upon Group’s existing eligibility requirements and composition of Members.

5. This Agreement is not effective until executed in writing by the duly authorized officer of Plan named below. No other employee or agent is authorized to bind Coverage.

6. No representative of Plan is authorized to waive or change any provision of this Agreement except in a writing signed by a duly authorized Plan officer. Notwithstanding that, a change can be made in accordance with Section 9.14 "Change in Agreement" of this Agreement.

7. The following specifications apply to this Agreement. If a conflict between these specifications and the following text of the Agreement, these specifications prevail:
A. "Full Time Employee" means:

All full-time or permanent employees employed by Group to work 17 ½ hours or more per week and meet group eligibility requirements as defined in the labor agreement with the union(s), and

All early retired employees not on Medicare, and

who meet the Group Waiting Period specified below.

B. Group Waiting Period:

Present Full Time Employees become eligible to enroll on the Effective Date of Coverage.

Future Full Time Employees become eligible to enroll as follows:

(i) For employees, on the first day of the month following becoming a Full Time Employee.

(ii) For early retirees/survivors, on the first day of the month following becoming a retiree

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C. Late Members must wait until the next Open Enrollment period to enroll in September for a November 1st effective date.

IN WITNESS WHEREOF, Plan and Group have caused this Agreement to be executed by duly authorized representatives as of the Effective Date of Coverage.

GROUP
Santa Clara County Office of Education
1290 Ridder Park Drive
San Jose, CA 95131-2304

By:

Philip J. Gordillo,
Executive Director
Date: ______________________

PLAN
Valley Health Plan

By:

Pat Cox,
Acting Chief Executive Officer, VHP
Date: ______________________

Approved By:

Paul A. Antigua,
Chief Financial Officer, VHP
Date: ______________________

Approved As To Form And Legality:

Jennifer S. Sprinkles,
Deputy County Counsel
Date: ______________________

COUNTY OF SANTA CLARA

By:

Mike Wasserman, President
Board of Supervisors
Date: ______________________

Approved By:

SCVHHS Finance
Date: ______________________

Signed and certified that a copy of this document has been delivered by electronic or other means to the President, Board of Supervisors

ATTEST

Lynn Regadanz
Clerk of the Board of Supervisors
Date: ______________________

Approved By:

René Santiago
Deputy County Executive, SCVHHS
Date: ______________________
SECTION 1 – DEFINITIONS

1.1 "Active Labor" means a labor at a time at which 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 may pose a threat to the health and safety of the patient or the unborn child.

1.2 "Acute Condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

1.3 "Agreement" means this Group Medical and Hospital Service Agreement, including but not limited to the Evidence of Coverage, any and all applications and information submitted by the Group and Members in applying for Coverage, all attachments and addenda and any amendments that may be added in the future.

This Agreement contains the exact terms and conditions of Coverage. It incorporates all of the contracts, promises, and agreements exchanged by the Group and the Plan. It replaces any and all prior or concurrent negotiations, agreements, or communications, whether written or oral, between both parties with respect to the contents of the Agreement.

1.4 "Approved Drug Usage" means, with respect to pharmaceuticals, (1) use for the labeled (FDA-approved) indications; (2) use by a Plan Physician for treatment of a life-threatening condition; or (3) use for which the drug has been recognized by the AMA Drug Evaluations, the American Hospital Formulary, the United States Pharmacopeia, or at least two articles from major, peer-reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

1.5 "Benefit Plan" means the Covered Services contained in this Agreement. Any date referenced in this Benefit Plan begins at 12:01 a.m., Pacific Standard Time.

1.6 "Behavioral Health Services/Treatment" means services rendered by or under the direction of a behavioral health care Plan Provider for the diagnosis or treatment of Mental Disorders, alcoholism or drug abuse. Services also means an authorized treatment plan for Members with Pervasive Developmental Disorders, which includes, but is not limited to, prescription drugs, medications, pharmacy services, occupational therapy (OT), speech therapy (ST), and physical therapy (PT). Including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism.

1.7 "Cal-COBRA (California Continuation Benefits Replacement Act)" means the California legislation that requires health plans to offer continued access to group health care coverage provided to employee, and their dependents, of employers with 2 to 19 eligible employees who are not currently offered continuation coverage under COBRA and whose coverage would end due to termination, layoff, or other change in employment status. Cal-COBRA also means Subscribers have the opportunity of group continuation coverage when coverage would otherwise cease due to the termination of COBRA. Maximum benefit period is up to 36 months.

1.8 "Calendar Year" means a 12 month period that begins on January 1 and ends 12 consecutive months later on December 31.
1.9 “Child(ren)” means the Subscriber’s or his/her spouse’s/Domestic Partner’s natural child(ren), legally adopted child(ren), step-child(ren) or child(ren) under legal guardianship of the Subscriber or the enrolled spouse/Domestic Partner pursuant to a valid court order.

1.10 “COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)” means the federal legislation that requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under the employer’s plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status.

1.11 “Continuation Coverage” means extended Coverage under this Benefit Plan for Subscribers and/or Eligible Dependents enrolled in this Benefit Plan upon the occurrence of certain events and subject to the terms set forth in Section 7 of this Agreement.

1.12 “Copayment” means a fee charged to a Member, which is approved by the Department of Managed Health Care of the state of California, provided for in this Agreement and disclosed in the Evidence of Coverage. Within 180 days after the end of any Calendar Year, a Subscriber may apply to Plan for a refund of the excess of Copayments paid over the Calendar Year in excess of the Copayment Maximum.

1.13 “Copayment Maximum” is the maximum amount a Member is required to pay for Covered Services during a Calendar Year. Copayments paid for eyeglasses, Dental Services, or any other supplementary benefit(s) that may be covered under this Benefit Plan are not counted against the Copayment Maximum.

1.14 “Coverage” means the right to receive Covered Services under this Agreement.

1.15 “Coverage Decision” means the approval or denial of Covered Services by Plan or Plan Providers. A Coverage Decision does not include a Disputed Covered Service(s).

1.16 “Covered Service(s) or Benefit(s)” means those Medically Necessary health care services and supplies which a Member is entitled to receive, and which are described in Section 11 (Principal Covered Services and Coverages) and not excluded or limited by Section 12 (Principal Exclusions) or Section 10 (Limitations) of this Agreement.

1.17 “Custodial or Domiciliary Care” means care that can be provided by a lay person, which does not require the continuing attention of trained medical or paramedical personnel, and which has no significant relation to the treatment of a medical condition. This definition does not refer to Behavioral Health Therapy (BHT) prescribed for Pervasive Developmental Disorder (PDD) or Autism. Custodial or Domiciliary Care includes, but is not limited to, activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medication, and care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification, or the presence of a supervising licensed nurse.

1.18 “Dental Services” means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Such services are considered Dental Services even if a condition requiring any of these services (such as Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by
such methods as crowning, wiring or repositioning teeth) involves a part of the body other than the mouth.

1.19 “Department of Managed Health Care” or “Department” is the state regulatory agency responsible for the regulation or oversight of health care plans in California.

1.20 “Disenrollment” means a Member’s voluntary withdrawal from the Benefit Plan.

1.21 “Disputed Covered Service(s)” means any Covered Service that has been denied, modified, or delayed by a decision of the Plan, or by one of its Plan Providers, in whole or in part due to a finding that the Benefit is not Medically Necessary. A decision regarding disputed health care services relates to the practice of medicine and is not a Coverage Decision.

1.22 “Domestic Partner” has the meaning set forth in Exhibit “C” attached hereto.

1.23 “Durable Medical Equipment” are the Medically Necessary medical supplies, equipment, and devices which (a) are intended for repeated use over a prolonged period; (b) are not considered disposable, with the exception of ostomy bags and diabetic supplies; (c) are ordered by the Member’s Plan Physician; (d) do not duplicate the function of another piece of equipment or device covered by Plan; (e) are generally not useful to the Member in the absence of illness or injury; (f) primarily serve a medical purpose; and (g) are appropriate for use in the home.

1.24 “Educational Services” means services or supplies whose primary purpose is to provide training in the activities of daily living, instruction in scholastic skills such as reading or writing, preparation for an occupation, or treatment for learning disabilities.

1.25 “Effective Date of Coverage” means the date that Coverage under the Benefit Plan begins.

1.26 “Eligible Dependent” is a person who meets the requirements set forth in Section 2.2 of this Agreement.

1.27 “Eligible Employee” means an individual who meets the requirements set forth in Section 2.1 of this Agreement. The term also includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the Group's business and included as employees in the Agreement; but does not include employees who work on a part-time, temporary, or substitute basis.

1.28 “Eligible Retiree” means an individual who meets the requirements set forth in Section 2.1 of this Agreement.

1.29 “Emergency Services” means the Covered Services which are furnished worldwide and required to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain and Active Labor) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

“Emergency Services” also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical
Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition or detoxification, within the capability of the facility.

1.30 **"Evidence of Coverage"** means the Combined Evidence of Coverage and Disclosure Form(s) and any document(s) issued to Members setting forth the Covered Services to which Members are entitled and any limitations on, or exclusions from such Covered Services.

1.31 **"Experimental or Investigational Treatment"** means services, tests, treatments, supplies, devices or drugs which Plan determines are not generally accepted by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by:

(A) The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;

(B) The Office of Health Technology Assessment of the U.S. Congress;

(C) The National Institute of Health;

(D) The Federal Food and Drug Administration; or

(E) The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS).

Approved Drug Usage will not be excluded as an Experimental or Investigational Treatment.

1.32 **"FDA-Approved Drug"** means drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

1.33 **"Formulary"** is the list of prescription drugs that have been reviewed and selected by VHP Plan Providers on the VHP Pharmacy and Therapeutic Committee in accordance with generally accepted medical standards for their medical and cost effectiveness. The Formulary includes both brand name and generic equivalent drugs, all of which are approved by the Food and Drug Administration (FDA).

1.34 **"Grievance"** means a dispute, complaint, or any expression of dissatisfaction by a Member or a Member’s appeal of the denial of a service or payment of a claim (in whole or part).

1.35 **"Group"** has the meaning ascribed to that term in the preamble of this Agreement.

1.36 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.

1.37 **"HIV or AIDS"- Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome** is a condition or disease that is medically interpreted broadly as a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling.
1.38 “Hospice” means a public agency or private organization that is a Plan Provider and is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

1.39 “Hospice Care” means services provided by Plan Providers to Members who are certified by a Plan Physician to be terminally ill (i.e. the Member’s medical prognosis is that the life expectancy is twelve months or less), emphasizing supportive services and dietary counseling under the direction of a Plan Physician and in accordance with a written plan of care.

1.40 “Hospital Services” means all Inpatient Hospital Services and Outpatient Hospital Services as herein defined.

1.41 “Initial Eligibility Period” means the period during which Eligible Employees or Eligible Retirees, and their Eligible Dependents may initially enroll in Plan, and is further defined as follows:

(A) For Group’s employees or retirees who are or will be Eligible Employees or Eligible Retirees on the initial Effective Date of Coverage under this Agreement, the Initial Eligibility Period is the 31 day period prior to the Effective Date of Coverage. This period also applies to survivors who are eligible for Group benefits on the Effective Date of Coverage.

(B) For future employees of Group who were not Eligible Employees on the Effective Date of Coverage, the Initial Eligibility Period is the applicable Group Waiting Period.

(C) For future retirees of Group who were not Eligible Retirees on the Effective Date of Coverage, the Initial Eligibility Period is the 31 day period after becoming a retiree. This period also applies to future survivors, of Eligible Employees or Eligible Retirees, who are eligible for Group benefits.

(D) For Late Members who lose coverage for any of the reasons listed below, the Initial Eligibility Period is the 31 day period following the date on which Late Member loses coverage:

(i) the termination of the employment of the Eligible Employee or of a person through whom the Eligible Employee or his or her Eligible Dependents were covered as a dependent;

(ii) a change in the employment status of the Eligible Employee or a person through whom the Eligible Employee or his or her Eligible Dependents were covered as a dependent;

(iii) termination of health benefits coverage from another employer, Covered California coverage, or Medi-Cal coverage;

(iv) reduction or cessation of an employer’s contribution toward an employee, retiree, or dependent’s coverage;
(v) death of the Eligible Employee/Retiree or person through whom the Eligible Employee/Retiree or his or her Eligible Dependents were covered as a dependent; or

(vi) divorce from the person through whom the Eligible Employee/Retiree or Eligible Dependent was covered as a dependent.

(E) For Eligible Dependent(s), between the age of 19 and 26 (i.e. from 19 through 25), the Initial Eligibility Period is the 31 day period following a change in their status as defined by Group.

1.42 "Inpatient Hospital Services" means those Covered Services, which are provided on an inpatient basis by a hospital, excluding long term non-acute care.

1.43 "Late Member" means an Eligible Employee/Retiree or his or her Eligible Dependents who declined to enroll in Plan during the Eligible Employee’s or Eligible Retiree’s Initial Eligibility Period or any subsequent Open Enrollment Period.

1.44 "Life-Threatening" means either or both of the following:

(A) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(B) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

1.45 "Lock-In" means that Covered Services are available only through Plan Providers in the VHP Network the Member selects (unless such care is rendered as worldwide Emergency Services or is Prior Authorized). If the Member seeks routine care or elective medical services from Non-Plan Providers without a VHP-approved referral, VHP will not pay for that care and the Member will be required to pay for the full cost of such services.

1.46 "Medical Director" means the Medical Director of Plan, who is a physician or designee with responsibility for implementing Plan utilization management system and quality of care review system. The Medical Director is the physician who determines appropriate Prior Authorization of Covered Services.

1.47 "Medical Services" means those professional services of physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and preventive services which are included in Section 11 (Principal Covered Services and Coverages) and which are performed, prescribed or directed by a Primary Care Physician or specialist Plan Physician.

1.48 "Medically Necessary" or "Medical Necessity" means any item or service that Plan determines (i) is appropriate and necessary for the diagnosis or treatment of the Member’s medical condition, in accordance with generally recognized professional standards of practice; (ii) is not mainly for the convenience of Member or Member’s Plan Physician or other provider; (iii) is the most appropriate item or level of service for the injury or illness; and (iv) is consistent with policies or criteria (if any) developed by Plan in accordance with the foregoing standards. For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.
1.49 “Member” is any Subscriber or Eligible Dependent who is enrolled in the Benefit Plan in accordance with the applicable eligibility requirements.

1.50 “Member Services Representative” means a Plan employee who is available to answer Member’s questions about Coverage, help Members with any service issues, and assist Members with special situations relating to Covered Services.

1.51 “Mental Disorders” means disorders of mental or behavioral functioning that (1) are severe enough to disrupt substantially the normal family, social, or work interactions, including the physical symptoms of such disorders, regardless of cause or origin, and (2) are conditions listed as an Axis 1 Disorder (except for V codes) by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Revised) (DSM-IV-R).

1.52 “Network” is a health care delivery service system within the Service Area, made up of Plan Physicians (such as Primary Care Physicians and Plan Specialists), Plan Facilities, and Plan Hospitals.

1.53 “Non-Plan Provider” is any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the appropriate regulatory agency to deliver or furnish health care services; and who is neither employed, owned, operated by, or under contract with Plan to deliver services to Members.

1.54 “Open Enrollment Period” means a period of no less than 30 calendar days or as defined by the Group and agreed upon by the Plan, and that occurs at least once annually. The Open Enrollment Period is a time, during which all Eligible Employees are given the opportunity to select from the alternative health care plans offered by the Group and when Subscribers may add or delete Eligible Dependents.

1.55 “Orthotic Device” means a Medically Necessary rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct a defect or function of an injured or diseased body part, excluding devices to enable the Member to continue ongoing athletic activity prior to medical recovery.

1.56 “Out-of-Network” means any provider that is not part of the VHP Network.

1.57 “Outpatient Hospital Services” or “Outpatient Care” means those Covered Services, which are provided by a hospital to Members who are not inpatients at the time such services are rendered.

1.58 “PHI” means Protected Health Information.

1.59 “Plan” or “VHP” means the Santa Clara County, doing business as Valley Health Plan, licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended.

1.60 “Plan Facility” means a facility (other than a Plan Hospital), such as a Skilled Nursing Facility, which has contracted with Plan to provide Medical Services and/or supplies to Members.

1.61 “Plan Hospital” means a duly licensed hospital which, at the time care is provided to a Member, has a contract in effect with Plan to provide Hospital Services to Members.
1.62 "Plan Pharmacy" means a pharmacy that provides medication(s) prescribed by Plan Providers to Members and is contracted with the Plan to deliver pharmacy services to Members.

1.63 "Plan Physician" means a duly licensed doctor of medicine or osteopathy who, at the time care is provided to a Member, is employed by or has a contract in effect with Plan to provide Medical Services to Members.

1.64 "Plan Provider" means a Plan Physician, Plan Hospital, or other licensed health professional or licensed health facility, including subacute facilities, who or which, at the time care is provided to a Member, is employed by or has a contract in effect with Plan to provide Covered Services to Members. Plan Provider must be licensed and/or certified by the State or as otherwise authorized under California Law. Information about Plan Providers may be obtained by telephoning Plan at 408.885.4760.

1.65 "Plan Specialist" means a physician who practices in a medical specialty and has contracted with Plan to deliver health care services to Members.

1.66 "Pregnancy" means the three trimesters of pregnancy and the immediate postpartum period.

1.67 "Premiums" means the prepayment fees paid by or on behalf of Members in order to be entitled to receive Covered Services.

1.68 "Prescription Unit" means the maximum amount (quantity) of medication that may be dispensed per prescription.

1.69 "Primary Care Physician" or "PCP" means a Plan Physician who (i) practices in the area of family practice, internal medicine, pediatrics, general practice, or obstetrics/gynecology; and (ii) acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping, and initiating referrals for specialist Plan Physicians, for Members who select such Primary Care Physician.

1.70 "Prior Authorized" or "Prior Authorization" means a system whereby written (or oral followed by written confirmation) advance approval is given by the Medical Director or designee before a Member can receive certain Medically Necessary Covered Services.

1.71 "Prosthetic Device" means an artificial device affixed to the body externally to replace a missing part of the body. Prosthetic Device also means surgically implanted devices and supplies.

1.72 "Psychiatric Emergency Medical Condition" means a mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to the Member or others, or Member is immediately unable to provide for or use, food, shelter or clothing due to the mental disorder.

1.73 "Reasonable Charges" means an amount equal to the lowest of (a) actual charges; (b) a provider's usual fees charged to non-Plan private-pay patients; (c) fees in an amount that is customary for services provided by providers of similar licensure, training and experience within the same geographic area; or (d) justifiable in consideration of any Medically Necessary special services.
1.74 "Reconstructive Surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) to improve function, or (b) to create a normal or uniform appearance, to the extent possible. Reconstructive Surgery includes Prosthetic Devices needed after a mastectomy and original and replacement prostheses devices to replace all or part of an external facial body part removed or impaired as a result of disease, injury, or congenital defect.

1.75 "Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(A) persists without full cure or worsens over an extended period of time; or
(B) requires ongoing treatment to maintain remission or prevent deterioration.

1.76 "Serious Emotional Disturbance(s) of a Child or Adolescent" means the mental disorder(s), as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, of a minor under the age of 18 years. A Serious Emotional Disturbance of a Child is a mental disorder that is other than a primary substance use disorder or developmental disorder, and which results in behavior inappropriate to the child’s age according to expected developmental norms.

1.77 "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.

1.78 "Service Area" means the Santa Clara County geographic area.

1.79 "Severe Mental Illness" means a mental disorder:

(A) which is severe in degree and persistent in duration,

(B) which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and

(C) which may result in an inability to maintain stable adjustment and independent function without treatment, support, and rehabilitation for a long or indefinite period of time.

Severe Mental Disorders include, but are not limited to, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder (manic-depressive illness), major depressive disorders, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders (e.g. Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder), Anorexia Nervosa, Bulimia Nervosa, as well as other affective disorders or other severely disabling mental disorders.

1.80 "Skilled Nursing Facility" means a facility where inpatient services are provided at a less intensive level than an acute care hospital but still requiring services by a licensed health care professional.

1.81 "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for eligibility, who meets all applicable eligibility requirements of Section 2 (Eligibility) and who has enrolled in accordance with that section.
1.82 “Totally Disabled” means that an individual is either (a) confined in a hospital as determined to be Medically Necessary, or (b) unable to engage in any employment or occupation for which the individual is (or becomes) qualified by reason of education, training or experience and, is not, in fact, engaged in any employment or occupation for wage or profit.

1.83 “Urgently Needed Services” means the Covered Services for an illness, injury, or Pregnancy for which, treatment cannot be delayed and, in the view of a prudent lay person or physician, would be likely to lead to a serious deterioration in the Member's health or significant disability.

1.84 “Vocational Rehabilitation” means evaluation, counseling and placement services designed or intended primarily to assist an injured or disabled individual find appropriate employment.

SECTION 2 – ELIGIBILITY

2.1 SUBSCRIBER ELIGIBILITY

To be eligible to enroll in Plan as a Subscriber, an individual must be a Full Time Employee of the Group and meet the requirements of A or B below.

(A) Prior to enrollment, the individual who is the employee must (i) continuously reside or work within the Service Area, (ii) be entitled to Group employee benefits, the premiums for which are paid by or through Group, and (iii) meet the applicable Group Waiting Period, or any applicable statutorily authorized requirements.

(B) Prior to enrollment, the individual who is a retiree must (i) continuously reside within in the Service Area, or within San Francisco County, or within any adjacent counties to the Service Area, (ii) be entitled to Group employee retirement benefits, the premiums for which are paid by or through Group, and (iii) meet the applicable Group Waiting Period or any applicable statutorily authorized requirements, or

A retiree, who is eligible for Group Benefits, may reside outside the Service Area in San Francisco, San Mateo, Alameda, Stanislaus, Merced, San Benito, Monterey, and Santa Cruz Counties, but will only be covered for Emergency or Urgently Needed Services when Out-of-Network. All follow-up or routine care must be received in the VHP Network through the Member's VHP PCP.

2.2 DEPENDENT ELIGIBILITY

To be eligible to enroll and to continue enrollment as a dependent, an individual must be either:

(A) A Subscriber’s lawful spouse or Domestic Partner pursuant to Exhibit “C” attached hereto and incorporated herein by this reference; or

(B) Any Child of a Subscriber or any Child of a Subscriber’s spouse or Domestic Partner who is:

(i) under the age of 26; or

(ii) 26 years of age or older, but incapable of holding a self-sustaining job by reason of mental retardation or physical handicap which commenced prior to age 26.
The Subscriber must furnish proof of incapacity and dependency to Plan within 31 calendar days following the date of the request; or

Plan has the right to require such proof of eligibility status as may be required, but no more frequently than annually after the initial two year period. Such proof will be without cost to Plan, and Plan's determination of eligibility will be conclusive.

Prior to January 1, 2014 the Plan may exclude eligibility if the adult dependent is eligible to enroll in an employer plan.

Eligible Dependents who are eligible for Group Benefits and who reside outside the Service Area will only be covered for Emergency or Urgently Needed Services when Out-of-Network. All follow-up or routine care must be received in the VHP Network through the Member's VHP PCP.

Uninsured young adults, aged 18 through 25, with a pre-existing condition may face a pre-existing condition exclusion of up to six months if they were uninsured for 63 days or more prior to gaining Coverage. In this case, VHP can exclude coverage of pre-existing conditions to the extent that is allowed by California state laws. Starting in 2014, pre-existing condition exclusions will no longer be permitted through Group Coverage.

2.3 OTHER RULES OF ELIGIBILITY

No person is eligible to enroll or re-enroll if such person's Coverage under this Agreement, or under any other large group agreement with Plan has been terminated for:

(A) Nonpayment by such person; or

(B) Fraud or other intentional misrepresentation of material fact by such person.

Note that the above restrictions under this Section “Other Rules of Eligibility” do not apply to Small Group Agreements.

No person who is otherwise eligible will be refused enrollment because of his or her health status; medical condition or type of illness, including both physical and mental illness; claims experience; medical history; genetic information; disability; treatment or requirements for health services; blindness; existence of a preexisting physical or mental disorder at the time of his or her enrollment; previous accident; or evidence of insurability including conditions arising out of acts of domestic violence.

2.4 GROUP'S ELIGIBILITY RULES; OBLIGATIONS

Group's eligibility requirements for Coverage in effect on the Effective Date of Coverage are material to the execution of this Agreement by Plan. No change in Group's eligibility or participation requirements shall affect the requirements for eligibility or enrollment under this Agreement unless such changes are agreed to in writing by Plan.

Group agrees to accept the responsibility for furnishing current electronic eligibility information and Plan may rely upon the latest information received as correct without further verification. Eligibility data to include: first name, last name, address, city, zip, phone number, date of birth, effective date,
gender, language spoken and written, race, and ethnicity. Unless otherwise agreed to in writing by Plan and Group, Plan will not refund to Group any Premiums paid for an ineligible person if the request for such refund is made later than 60 days after the receipt of payment by Plan for said ineligible person.

Plan reserves the right to verify eligibility data maintained by Group and to review all employee records maintained by Group as they relate to establishment and maintenance of eligibility for Plan membership.

2.5 ENLISTMENT IN UNIFORMED SERVICES

VHP may terminate Subscriber membership or the membership of Eligible Dependent(s) if Subscriber or Eligible Dependent(s) enter full-time service in any branch of the armed forces (enlistment) and become eligible for and become covered by other health coverage. A Subscriber or Eligible Dependent can elect to continue coverage under the Plan. If continued Group Coverage is elected, Group will notify VHP and will submit the required premium to VHP.

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 Group or Member Services for information on how to apply for reinstatement of Coverage following active duty as a reservist.

2.6 MEDICARE ELIGIBLE MEMBERS

If Group employs twenty or more employees for each working day in each of 20 or more weeks in the current Calendar Year or the preceding Calendar Year, and thus is obligated to comply with the Tax Equity and Fiscal Responsibility Act (TEFRA) laws and regulations, as amended, then Subscribers who are:

(i) employees actively at work (including reemployed retirees or annuitants) and who are age 65 or older, and/or

(ii) employees actively at work who have a covered Eligible Dependent age 65 or older who elects Coverage under this Agreement, will be subject to the same benefits, prepayment fees, and other conditions as other Members, and

Plan will provide primary Coverage with respect to such active employees and/or covered Eligible Dependent. Members who are or who become Medicare eligible shall enroll in Medicare (Part A) as a condition of continued eligibility for Plan Benefits.

Except as otherwise provided in the next paragraph, if Group normally employs at least 100 employees on a typical business day during the previous Calendar Year, then Members under age 65 who are entitled to Medicare based on disability shall be subject to the same benefits, prepayment fees, and other conditions as other Plan Members, and Plan will provide primary Coverage with respect to such disabled Members. Members who are or who become Medicare eligible shall enroll in Medicare (Part A) as a condition of continued eligibility for Plan Benefits.

Irrespective of the number of employees of Group, Members who are under age 65 and who are entitled to Medicare solely on the basis of End Stage Renal Disease shall, for a period of 18 months from inception of Medicare eligibility, or such other period as may be required by law, be subject to
the same benefits, prepayment fees and other conditions as other Plan Members, and Plan will provide primary Coverage to such Members for such time period. Notwithstanding any other limitation contained herein, Members who have End Stage Renal Disease (whether or not entitled to Medicare) will also be subject to the same benefits and the same prepayment fees as other Plan Members who do not have End Stage Renal Disease, provided that following the 18-month period or such other period as may be required by law, Plan will provide secondary Coverage with respect to such Members who are Medicare eligible.

Except as otherwise provided above, Members who are or who become Medicare eligible shall enroll in Medicare (Parts A and B) as a condition of continued eligibility for Plan benefits. Plan will provide with respect to such Members only secondary Coverage with Medicare deemed to be primary.

2.7 REPLACEMENT COVERAGE

Whereas this Agreement provides replacement Coverage within 60 days after the discontinuance of a prior group HMO contract or insurance policy, then all persons who were validly covered under the previous contract or policy at the date of discontinuance and who otherwise meet the eligibility requirements of this Agreement are eligible to enroll, subject to the limitations of this paragraph and the paragraphs below.

Members who are initially eligible and enrolled under the paragraph above, qualify for full benefits under this Agreement upon meeting all eligibility requirements and complying with the enrollment requirements set forth below in the paragraphs entitled Enrollment. Full Coverage will commence as described in paragraphs entitled Commencement of Coverage as if the Member became newly eligible and enrolled after the Effective Date of Coverage.

2.8 LATE MEMBERS

A Late Member is not eligible to enroll for membership in Plan until the Group’s next Open Enrollment Period following the date of any request for membership subsequent to the Initial Eligibility Period.

A Member is not a Late Member if any of the following conditions apply:

(A) The individual meets all of the following requirements:

1. The individual was covered under another employer health benefit plan, Covered California coverage, or Medi-Cal coverage at the time the individual was eligible to enroll;

2. The individual certified in writing at the time of the initial enrollment that coverage under another employer health benefit plan, Covered California coverage, or Medi-Cal coverage was the reason for declining enrollment, provided that the individual was given the opportunity to make such certification and was notified that failure to do so could result in later treatment as a Late Member;

3. The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment, change in employment status, termination of the other plan’s coverage, cessation of an employer’s
contribution toward coverage, divorce or death of a person through whom the individual was covered as a dependent; and

(4) The individual requests enrollment within 31 days after termination of coverage or cessation of employer contribution toward coverage provided under another employer’s health benefit plan;

(B) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during the period of initial eligibility (see Section 1 definition “Initial Eligibility Period”) and the individual’s other employer health plan’s coverage terminates. The individual must request enrollment within 31 days after termination;

(C) A court has ordered Coverage for a spouse or minor Child and request for enrollment is made within 31 days after issuance of the court order;

(D) The individual is an Eligible Dependent who previously lost Coverage under this Agreement and elects to re-enroll, the individual must request enrollment during open enrollment or as defined by Group;

(E) The individual is an Eligible Employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf, and on behalf of his or her dependent within 31 days following the date of marriage, birth, adoption, or placement for adoption. The effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received or the date of marriage, the date of birth, or the date of adoption, or placement for adoption, whichever applies; or

(F) The individual is an Eligible Employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period and enrollment is requested within 31 days of the loss of such coverage.

2.9 ENROLLMENT

Each person eligible to become a Subscriber, who submits to Plan a complete membership application for himself/herself and his/her Eligible Dependents on forms provided or approved (prior to use by Group) by Plan no later than 31 days after he/she first becomes eligible (see Section 1 definition “Initial Eligibility Period”), and who has fulfilled the requirements of this section, shall have fulfilled the conditions of enrollment.

If an application for membership as a Subscriber is not received by Plan within 31 days after a person first becomes eligible to become a Subscriber, Plan will refuse such membership until the Group’s next Open Enrollment Period.
If an application for membership for an Eligible Dependent is not received by Plan within 31 days of the day on which that Eligible Dependent first becomes eligible for membership, Plan will refuse such membership until Group’s next Open Enrollment Period.

Applicants for membership must complete and submit to Plan such applications or other forms or statements as Plan may reasonably request. Subscribers represent that all information with respect to Subscriber and his/her Eligible Dependents contained in such applications, questionnaires, forms or statements submitted to Plan incident to enrollment under this Agreement or the administration hereof shall be true, correct and complete and all rights to benefits hereunder are subject to the condition that all information shall be true, correct and complete.

At the time of enrollment, all Members must designate a Primary Care Physician, who will be responsible for the coordination of Member’s health care. Subscribers may select a different Primary Care Physician for each Eligible Dependent. If an enrollment form is received without selection of a Primary Care Physician, Plan will assign a Primary Care Physician, but the Member may request a change to another Primary Care Physician. If a Member wishes to change Primary Care Physicians, the Member must first contact Plan and follow the instructions which are provided.

2.10 COMMENCEMENT OF COVERAGE

After fulfilling all conditions of enrollment as stated above, and provided that the Premiums have been paid and all other conditions of this Agreement, have been met, Coverage will commence as follows:

(A) For a Subscriber and his/her Eligible Dependents who are enrolled on the original Effective Date of Coverage, Coverage will commence as of the Effective Date of Coverage;

(B) For a Subscriber who is enrolled after the Effective Date of Coverage and for his/her Eligible Dependents, Coverage is effective as of the first (1st) day following the month in which the Subscriber satisfies the Group’s eligibility criteria;

(C) For an Eligible Dependent of a Subscriber who becomes newly eligible after such Subscriber has been enrolled, Coverage will commence as of the first day of the month following the date eligibility occurred as defined by Group or on the effective date of the qualifying event (i.e. marriage, birth, adoption, or placement for adoption) whichever applies.

(D) For any Subscriber and his/her Eligible Dependents who apply for enrollment or re-enrollment during the Group’s Open Enrollment Period, Coverage is effective as of the first day of the month mutually agreed upon by Group and Plan. However, no enrollment shall be effective unless the Member’s completed application is received by Plan within 31 days after such Coverage was to become effective.

SECTION 3 – CHOICE OF PHYSICIANS AND PROVIDERS

3.1 REQUIRED USE OF PARTICIPATING PROVIDERS

3.1.1 Lock-in provisions apply. The benefits described in this Agreement are Covered Services only if, and to the extent that, they are Medically Necessary and meet the following requirements:
(A) They are provided by, or prescribed or referred in advance by, the Member’s designated Primary Care Physician, and

(B) They are obtained from a Plan Provider.

3.1.2 The only exceptions to the above requirements are:

(A) When a Member requires Emergency Services; or

(B) When a Member requires Urgently Needed Services and while Out-of-Network when out of the Service Area; or

(C) When the requested service is Medically Necessary and Prior Authorization is granted by the Medical Director.

Certain services or supplies within the Service Area also require Prior Authorization. Members must identify themselves to the Plan Provider as a Plan Member before receiving any service or supply.

Members also have a right to a second medical opinion, when medically appropriate, from another Plan Physician within the VHP Network; authorization is required. If the Member requests a second opinion about care from a specialist, the second opinion shall be provided by any provider of the Member’s choice within the Plan Physician network of the same or equivalent specialty.

3.2 SELECTION OF A PRIMARY CARE PHYSICIAN AND ASSOCIATED HOSPITAL

At enrollment, Plan requires each Member to designate a Primary Care Physician. If a Member does not designate a Primary Care Physician, Plan will assign the Member to a Primary Care Physician. Primary Care Physicians are then notified of the selection. A Primary Care Physician is one who is identified by Plan as such and who is willing to assume responsibilities regarding continuity of care, record keeping and referrals to specialist Plan Physicians.

Once the Primary Care Physician is designated, the Member must contact his/her Primary Care Physician before seeking Medical Services or Hospital Services unless the Member requires Emergency Services. When a Member requires Emergency Services, the Member may obtain the nearest available medical care.

Each Primary Care Physician is a member of a Network that includes a Plan Hospital and facilities providing subacute, transitional inpatient and skilled nursing services. The Member must use the Plan Hospital and the facilities providing subacute, transitional inpatient and skilled nursing services in the Primary Care Physician’s Network unless it is Medically Necessary to receive services elsewhere, for example, when Emergency Services are required.

In a health care matter beyond the normal practice of the Primary Care Physician, he or she may refer the Member to a specialist Plan Physician who will usually be a member of the Primary Care Physician’s Network. The Primary Care Physician will manage referrals and ongoing care supplied by other Plan Providers.

Prior Authorization must be obtained from the Medical Director by a Member’s Primary Care Physician before a referral is made. Except as listed below, services obtained from or prescribed by Plan Specialists or other Plan Providers without the advance referral of the Primary Care Physician will not be paid for by Plan. Covered Services not requiring a referral are limited to:
(A) Emergency Services or out of Service Area Urgently Needed Services;

(B) Services provided by on-call physicians who are providing care in the Primary Care Physician’s place;

(C) Obstetrical/gynecological or dermatological services, once the Member has properly designated a Primary Care Physician;

(D) Outpatient Mental Health Counseling Covered Services provided by a VHP Mental Health Provider that is a Psychologist (PhD), Marriage and Family Counselor (MFC/MFT) or Licensed Clinical Social Care Worker (LCSW). No authorization is required for Outpatient Mental Health Counseling Services; however the Member can contact the VHP Utilization Management Department for assistance in obtaining care or the Member may contact their Primary Care Physician.

Except in the case of Emergency Services or out of Service Area Urgently Needed Services, Plan does not cover services provided by Non-Plan Providers or by Plan Providers outside of the Primary Care Physician’s Network unless Prior Authorization has been obtained.

Members do have the right to Covered Services for continuity of care. If the Member or their Dependents have an Acute Condition, a Serious Chronic Condition, a Pregnancy, a terminal illness, or a newborn child between birth and age 36 months is under medical care, the Member may be eligible to continue to receive treatment from their provider (e.g. physician or hospital) either at the time of a Plan Provider’s termination as a VHP Plan Provider, or from a non-participating provider at the time of enrollment in the VHP Plan. Members can request a copy of the Plan’s Continuity of Care policy. Continuity of care Covered Services will be provided to qualified Members from their provider for up to 12 months as deemed appropriate for a safe transfer of the Member to a Plan Provider. Continuity of care Covered Services may exceed 12 months in the event of a terminal illness. Treatment will be provided on a timely and appropriate basis as determined by the Plan Physician. In the case that the Member is pregnant, continuum of care Covered Services will be provided until postpartum services related to the delivery are complete or until such time as it is deemed appropriate. Plan Providers will consult with the Member’s provider to determine when it is safe to transfer.

3.3 CHANGING PRIMARY CARE PHYSICIANS

If a Member wishes to change his/her Primary Care Physician, the Member must first contact Plan and follow the instructions which are provided. The Primary Care Physician may decide to refuse the relationship at any time when allowed by medical ethics and contract, and will require the Member to change his/her Primary Care Physician designation.

Failure to comply with any of the provisions regarding selection and changing of Primary Care Physicians will result in the Subscriber or Eligible Dependent being responsible for the charges.

3.4 REIMBURSEMENT PROVISIONS

It is not anticipated that Member will make payments to any provider for the Covered Services under this Agreement except for:

(A) The applicable Copayments; and

(B) When Emergency Services are obtained outside the Service Area.
If a Member pays a Plan Provider for Covered Services (other than Copayments), the Member must advise the Plan Provider and request that he/she bill Plan directly. The Member will be reimbursed by the Plan Provider for amounts paid for Covered Services (other than Copayments).

If a Member pays a Non-Plan Provider for Covered Services (e.g., Emergency Services outside the Service Area), the Member must furnish evidence satisfactory to Plan that payment to such person or institution has been made for Covered Services. Plan will reimburse Member for such charges less applicable Copayments and less any payments made by Plan prior to receipt of Member’s evidence of payment.

If a Member obtains medical transportation services from a non-Plan medical transportation provider, Member shall file a claim for such services with Plan. Plan will reimburse directly such non-Plan medical transportation provider if such provider has not received payment for those services from any other source. The medical transportation provider may bill the Member for any unpaid portion of the medical transportation provider’s fee only after receipt of payment from Health Plan.

Medical and pharmacy claim instructions are available by contacting a VHP Member Services representative at 1.408.885.4760 or 1.888.421.8444 (toll-free) or by going to VHP’s website at 222.valleyhealthplan.org Under no circumstances will Plan reimburse for charges unless written proof of the charge is furnished to Plan within 180 days after performance of the service.

All such charges will be paid within 45 days of Plan’s receipt of the satisfactory evidence described above, provided that all required information has been supplied and that Plan does not contest the claim. If Plan contests the claim, Plan will notify the Member within 30 days. Information required of Member may include but is not limited to reports, statements, releases, consents and assignments.

3.5 TIMELY ACCESS TO CARE

VHP provides and arranges for the provision of Covered Services in a timely manner appropriate for the nature of the Member’s condition and consistent with professionally recognized standards of practice. VHP has Timely Access to Care standards as set forth in Section 1300.67.2.2 of Title 28 of the California Code of Regulations. These services include:

- A “24-Hour Medical Advice Line” that Members can call at any time to obtain triage or screening for the purpose of determining the urgency of the Member’s need for care.

- An Authorization system in place that allows Members to self-refer through Direct Access to OB/GYN, or through obtaining standing referrals to Plan Specialists. This Authorization system includes timely referrals for other Medically Necessary Covered Services through the Plan Provider Network.

- A process to schedule or reschedule health care appointments. VHP has a website www.valleyhealthplan.org that directs Members to VHP Providers or to locations. This website directs the Member to Plan Providers, including emergency and urgent care. The website details provider telephone numbers and gives the Member Urgent Care Clinic’s hours of operation. Many of VHP’s Urgent Care Clinics offer self-referral/walk-in same day urgent care services. Appointments are not necessary but it can usually save the Member time if s/he calls ahead.
• A Member Services Department, with English, Vietnamese, and Spanish speaking representatives, who offer assistance in obtaining Covered Services and resolving Members health care issues. Additional interpreter services are available, as needed, at the time of the appointment or in the interpretation of critical documents, such as needed during the Plan’s Grievance Process.

• Professionally recognized standards of practice used to determine wait times when scheduling appointments that meet legislative requirements. Such standards do not prohibit the Plan or the Plan Providers from accommodating a Members’ preference to wait for a later appointment from a specific Plan Provider.

SECTION 4 – FEES AND CHARGES

4.1 PREPAYMENT FEES

Group will pay Plan Premiums in the amounts and on the dates set forth in the Rate Schedule attached hereto as Exhibit “A” and incorporated herein by this reference, as amended from time to time as provided herein. Any contribution to the fees by Subscribers will be arranged solely by and between Group and Subscriber. If Group requires such contributions from Subscribers, Group will provide a payroll deduction plan comparable to that made available to any alternative health benefit plan or insurance plan offered by Group.

Only Members for whom the stipulated payment is actually received by Plan are entitled to Covered Services under this Agreement for the period for which such payment is received.

Unless otherwise stated on the Rate Schedule, Premiums will be paid by Group to Plan at its offices on the last day of each calendar month, as payment for Coverage in the succeeding calendar month. Plan will determine any Premiums due from Group for a period of less than one month and any Premium credit for a period of less than one calendar month. If a Member is no longer eligible to receive Coverage under this Agreement and the Group has paid Premiums for this Member after the Member was eligible, the Group will be eligible to receive credit for any such Premiums paid for the Member’s Coverage; provided Group has notified Plan in writing within 60 days after the Member is no longer eligible and Plan has not provided or arranged any Medical or Hospital Services for the Member within these 60 days.

Plan will allow a grace period for the payment of Premiums between the due date for such payment (the last day of the month) and the 15th day of the next calendar month. If the required Premiums are not paid in full on the date the grace period expires, then Group will be in default and Plan may deem the failure of Group to pay Premiums as action by Group to cancel this Agreement in accordance with Section 6 (Term, Cancellation and Related Provisions), subject to the reinstatement provisions of set forth in that section. Further, Plan will notify Group that it has failed to make the required prepayment and Group will immediately notify the Member(s) of such failure. If Group fails to give this required notice within five days of the notification of delinquency, Plan may give such notice.

If Group defaults in the payment of Premiums and any amount remains due, Group will pay to Plan a late payment penalty in an amount equal to one and one-half percent of the Premiums past due. Such late payment penalty is due and payable with the Premiums then owing to Plan.
4.2 OTHER CHARGES

Members will be required to make certain Copayments for the Covered Services as indicated in Section 11, (Principal Covered Services and Coverages) and the Copayment Schedule. Copayments must be paid at the time the Covered Services are rendered. Upon application by the Subscriber no later than 60 days after the end of the contract year, Plan shall reimburse Copayments in excess of the Maximum Copayment. Reimbursement will not be made unless all receipts and records are submitted to Plan within such 60 day period.

4.3 CHANGES IN FEES AND CHARGES

Plan reserves the right to change the Premiums or Copayments for any reason, on any renewal date of this Agreement, provided that written notice of such change must be emailed, mailed (postage paid), or hand delivered at least 60 days in advance of the renewal date on which such change is to take effect.

Plan will have the right to change the Premiums or Copayments as agreed to by Group as of any date during the Agreement period. Plan or Group will give written notice 60 days before such change in Premiums or Copayments take effect.

Payment of any Premiums as changed in accordance with this section constitutes acceptance of continued Coverage at the changed Premiums.

4.4 PREMIUMS AND HEALTH CARE BENEFITS RATIO

Beginning January 1, 2011, regulations require that VHP spends on average at least 85% of premiums on health care benefits, this requirement is known as a "medical loss ratio" or "minimum loss ratio" (MLR). MLR is the ratio of administrative costs, including taxes and fees, vs medical costs.

Premiums are adjusted on an annual basis and are outlined in the Agreement. VHP spends [87%] of its Premiums or MLR for the geographic area of Santa Clara County. Santa Clara County is the Service Area for the Plan.

SECTION 5 – RECORDS

5.1 MAINTENANCE OF RECORDS

Plan will keep a record of Members. Group will forward the information periodically required by Plan in connection with the administration of this Agreement. Plan's liability for the fulfillment of any obligation that is dependent on information to be furnished by Group or Member shall not arise prior to receipt of that information in the form requested by Plan. Nor will Plan be liable for any obligation resulting from information incorrectly supplied by Group or Member. All records of Group, which have a bearing on Coverage, will be open for inspection by Plan at any reasonable time. Plan adheres to HIPAA and protects PHI as required by law.

5.2 SUBMISSION OF CORRECT INFORMATION BY MEMBER

Members or applicants for membership will be required to complete and submit to Plan such applications, medical review questionnaires, or other forms or statements as Plan may reasonably request. Members will be required to warrant that all information contained in such applications, questionnaires, forms or statements submitted to Plan incident to enrollment under this Agreement or
the administration hereof will be true, correct, and complete. Any breach of this warranty may give rise to termination of Coverage as provided in Section 6 (Term, Cancellation and Related Provisions).

5.3 AUTHORIZATION OF DISCLOSURE

Plan is entitled to receive from any provider of services to Member, information reasonably necessary in connection with the administration of this Agreement. By acceptance of Coverage under this Agreement, each Member authorizes every provider of medical services to such Member to disclose all facts pertaining to such care and treatment, and physical condition of such Member, to Plan upon request, to render reports pertaining to the same, and permit copying of records by Plan. Plan adheres to HIPAA and protects PHI as required by law.

5.4 CONFIDENTIALITY

Information from medical records of Members and information received from physicians, surgeons or hospitals pursuant to the doctor-patient relationship will be kept confidential; and, except for use incident to bona fide medical research or education, or reasonably necessary in connection with the administration of this Agreement, the aforementioned information will not be disclosed without the written consent of Member or as required by law. Plan adheres to HIPAA and protects PHI as required by law.

SECTION 6 – TERM, CANCELLATION AND RELATED PROVISIONS

6.1 TERM

This Agreement will continue in effect for the term indicated in the Declarations; provided however, that Plan reserves the right to change the Premiums set forth in the Rate Schedule and the benefits and coverages herein, on each anniversary date of this Agreement. This Agreement will renew automatically from year to year on the anniversary date unless terminated pursuant to this section, and subject to any changes in Premiums, other charges, benefits and coverages pursuant to Section 4 (Changes in Fees and Charges) and the paragraph entitled “Change in Agreement” under Section 9 (General Provisions).

6.2 EFFECT OF CANCELLATION

Upon termination of this Agreement and/or an individual Member’s Coverage under this Agreement, all rights of Group’s Members or such individual Member to receive Covered Services hereunder are terminated subject to any applicable provisions for reinstatement, temporary continuation of benefits, Continuation Coverage, or extension of benefits. Cancellation of this Agreement cancels Coverage for all Subscribers of Group and their Eligible Dependents. Cancellation of a Subscriber’s Coverage cancels Coverage for such Subscriber’s Eligible Dependents.

This Agreement and/or an individual Member’s Coverage may be cancelled for the reasons identified below. When cancelled, all Coverage and rights hereunder will terminate at the time indicated below. Any benefits or services received after the effective cancellation date will be directly chargeable to the Member.
6.3 CANCELLATION OF INDIVIDUAL MEMBERS

6.3.1 Loss of Eligibility

If a Member ceases to meet the eligibility requirements of Section 2 (Eligibility), then (subject to any applicable provisions for continuation of benefits) the Member’s Coverage terminates at midnight on the last day of the month in which loss of eligibility occurs. Group and Members agree to notify Plan immediately if a Member ceases to meet the eligibility requirements.

6.3.2 Disenrollment by Member

If a Member elects coverage under an alternative health benefits plan offered by or through Group as an option in lieu of Coverage under this Agreement, then Coverage for such Member terminates automatically at the time and date the alternate coverage becomes effective. In such event, Group agrees to notify Plan immediately that the Member has elected coverage elsewhere.

Member may voluntarily disenroll from Plan at any time for any reason by notifying Group of the intent to cancel membership. The Member’s Coverage terminates at midnight on the last day of the month during which the Group notified Plan of the Member’s intent to disenroll.

6.3.3 Cancellation of Members For Cause

(A) Nonpayment. If a Member fails to pay or fails to make satisfactory arrangements to pay any Premium due Plan, then Coverage may be cancelled following a notice of cancellation. Notice of cancellation can be mailed or hand delivered and must give the Member a 30 day grace period to pay Premium due Plan (State law required 30 day notice).

(B) Fraud or Deception. If a Member engages in fraud or deception in the use of membership, Plan, or a Plan Provider or permits such fraud or deception by another then Coverage may be cancelled. Some examples of fraud or deception include:

- Intentional failure or with willful misrepresentation to provide material information required in connection with enrollment in this Agreement, or provides materially incorrect or misleading enrollment information or updated enrollment/eligibility information. If the Member does not furnish or make satisfactory arrangements to provide materially correct and complete enrollment/eligibility information within 15 days of mailing of Plan’s written request to do so, then Plan may cancel Coverage of the Member effective at midnight on the 15th day after the day Plan mails or hand delivers a notice of cancellation (State law required 30 day notice).

- Unauthorized use of a Plan identification card by permitting a non-Member to use a Member identification card to obtain Benefits, then Plan may cancel the Coverage of the Member(s) involved effective as of the date that Plan mails notice of cancellation to such Member(s).
- Engaging in deception in the use of VHP services or facilities, Plan Providers, or Non-Plan Providers, then Plan may cancel the Coverage of the Member(s) involved effective as of the date that Plan mails notice of cancellation to such Member(s).

As agreed to by Plan and Group, Plan may cancel Coverage of a Member as a result of the following:

(C) **Medicare Enrollment.** As per Group labor agreements, if a non-TEFRA Member (see Section 2 — Eligibility) fails to enroll for Medicare coverage when eligible to purchase Medicare, Group will notice Plan and Plan may cancel Coverage of that Member.

(D) **Enlistment in Uniformed Service.** If a Member fails to notify Plan when enrolled in Uniformed Service, Plan may cancel Coverage of that Member. The Plan will reinstate a Member’s Coverage provided Member enrolls and is eligible to enroll at a later date.

6.4 CANCELLATION OF ENTIRE AGREEMENT

6.4.1 Nonpayment

If the Group fails to pay when due any Monthly Premium on behalf of each Member, then Plan may cancel this Agreement. Upon such default, all rights to benefits terminate at the end of the period for which Premiums have been paid for all Members, including those who are hospitalized or undergoing treatment for an ongoing condition unless Member may be covered under the paragraph entitled “Extension of Covered Services” in Section 7 (Individual Continuation of Group Covered Services) due to Total Disability. In such event, Plan will give Group 15 days written notice of the effective date of termination. Group will promptly mail to each Subscriber a legible, true copy of the notice of termination and will promptly provide Plan proof of such mailing and the date thereof.

6.4.2 Fraud

If Group knowingly furnishes materially incorrect, incomplete or misleading enrollment or other requested information regarding Group, its business, or any Member; or if Group knowingly permits fraud or deception by any of its Members, Plan may give Group written notice of termination. Group will promptly mail to each Subscriber a legible, true copy of the notice of termination and will promptly provide Plan proof of such mailing and the date thereof. Termination will be effective 15 days after the notice is mailed to the Subscriber.

6.4.3 Cancellation by Group

This Agreement may be terminated by Group by giving 60 days prior written notice to Plan. In such event, all rights to benefits hereunder cease as of the effective date of termination of this Agreement regardless of whether a condition or course of treatment commenced while Coverage was in effect. Plan has no obligation to notify Subscribers in the event of such termination by Group. Group will promptly notice each Subscriber of Group’s termination of Plan Agreement. Such notice will be to all Members on COBRA or Cal-COBRA and notification will be provided as required by Section 1366.25 of the Health and Safety Code.
6.4.4 Cancellation by Plan for Cause

Plan may decline to renew or may terminate this Agreement for material noncompliance with or breach of this Agreement (collectively, "Breach"), which Breach is not cured by Group within 60 days after written notice to the Group of the nature of the Breach. If such Breach cannot be cured within such 60 day period, then the commencement of such cure within such 60 day period and its diligent prosecution to completion will automatically rescind the notice of termination. In the event of nonrenewal or termination, Group will promptly mail to each Subscriber a legible, true copy of the notice of termination and will promptly provide Plan proof of such mailing and the date thereof.

Plan may decline to renew or may terminate this Agreement if Plan ceases to provide or to arrange for the provision of health care services for new health benefit plans in this state. In the event of such termination, Plan will give written notice to Group by mail (postage prepaid) or hand delivery at least 180 days in advance of the effective date of such termination.

6.5 NOTICE OF CANCELLATION

6.5.1 Notice When Individual Member’s Coverage is Cancelled

If Plan cancels or refuses to renew an individual Member’s enrollment under this Agreement, Plan will mail notice thereof to the Subscriber at the Subscriber’s address of record with Plan or hand deliver such notice to the Subscriber.

6.5.2 Notice Where Agreement With Group is Cancelled

If Plan cancels or refuses to renew this Agreement, the following provisions will apply regarding notice to all Subscribers of Group:

(A) Group’s Obligation to Give Notice. If Plan mails or hand delivers a notice of cancellation to Group (by address or delivery to the person signing this Agreement on behalf of Group or such person’s successor) with instructions that Group give notice to all Subscribers under this Agreement, then Group will promptly mail a legible, true copy of such notice to each Subscriber under this Agreement at the Subscriber’s current address. Group will promptly provide proof of such mailing and the date thereof to Plan.

(B) Plan’s Obligation to Give Notice. If Plan does not mail or deliver a notice of cancellation to the Group with instructions that Group give notice to Group’s Subscribers, Plan will mail a notice of cancellation to each Subscriber under this Agreement at each Subscriber’s address of record with Plan.

Notice that is given to each Subscriber is deemed notice given to each Eligible Dependent who receives Coverage through the Subscriber.

6.6 CESSATION OF COVERAGE

Plan does not cover any services or supplies provided after the effective date of termination of this Agreement or of a Member. Coverage ceases regardless of whether a condition or course of treatment
commenced while Coverage was in effect. The only exceptions are the provisions set forth in Section 7 (Individual Continuation of Group Covered Services), where applicable. Where termination is for fraud or for any of the reasons set forth in Paragraph 6.3.3 (Cancellation of Members For Cause), Members are not entitled to individual continuation of group benefits set forth in Section 7.

6.7 REINSTATEMENT

Receipt by Plan of the proper Monthly Premium after termination of Group for non-payment of Premiums will reinstate Group as though there never was a termination, if such payment is received on or before the due date for the succeeding Monthly Premium, unless:

(A) in the notice of termination, Plan notifies Group that if payment is not received within 15 days, a new application is required and the conditions on which a new contract will be issued or the original contract reinstated;

(B) such payment is received more than 15 days after issuance of the notice of termination, and Plan refunds such payment within 20 business days; or

(C) such payment is received more than 15 days after issuance of the notice of termination, and Plan issues to Group within 20 business days or receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

6.8 REFUNDS IN THE EVENT OF CANCELLATION

In the event of cancellation by either Plan or Group, Plan will return to Group, within 30 days of the effective cancellation date, the pro rata portion of the Premiums paid to Plan which correspond to any unexpired period for which payment had been received together with amounts due Members on claims for reimbursement of charges (for Covered Services) incurred prior to the effective date of termination, if any, less any amounts due Plan or Plan Providers, and neither Plan nor Plan Providers has any further liability or responsibility under this Agreement. However, no such refund will be made where cancellation is in the case of fraud or deception in the use of services or facilities of Plan or knowingly permitting such fraud or deception by another.

6.9 MEMBER’S RIGHT TO REVIEW OF CERTAIN CANCELLATIONS

A Member who alleges that Member’s Coverage, subscription or enrollment has been cancelled or not renewed because of the Member’s health status or requirements for health care services, may request a review by the California Department of Managed Health Care.

SECTION 7 – INDIVIDUAL CONTINUATION OF GROUP BENEFIT

7.1 CONTINUED GROUP COVERAGE UNDER COBRA/CAL-COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), an employer who maintains a group health plan and employs 20 or more employees on a typical business day during the prior Calendar Year is required to provide Members with the opportunity to elect to continue their Coverage in certain circumstances where Coverage would otherwise terminate. Similarly, under the California Continuation Benefits Replacement Act (“Cal-COBRA”), an employer who maintains a group health plan, employs two to 19 employees on at least 50% of its working days in the prior Calendar Year (or previous calendar quarter, if the employer was not in business during
any part of the preceding year), and is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement or Income Security Act is required to offer Continuation Coverage in certain circumstances where Coverage would otherwise terminate. Such employers and their group health plan’s administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (1) provide Members with notice of the opportunity to elect Continuation Coverage; and (2) administer the Continuation Coverage.

The obligation to provide notice includes general notification to Members of their right to elect Continuation Coverage. In addition, each Member must be provided notification of the right to Continuation Coverage within a specific time period after the occurrence of the event, which triggers the Continuation Coverage option. In the event that Group terminates the Agreement, Group must notice Members either 30 days prior to the termination of Agreement, or when all enrolled employees are notified, whichever is later. Group must ensure that the notice is distributed to its Continuation Coverage Members and that these Members are eligible to enroll in continuation coverage in any successor health plan that Group enrolls in.

Group hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to Continuation Coverage. Group also agrees to forward to Plan in a timely manner copies of any notice regarding Continuation Coverage provided to Members. Group further acknowledges that in the event a Subscriber is terminated by Group because of gross misconduct, the Group will notify Plan immediately or within ten days of termination of employment; such Subscriber would not be eligible for Continuation Coverage.

7.1.1 Eligibility for Continuation of Coverage

The following persons are entitled to elect Continuation Coverage:

(A) Subscribers whose Coverage under this Agreement ends because of termination of Subscriber’s employment (unless employment is terminated because of gross misconduct), or whose Coverage terminates because of a reduction in hours of employment, have the right to elect Continuation Coverage for themselves and their Eligible Dependents;

(B) Eligible Dependents of Subscribers have the right to Continuation Coverage if they would lose Coverage for any of the following reasons:

(1) Death of the Subscriber;

(2) Divorce or legal separation from the Subscriber;

(3) Enrollment of Subscriber in Medicare;

(4) Termination (other than for gross misconduct) or reduction of hours of the Subscriber’s employment; and

(5) Loss of Eligible Dependent status by a dependent enrolled in Plan.

(C) Certain retired Subscribers and their Eligible Dependents whose employer files for bankruptcy under Chapter 11 may be eligible for Continuation Coverage. (Special rules apply in this instance and employees should consult their employer or plan administrator.)
The occurrence of an event that causes any Member to be entitled to elect Continuation Coverage is referred to herein as a “qualifying event”.

7.1.2 Maximum Time Periods of Coverage

Continuation Coverage begins on the date of the event that would otherwise trigger the loss of Coverage under this Agreement and terminates no later than 36 months thereafter, except if Coverage for the Subscriber and Eligible Dependents ends because of the termination or reduction in hours of Subscriber’s employment. In that instance, Continuation Coverage will terminate no later than 18 months thereafter; provided, however, that:

(A) If the Subscriber or Eligible Dependent notifies the plan administrator within 60 days after the date of a determination, under Titles II or XVI of the Social Security Act, that he or she was disabled at any time within the first 60 days of Continuation Coverage, Coverage will terminate no later than 29 months thereafter.

(B) If during the 18 month period or, where applicable, 29 month period from the date of the termination or reduction in hours of Subscriber’s employment, one of the events described in subsection 7.1.1 (B)(1), (2), (3) or (5) above occurs, Coverage under this Agreement will terminate no later than 36 months from the date of the termination of employment or reduction in hours.

(C) If within 18 months of an event described in subsection 7.1.1 (B)(3) above, the Subscriber subsequently loses Coverage because of an event described in subsection 7.1.1 (B)(4) above, the Eligible Dependents, other than the Subscriber, shall be entitled to elect Continuation Coverage for a period of up to 36 months from the date of the event described in subsection 7.1.1 (B)(3) above.

(D) If the Subscriber or Eligible Dependent notifies the employer or plan administrator within 60 days after the date of a determination, under Section 1366.29 of the Health and Safety Code, that he or she has exhausted continuation coverage under COBRA, Coverage will terminate no later than 18 months from the COBRA termination. Continuation Coverage under this subsection 7.1.2 (D) will terminate no later than 36 months from the date of the qualifying event.

7.1.3 Exceptions to Maximum Time Periods of Coverage

Notwithstanding the maximum time periods set forth above, Continuation Coverage will end upon the occurrence of any one of the following events:

(A) On the date Group ceases to provide any group health plan to any employee. For purposes of this Section 7 the term “employer” is that term as defined under COBRA and applicable regulations; provided, however, that if Group employs two to 19 employees, then the term “employer” shall have the meaning ascribed to it under Cal-COBRA and applicable regulations;

(B) On the date Member becomes covered under another health plan which does not contain any exclusion or limitation with respect to any preexisting condition of the Member;
On the date Member is enrolled for Medicare benefits; or

In the case of the 11 month extended Coverage provided due to a disability, on the first (1st) day of the month which starts at least 30 days after a final determination, under the Social Security Act, that Member is no longer disabled.

7.1.4 Type of Coverage

Coverage provided under the Continuation Coverage option will be identical to the Coverage Group provides to similarly situated persons who have not lost group Coverage under this Agreement. Continuation Coverage will not be conditioned on evidence of insurability.

7.1.5 Premiums

Group may require the Member to pay for Continuation Coverage as long as the amount does not exceed 102% of the applicable premium, except that:

(A) In the case of a Member who is entitled to the 11 month extended Continuation Coverage period as a result of a disability, such Member may be required to pay up to 150% of the applicable premium for the Coverage during that extended period of Coverage.

(B) In the case of a Member who is entitled to up to the 18 month extended Continuation Coverage period as a result of exhausting continuation coverage under COBRA Coverage, such Member may be required to pay up to 110% of the applicable premium for the Coverage during that extended period of Coverage.

"Applicable premium" for any 12 month period of Continuation Coverage under (A) and (B) above means the Premium paid by the Group to Plan for such Coverage during the period for similarly situated persons who did not lose Group Coverage under this Agreement.

Group will remit to Plan the Premiums for Members who elect Continuation Coverage with Group’s regular monthly payment. If Group requires a Subscriber or Eligible Dependent electing Continuation Coverage to pay all or any part of the Premiums for such Continuation Coverage, Group will be solely responsible for collecting those Premiums. Group agrees that Continuation Coverage will be provided only for persons eligible for such Continuation Coverage under applicable law and regulations and for whom applicable Premiums have been received by Plan.

Plan will provide Group a grace period of 30 days prior to terminating Coverage for failure to pay premium. However, Group will immediately notify Plan if the Group fails to receive the Member’s Premiums on the due date. If a Member elects Continuation Coverage after the date of the event which entitles him or her to Continuation Coverage, Group must remit the first premium retroactive to the date Coverage would otherwise have terminated within 45 days of the date of the election. No grace period applies to this first premium.
Eligible persons will be terminated from Coverage upon a qualifying event but will be enrolled retroactively to the qualifying event upon timely election of Continuation Coverage under COBRA [or Cal-COBRA]. If an eligible person requires services before election, the eligible person must either (1) elect and pay for the Coverage or (2) pay Reasonable Charges (i.e. reasonable and customary charges) for the services subject to reimbursement by Plan within 30 days of such person’s timely election of Continuation Coverage under COBRA [or Cal-COBRA].

7.1.6 Notice of Qualifying Event

In the event of eligibility for Continuation Coverage due to divorce, legal separation, a Child losing Eligible Dependent status, or the exhaustion of continuation coverage under COBRA, the Member has the responsibility to notify the administrator of Group’s health benefit plan of such qualifying event within 60 days after the date of such event. If the Member fails to give that notice within the 60 day period, he or she will not be entitled to Continuation Coverage. The plan administrator is designated in the document establishing Group’s health benefits plan. In the absence of such designation, the administrator is the employer. Group must notify the plan administrator (if Group and plan administrator are not the same) within 30 days of the occurrence of any other qualifying event. In turn, the plan administrator is obligated to notify Subscriber and Eligible Dependents of the opportunity to elect Continuation Coverage within 14 days after receiving notice of the qualifying event.

7.1.7 Nonliability of Plan

Plan will cooperate with Group to assist Group in meeting its obligations regarding Continuation Coverage, provided that, except as otherwise set forth in the following subsection, Plan assumes no responsibility for Group’s compliance with Group’s obligations under federal laws or regulations concerning Continuation Coverage. Group hereby indemnifies and holds Plan harmless from any and all claims, liability and expenses arising out of Group’s failure to comply with its obligations under federal laws or regulations regarding Continuation Coverage, unless such claims, liability and/or expenses result from the Plan’s breach of its obligations under this Agreement or its willful negligence or intentional misconduct.

7.1.8 Coordination of Covered Services

If a Member who has elected Continuation Coverage under this Agreement subsequently becomes covered under another group health care plan or policy which has an exclusion for preexisting conditions, the Continuation Coverage under this Agreement will be secondary to coverage under such other plan or policy; except that the Continuation Coverage under this Agreement will be primary with respect to the preexisting conditions which are excluded under such other group plan or policy.

7.1.9 Regulations

If federal or state laws or regulations are enacted or issued governing Continuation Coverage and the application of such laws or regulations would modify this section regarding benefits under COBRA [or Cal-COBRA], such laws or regulations will supersede any contrary provision provided herein.
7.2 CONTINUED GROUP COVERAGE AFTER TERMINATION OF COBRA

If a Subscriber elects to extend group health benefits under COBRA [or Cal-COBRA], the Subscriber, the Subscriber’s spouse, and/or former spouse(s) may be entitled to an extension of those group health benefits after COBRA [or Cal-COBRA] benefits terminate. Group must notify the Subscriber, the Subscriber’s spouse and/or former spouse(s) if they are eligible for extended benefits upon termination of Continuation Coverage under COBRA [or Cal-COBRA].

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member’s continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends. Group or Group COBRA administrator will notify Member of eligibility to continue coverage under Cal-COBRA. Member has 60 days from that notification to contact VHP to continue Group Coverage under Cal-COBRA.

Note: COBRA enrollees must exhaust the entire COBRA coverage to which they are entitled before the Member can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of Group Coverage under COBRA, Cal-COBRA, or a combination of both be extended for more than three years from the date such Coverage began.

7.3 EXTENSION OF BENEFITS

Except as expressly provided in this section, all rights to services and other benefits hereunder terminate as of the effective date of termination of this Agreement.

If, when this Agreement is terminated as to the entire Group, a Member is receiving treatment for a condition for which benefits are available under this Agreement and which condition has caused such Member to be Totally Disabled as determined by Plan, then such Member will be covered, subject to all limitations and restrictions of this Agreement, including payment of Copayments and the Monthly Premium, for Covered Services directly relating to the condition causing the Member to be Totally Disabled. This extension of benefits terminates upon the earlier of (1) the end of the twelfth month after termination of this Agreement, or (2) the date the Member is no longer Totally Disabled as determined by Plan, or (3) the date the Member’s coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfies the definition of Totally Disabled in this Agreement.

If Plan terminates this Agreement for cause as specified in Paragraph 6.4.4 (Cancellation by Plan for Cause), any Member who is a registered bed patient in a hospital at the effective date of termination will, subject to payment of the periodic prepayment fee and applicable Copayments, receive all benefits otherwise available hereunder to institutionalized patients for the condition under treatment during the remainder of the particular episode of institutionalization, until either (1) the expiration of such benefits or (2) determination by Plan that hospitalization is no longer Medically Necessary, whichever occurs first.

If prior to termination there has been no default in the payment of the Monthly Premium or those made on the Member’s behalf, and the Subscriber or Subscriber’s Eligible Dependent are receiving inpatient obstetrical care at the date of termination, Plan will continue Coverage of the obstetrical care for the mother until discharge from the hospital.
SECTION 8 – GRIEVANCE PROCEDURE

8.1 GRIEVANCE PROCEDURE

A Member who has a question or complaint regarding a denial of Prior Authorization or referral can contact his or her Primary Care Physician or Plan directly. If the Member is not satisfied with the Plan's or Primary Care Physician's decision or if the Primary Care Physician does not act in the time period allowed, the Member may file a grievance with Plan. A Member who has a complaint may request that a Grievance be filed with the Plan in accordance with Plan procedures; the Member, the Member's Plan Provider or authorized representative of the Member may submit a written Grievance directly to Plan. A copy of the Grievance plan and forms for written complaints or concerns are provided to all Plan Providers’ offices. Complaints may also be filed at Plan's office by writing to or visiting the Plan office located at 2480 N. First Street, Suite 200, San Jose, California 95131 or by calling 408.885.4760, Attention Grievance Department. Alternatively, a Member may file a Grievance online with the Plan via forms available through the VHP's internet website http://valleyhealthplan.org. Complaints must be filed with the Plan within 180 days from the date of the event, which caused a Grievance. As needed, the 180 days starts on the date the Plan provides Member with a Grievance Form translated into the language of the Member’s choice.

The Plan will provide the Member with written responses to Grievances and Disputed Covered Services with explanations of the reasons for the Plan’s responses. If the Plan makes a Coverage Decision and denies services on the basis that they are not Medically Necessary, the Plan will provide the clinical reasons related to Medical Necessity. If the Plan denies services on the basis that the services are not covered Benefits, the Plan will state provisions that exclude such services. The Plan will resolve all Grievances within 30 days.

Upon completion of the grievance process, a Member who is dissatisfied with the final resolution may submit a grievance to the Department of Managed Health Care (Department) for review after completion of the grievance process or participation in the grievance process for at least 30 days.

If the grievance involves an imminent and serious threat to a Member’s health and/or a Life-Threatening or Seriously Deleterious state, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan will provide an expedited review as required by Section 1368.01(b) of the Health and Safety Code. The Member may also submit the grievance or Disputed Covered Service grievance involving an imminent and serious threat to a Member to the Department prior to completion of the grievance process or prior to participation in the grievance process for 30 days.

The Plan does not have a requirement that the Member must first participate in the Plan's Grievance process before requesting the Department to review a Grievance. Refer to the section titled "Independent Medical Review."

Members also have the right to receive vital documents, such as the Plan Grievance Form or Plan Application form, in threshold languages as defined by Section 1259 of the Health and Safety Code. Plan will provide translation services in accordance with the 21 day timeframe stipulated in Section 1367.04 of the Health and Safety Code.
8.2 REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care (the "Department") is responsible for regulating health care service plans. If a Member has a Grievance against the Plan, the Member should first telephone Plan at 408.885.4760 and use the Plan’s Grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member. If the Member needs help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by Plan, or a Grievance that has remained unresolved for more than 30 days, the Member may call the Department for assistance. The Member may also be eligible for an Independent Medical Review (IMR). If the Member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by the Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for Emergency or Urgently Needed Services. The Department has a toll-free telephone number (1.888.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The Department’s Internet Website http://www.hmohelp.ca.gov has complaint forms, IMR application forms, and instructions online.

8.3 INDEPENDENT MEDICAL REVIEW

If VHP denies the Member health care services on the basis that the service is not Medically Necessary, the Member or his designee can request an Independent Medical Review (IMR). The Member must first have completed the VHP Grievance process or have participated in the grievance process regarding a Disputed Covered Service for at least 30 days. However, the Member can directly request an IMR review in the event the denied services are Experimental or Investigational Treatments. The IMR request for review of Experimental or Investigational Treatments must be based on the following requirements that the Member’s Plan Physician certifies that the disease or condition is:

(A) Life-Threatening and Seriously Debilitating, or

(B) due to a terminal condition that has a high probability of causing death within two years and that the Member’s Plan Physician certifies that standard therapies used have not been effective to improve the condition, would not be medically appropriate, or there is no other beneficial standard therapy covered by the plan than the proposed drug, device, procedure or therapy,

(C) the specific drug, device, procedure, or other therapy recommended by the Plan Physician would be a Covered Benefit, except for the Plan's determination that the therapy is Experimental or Investigational.

An Independent Medical Review or IMR means a review process conducted by health care professionals that are not associated with a health plan. It is a way for doctors and other health care professionals outside the Plan to make an independent decision about the Member’s health care. The Department of Managed Health Care’s HMO Help Center operates the Independent Medical Review Program.

The Member must submit a request for an IMR to the DMHC within 6 months of receiving a denial from the Plan. The Member may request an IMR only for a service that is a Covered Benefit. The Member can obtain more information on the IMR process by accessing the Department of Managed
Health Care’s website at www.dmhc.ca.gov/imr or by calling a VHP Plan Member Services Representative at 408 885.4760.

Nothing in this section shall preclude a Member from seeking assistance directly from the Department in cases involving an imminent or serious threat to the health of the Member or where the Department determines an earlier review is warranted. In such cases, the Department may require the plan and contracting providers to expedite the delivery of information.

SECTION 9 – GENERAL PROVISIONS

9.1 CHANGE IN COVERED SERVICES

Plan will not decrease Covered Services during the term of this Agreement except as agreed to in writing between Group and Plan; however Plan may decrease Covered Services with at least 30 days written notice prior to the effective renewal date of the Agreement. Such written notice will be made by postage-paid mail to the Group or will be hand delivered to the Group.

9.2 NOTICE OF PLAN PROVIDER’S INABILITY TO PERFORM

Plan will provide Group written notice within a reasonable time of any termination or breach of contract by, or the inability to provide Covered Services by any Plan Provider, or any other person with whom Plan has a contract to provide Covered Services hereunder, if Group or any Member may be materially and adversely affected thereby.

9.3 NECESSARY DOCUMENTS

Any Member who fails to submit any documents requested under this Agreement must pay the charges for services received.

9.4 I.D. CARDS

Cards issued by Plan to Members are for identification only. Possession of a Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges and Premiums under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement must pay applicable charges.

9.5 SERVICES NON-TRANSFERABLE

No person other than a Member is entitled to receive Covered Services under this Agreement. Such right to Covered Services is not transferable.

9.6 WORKER’S COMPENSATION INSURANCE

This Agreement is not in lieu of and does not affect any requirement of coverage by Workers’ Compensation insurance. All benefits paid or payable by Workers’ Compensation for Covered Services are payable to Plan under the paragraph entitled “Third Party Responsibility” in Section 10 (Limitations).
9.7 RULES AND CRITERIA

Plan may adopt reasonable policies, procedures, rules, criteria and interpretations to promote orderly and efficient administration of this Agreement.

9.8 NO MEMBER LIABILITY FOR PLAN’S FAILURE TO PAY PLAN PROVIDERS

As required by law, every contract between Plan and a Plan Provider specifies that if Plan fails to pay such Plan Provider, the Member will not be liable to the Plan Provider for any sums owed by Plan.

9.9 MEMBER LIABILITY TO NON-PLAN PROVIDERS

If Plan fails to pay a Non-Plan Provider, the Member may be liable to such Non-Plan Provider for the cost of such Non-Plan Provider’s services, unless Prior Authorization has been obtained from Plan or the services were Emergency Services.

9.10 PLAN LIABILITY FOR CHARGES

Upon termination of a Plan Provider contract, Plan will be liable for Covered Services (other than for Copayments) rendered by such Plan Provider for a Member under the care of such Plan Provider at the time of such termination until the Covered Services are completed, unless (i) Plan makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Plan Provider or (ii) Plan arranges for the continuation of Covered Services by the terminated provider at the time of termination and at the request of a Member who is undergoing a course of treatment for one of the following conditions:

(A) An Acute Condition.

(B) A Serious Chronic Condition.

(C) A high risk Pregnancy that has reached the second or third trimester.

(D) A terminal illness.

(E) The care of a newborn child between birth and age 36 months.

(F) The performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment.

In cases involving an Acute Condition, a Serious Chronic Condition or newborn child, the Plan will furnish the Member with Covered Services on a timely and appropriate basis from the terminated provider for up to 12 months. In cases involving the performance of a surgery or other procedure that is authorized by the Plan, the Plan will furnish Covered Services for up to 180 days from the date of Plan Provider’s termination.

The Plan will require that the terminated provider whose services are continued beyond the contract termination date to agree in writing to the same contractual terms and conditions that were imposed upon the provider prior to termination.
9.11 NONDISCRIMINATION

Plan shall not refuse to enter into any contract, cancel or decline to renew or reinstate any contract, nor shall Plan modify the terms of a contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, genetic characteristics, or age (except as provided in Section 2, Eligibility) of any contracting party, or person reasonably expected to benefit from such contract.

9.12 RELATIONSHIPS AMONG THE PARTIES

The relationship between Plan and Plan Providers is that of independent contractors. Plan Providers are not employees or agents of Plan nor is Plan nor any employee of Plan an employee or agent of Plan Providers. No Member is an agent or representative of Plan, its agents or employees, or Plan Providers, or any person or organization with which Plan made or will make arrangements for the performance of services under this Agreement.

Plan Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all of their services. In no event will Plan be liable for the negligence, wrongful acts, or omissions by a Plan Provider in the course of delivery of services (regardless of whether such services are Covered Services), nor will Plan be liable for services or facilities which are unavailable to the Member for any reason beyond Plan’s control. Neither Group nor any Member is the agent or representative of Plan and neither will be liable for any acts or omissions of Plan, its agents or employees, any Plan Provider, Medical Group or any other person or organization with which Plan has made or hereafter makes arrangements for the performance of services under this Agreement.

9.13 BINDING EFFECT UPON MEMBERS

By this Agreement, Group makes Plan Coverage available to persons who are eligible and duly enrolled under Section 2 (Eligibility). By enrollment or accepting services or benefits under this Agreement, Members legally capable of contracting and legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof and thereby agree to be bound by this Agreement.

9.14 CHANGE IN AGREEMENT

The Plan may, at any time propose an amendment to this Agreement by giving the Group 60 days written notice. Otherwise this Agreement may not be changed, amended, or modified except in writing executed by the Group and Plan.

Notwithstanding the above, changes in premium rates or changes in coverage can only become effective (i) on the renewal effective date of the Agreement if the Plan gives the Group at least 60 days written notice prior to the renewal effective date or (ii) at any time in writing if executed by the Group and Plan.

9.15 NONWAIVER

No delay or failure by Plan to exercise any right under this Agreement will be deemed a waiver of such right in the future. The provision by Plan of extra contractual benefits to a Member will not create any rights to extra contractual benefits, either to the same Member in the future or as to any other Member.
9.16 ASSIGNMENT

This Agreement is not assignable by Group without the prior written consent of Plan. The rights, benefits and any payments under this Agreement are not assignable by Members without the written consent of Plan.

9.17 NOTICES

Unless otherwise specified in this Agreement, the Group agrees to disseminate to its Members any disclosure forms, plan summaries or other notices regarding material matters in the next regular communication to such Members, but in no event later than 30 days after receipt thereof from Plan.

Notice will be sent by United States mail, first class, postage prepaid, addressed to:

To Plan: Valley Health Plan
2480 N. First Street, Suite 200
San Jose, California 95131
Attn: Chief Executive Officer

To Member: Member’s last address known to Plan

To Group: Group’s last address known to Plan

9.18 PARAGRAPH HEADINGS

The paragraph headings and captions of this Agreement are for ease of reference and will not limit, amplify or otherwise affect the meaning of any provision of this Agreement.

9.19 GOVERNING LAW

Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health & Safety Code and applicable regulations developed by the Director of the Department of Managed Health Care as set forth in Title 28 of the California Code of Regulations. Any provisions required by either of the above will bind the parties to this Agreement whether or not provided in this Agreement.

9.20 ENTIRE AGREEMENT

This Agreement, addenda and membership applications constitute the entire agreement between the parties as of the Effective Date of Coverage, and supersedes all other agreements between the parties. No representation by any broker, agent, or marketing representative or any other person will be binding upon Plan unless expressly set forth in this Agreement.

SECTION 10 – LIMITATIONS

10.1 CIRCUMSTANCES BEYOND PLAN’S CONTROL

If, due to circumstances not reasonably within the control of Plan, such as complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, or similar causes, the rendition of Covered Services is delayed or rendered impractical, then neither Plan nor any Plan Provider will have any liability or obligation on account of such delay or failure to provide or arrange for services, except that Plan will make a good faith effort to provide or arrange for such Covered
Services under this Agreement within the limitations of such policies and personnel as are then available. In the case of labor disputes, the obligation of Plan will be to arrange and pay for an alternate method of receiving care.

10.2 NON-DUPLICATION OF BENEFITS

The benefits under this Agreement are not designed to duplicate any benefits for Members who are entitled to receive benefits under Workers' Compensation, employer liability laws, Medicare, or CHAMPUS. All sums paid or payable for Covered Services provided pursuant to this Agreement will be payable to and are deemed assigned to Plan. By executing an enrollment application, Subscriber agrees for himself/herself and his/her enrolled Eligible Dependents to submit to Plan the necessary claim forms, consents, releases, assignments and other documents reasonably requested by Plan, including enrollment under Parts A and B of the Medicare Program, in order to assist Plan in recovering the Reasonable Charges (i.e. reasonable value of services) provided to a Member who receives benefits covered under Medicare, CHAMPUS, the Workers' Compensation Law or any other health plan or insurance policy. Any Member who fails to submit such documents reasonably requested must pay charges for services received, as determined by Plan, and will be subject to termination. When a Member has available benefits with another health plan or insurance policy, Plan as a secondary payor will pay only the remaining allowable charges whether or not a claim is made to the primary payor. The fact that a Member has duplicate coverage in no way reduces the Member's obligation to make all required Copayments. The non-duplication provisions of this paragraph apply to the full extent permitted by law.

10.3 REIMBURSEMENT RESPONSIBILITY OF PLAN

If Plan for any reason beyond its control, is unable to provide Covered Services, then Plan will be liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through non-participating providers to the extent required by the California Department of Managed Health Care.

10.4 THIRD PARTY RESPONSIBILITY

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and injuries and illnesses covered by Workers' Compensation) and complications incident thereto, Plan will furnish Covered Services. However, if any recovery from a third party is received on account of such injuries, Member will reimburse Plan for the value of the services and benefits, as set forth below. By executing an enrollment application, each Member grants Plan a lien on any such recovery and agrees to protect the interests of Plan when there is a possibility that a third party may be liable for a Member's injuries. Each Member specifically agrees as follows:

(A) Each Member will give prompt notification to Plan of the name and location of the third party, if known, and of the circumstances which caused the injuries;

(B) Each Member will execute and deliver to Plan or its nominee any and all lien authorizations, assignments or other documents requested by Plan which may be necessary or appropriate to protect the legal rights of Plan or its nominee fully and completely; and

(C) Immediately upon receiving a monetary recovery based on a judgment, award or negotiated settlement on account of such injury, each Member will reimburse Plan for
the value of all such services and benefits provided or arranged by Plan at the "Plan Provider's rates". All Covered Services provided through Plan Hospitals or Plan Physicians will be deemed provided to Members in the form of services rather than cash payments. "Plan Provider rates" means the rates charged for the services and benefits for medical, surgical, hospital and related health care services as provided or arranged by Plan. Any such monetary recovery by or on behalf of Member or Member's attorney or other representative will be held in trust for the benefit of Plan, and will not be used or disbursed for any other purpose without Plan's express prior written consent.

(D) The reimbursement required by this section will not exceed the total amount of recovery obtained by Member. The obligation to reimburse Plan for the value of services and benefits provided or arranged by Plan applies to the full amount of the recovery even though the judgment, award or settlement is less than the total amount of the Member's alleged damages, or does not specify a monetary amount for medical expenses, or specifies that all or part of the recovery is for damages other than medical expenses.

10.5 COORDINATION OF BENEFITS

(A) Covered Services Subject to This Provision

All of the benefits provided under this Plan contract are subject to this provision.

(B) Definitions for Purposes of This Section

(1) "Health Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:

(a) Employer, blanket, or franchise insurance coverage;

(b) Service plan contracts, group practice, individual practice, and other prepayment coverage;

(c) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

(d) Any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Health Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other Health Plans into consideration in determining its benefits and that portion which does not.

(2) "This Health Plan" means that portion of this Agreement which provides the benefits that are subject to this provision.

(3) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Health
Plans covering the person for whom the claim is made. When a Health Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

(4) “Claim Determination Period” means a Calendar Year.

(C) Effect on Covered Services

(1) This Section (C) will apply in determining the benefits as to a person covered under This Health Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person for such period, the sum of:

(a) The value of the benefits that would be provided by This Health Plan in the absence of this Coordination of Benefits (COB) provision; and

(b) The benefits that would be payable under all other Health Plans in the absence therein of provisions of similar purpose to this provision, would exceed such Allowable Expenses.

(2) As to any Claim Determination Period to which this COB provision is applicable, the benefits that would be provided under This Health Plan in the absence of this COB provision for the Allowable Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Health Plans, except as provided in subparagraph (3) of this Section (C) will not exceed the total of such Allowable Expenses. Covered Services payable under another Health Plan include the benefits that would have been payable had claim been duly made therefore.

(3) If

(a) Another Health Plan which is involved in subparagraph (2) of this Section (C) and which contains a provision coordinating its benefits with those of This Health Plan would, according to its rules, determine its benefits after the benefits of This Health Plan have been determined, and

(b) The rules set forth in subparagraph (4) of this Section (C) would require This Health Plan to determine its benefits before such other Health Plan, then, the benefits of such other Health Plan will be ignored for the purposes of determining the benefits under This Health Plan.

(4) For the purposes of subparagraph (3) of this Section (C), the rules establishing the order of benefit determination are:

(a) The benefits of a Health Plan which covers the person on whose expenses claim is based other than as an eligible dependent, will be determined before the benefits of a Health Plan which covers such person is covered as an eligible dependent, except that if the person is
also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. Secondary to the Health Plan covering the person as an eligible Dependent; and

2. Primary to the Health Plan covering the person as other than an eligible Dependent (a retired employee);

then the benefits of the Health Plan covering the person as an Eligible Dependent are determined before those of the Health Plan covering that person as other than an eligible Dependent.

(b) Except for cases of a person for whom claim is made as a Child whose parents are separated or divorced, the benefits of a Health Plan which covers the person on whose expenses claim is based as an Eligible Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year, will be determined before the benefits of a Health Plan which covers such person as an Eligible Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year. If either Health Plan does not have the provisions of this subparagraph which results either in each Health Plan determining its benefits before the other or in each Health Plan determining its benefits after the other, the provisions of this subparagraph will not apply, and the rule set forth in the Health Plan which does not have the provisions of this subparagraph will determine the order of the benefits.

(c) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a Child whose parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a Health Plan which covers the child as an Eligible Dependent of the parent with custody of the Child will be determined before the benefits of a Health Plan which covers the Child as a dependent of the parent without custody.

(d) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a dependent Child whose parents are divorced and the parent with custody of the Child has remarried, the benefits of a Health Plan which covers the Child as a dependent of the parent with custody will be determined before the benefits of a Health Plan which covers that Child as a dependent of the stepparent, and the benefits of a Health Plan which covers that Child as a dependent of the stepparent will be determined before the benefits of a Health Plan which covers that Child as a dependent of the parent without custody.

(e) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then,
notwithstanding subparagraphs (4)(c) and (4)(d), the benefit of a Health Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Health Plan which covers the child as a dependent child.

(f) Except as provided in subparagraph (4)(g) of this Section (C), the benefits of a Health Plan covering the person for whose expenses claim is based as a laid off or retired employee, or Eligible Dependent of such person, will be determined after the benefits of any other Health Plan covering such person as an employee, other than a laid off or retired employee or Eligible Dependent of such person.

(g) If either Health Plan does not have a provision regarding laid off or retired employees, which results in each Health Plan determining its benefits after the other, then the rule under subparagraph (4)(f) of this Section (C) will not apply.

(h) If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Health Plan, the following will be the order of benefit determination:

1. First, the benefits of a Health Plan covering the person as an employee, member, or subscriber, or as that person’s Eligible Dependent;

2. Second, the benefits under Continuation Coverage. If the other Health Plan does not have the rules described above, and if, as a result, the Health Plans do not agree on the order of benefits, the rule under this subparagraph (4)(h) of Section (C) is ignored.

(i) When subparagraphs (4)(a) through (4)(h) of this Section (C) do not establish an order of benefit determination, the benefits of a Health Plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a Health Plan which has covered such person the shorter period of time.

(5) When this COB provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Health Plan during any Claim Determination Period, each benefit that would be payable in the absence of this COB provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of This Health Plan.

(D) Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of This Health Plan or any provision of similar purpose of any other Health Plan, This Health Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which This Health Plan deems to be necessary for such purposes. Any person claiming benefits under This
Health Plan will furnish such information as may be necessary to implement this provision.

(E) Facility of Payment

Whenever payments which should have been made under This Health Plan in accordance with this COB provision have been made under any other Health Plans, This Health Plan will have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under This Health Plan and, to the extent of such payments, This Health Plan will be fully discharged from liability under This Health Plan.

(F) Right of Recovery

Whenever payments have been made by This Health Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this COB provision, This Health Plan will have the right to recover such payments, to the extent of such excess, from one or more of the following, as This Health Plan will determine: any persons to or for or with respect to whom such payments were made, any insurers, service plans or any other organizations.

SECTION 11 – PRINCIPAL BENEFITS AND COVERAGES

The benefits described in this Agreement are Covered Services only if, and to the extent, they are Medically Necessary and meet the following requirements:

(A) They are provided by, or prescribed or referred in advance by, the Member’s designated Primary Care Physician; and

(B) They are obtained from a Plan Provider in the Member’s Network.

The only exceptions to the above requirements are:

(A) When a Member requires Emergency Services; or

(B) When the requested service is Medically Necessary and Prior Authorization is granted by the Medical Director before receiving the service; or

(C) When a Member may self refer to Plan Providers.

Certain services or supplies within the Service Area also require Prior Authorization. Members must identify themselves to a Plan Provider as a Plan Member before receiving any service or supply.

Subject to all terms and conditions stated in this Agreement, the following are the basic health services offered by Plan without charge to the Member except for the Copayments stated on the Copayment Schedule attached hereto as Exhibit “B” and incorporated herein by this reference, as amended from time to time as provided elsewhere herein.

Valley Health Plan believes this Coverage is a "grandfathered health plan" under the Patient Protection
and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a
grandfathered health plan can preserve certain basic health coverage that was already in effect when
that law was enacted. Being a grandfathered health plan means that the Member’s Coverage may not
include certain consumer protections of the Affordable Care Act that apply to other plans, for example,
the requirement for the provision of preventive health services without any cost sharing. However,
grandfathered health plans must comply with certain other consumer protections in the Affordable
Care Act, for example, the elimination of lifetime limits on benefits.

11.1 PROFESSIONAL SERVICES

Unless otherwise stated in this Agreement, for particular treatments, the following professional
services are provided subject to the Copayments stated on the Copayment Schedule. Member is
responsible for charges by a provider for appointments that are missed without notice to the provider.

(A) Primary Care Physician services, including office visits, examinations, diagnostic and
in-office surgical procedures.

(B) Specialty care Plan Physician services, including office visits, examinations and in-
office surgical procedures.

(C) Surgical services in a hospital or licensed outpatient surgical facility, including surgical
assistant and anesthesiologist services performed in connection with surgical services.

(D) Physician services for visits and examinations during a confinement in a hospital or
skilled nursing facility.

(E) Physician services for visits, examinations and surgical procedures in a Plan Physician’s
office.

(F) Physician services in the Member’s home, if the Member is too ill or disabled to be
seen during regular working hours at the Plan Physician’s office, upon Prior
Authorization. Member will pay the Copayment listed on the Copayment Schedule
listed for Plan Physician office visits for each such visit.

(G) Diagnostic radiological, laboratory and other services, such as electrocardiography and
electroencephalography.

(H) Therapeutic radiological services including radiation therapy and radioactive isotope
therapy.

(I) Physician services and materials for chemotherapy.

(J) Physician Services for the treatment of HIV or AIDS or other infectious diseases.

(K) Outpatient physical, speech and occupational therapy upon referral from a Primary Care
Physician. Rehabilitation services are limited to treatment provided in the amount,
frequency, or duration, as the physician deems medically appropriate.

Speech therapy is limited to treatment for speech impairments of specific organic origin
and must receive Prior Authorization from the Medical Director. Occupational therapy
is limited to services to achieve and maintain improved self-care and other customary activities of daily living, and must receive Prior Authorization from the Medical Director. Vocational Rehabilitation is excluded.

(L) Oral surgical services for the following conditions, provided Prior Authorization is obtained:

(1) The treatment of neoplasms (tumors) of the face, facial bones, or mouth.

(2) Surgical treatment of disorders of the temporomandibular joint.

(3) Surgical treatment of disorders of the maxilla and mandible.

(M) Podiatrist’s services for all visits, examinations and surgical procedures in a podiatrist’s office.

11.2 PREVENTIVE HEALTH SERVICES

Members are entitled to receive the following preventive health services (including services for the detection of a symptomatic disease), subject to the Copayments stated on the Copayment Schedule.

(A) Well baby care visits including newborn hospital visits and visits to a Plan Physician’s office during the first 24 months of life on an average of one visit every three months.

(B) Annual health appraisal examinations in a Plan Physician’s office, from age two, including all ancillary services authorized by the Plan Physician in the performance of the examination. For female Members, a yearly breast and pelvic examination to include an annual Pap smear test, human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and, at the option of the Member, any cervical cancer screen test approved by the FDA (e.g. liquid based prep test) as a Covered Service. For male Members, annual examinations to include Plan Physician recommended Prostate Specific Antigen (PSA) tests as a Covered Service. Frequency of these examinations is based on the health status and medical needs of the Member.

Non-Medically Necessary health appraisal examinations beyond the maximum stated are not Covered Services (such as for the purposes of continuing or obtaining employment, insurance, governmental licensure, school admissions or sports participation). Medically Necessary health appraisal examinations beyond the maximum are considered Plan Physician office visits and are subject to the applicable Copayment for Plan Physician office visits.

(C) Pediatric and adult immunizations by a Plan Physician, in accordance with the recommendations of the American Academy of Pediatrics and the United States Preventative Services Task Force including immunizations for the purpose of travel.

(D) Testing for allergy and allergic conditions rendered in a Plan Physician’s office, upon Prior Authorization.

(E) Therapeutic injections including allergy injections rendered in a Plan Physician’s office, upon Prior Authorization.
(F) One eye and ear examination per year for Children as recommended in the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics to determine the need for sight or hearing correction.

(G) Lead poisoning screening for Children who are at risk for lead poisoning (as determined in accordance with protocols and screens of the Medical Director) when prescribed by a Plan Physician.

(H) Mammography according to American Cancer Society Guidelines.

(I) Screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.

(J) Testing and treatment of Phenylketonuria (PKU).

(K) Testing and treatment of HIV or AIDS or other infectious diseases; HIV testing is covered regardless if related to a primary diagnoses.

(L) All generally medically accepted cancer screening tests.

11.3 **OUTPATIENT HOSPITAL SERVICES**

Unless otherwise stated in this Agreement for particular treatments, the following outpatient services are provided subject to the Copayments stated on the Copayment Schedule. The Member must use the hospital with which his/her Primary Care Physician is associated unless it is Medically Necessary to receive Hospital Services elsewhere, for example, when a Member requires Emergency Services.

(A) All of the Hospital-provided services listed under Inpatient Hospital Services provided in connection with outpatient surgical treatment.

(B) Hospital Outpatient Care in an emergency room for the appropriate provision of Emergency Services. When emergency room visits are made in non-emergency situations, a Member reasonably should have realized that Emergency Services were not required, the Member will be responsible for the entire cost of the Charge for the visit.

11.4 **INPATIENT HOSPITAL SERVICES**

The following acute Inpatient Hospital Services are covered if provided by a hospital licensed to provide such services. Hospital Services are covered only when they are Medically Necessary in connection with a treatment or a condition that is covered by this Agreement. Inpatient Hospital Services are subject to the Copayments stated on the Copayment Schedule. The Member must use the Plan Hospital which is in the Member’s Primary Care Physician’s Network unless it is Medically Necessary to receive Hospital Services elsewhere, for example, when a Member requires Emergency Services.

(A) Semi-private room necessary for Covered Services including general nursing care but excluding expenses for nonmedical, personal and comfort items. If a private room is occupied without Prior Authorization by the Medical Director, the Member will be responsible for all room and board charges above those normally charged by the facility
for semi-private accommodations unless the private room assignment was beyond the control of the Member.

(B) Meals, special diets and dietician services when Medically Necessary.

(C) Use of operating room and related facilities and specialized treatment rooms.

(D) Non-psychiatric intensive care and special unit services.

(E) Surgical and anesthetic supplies furnished by the hospital as a regular service.

(F) Special duty nursing upon Prior Authorization.

(G) Anesthesia and oxygen services.

(H) Hospital ancillary services, including laboratory, pathology, radiology, radiation therapy, inhalation and respiratory therapy, physical therapy, occupational therapy, and speech therapy.

(I) Oxygen, drugs, medications, and biologicals to the extent they are FDA-Approved Drugs or used for Approved Drug Usage, and furnished by and in the hospital.

(J) Administration of Medically Necessary blood, blood products, and blood plasma including the cost of blood products, blood plasma, and replaced blood.

(K) Diagnostic and therapeutic services.

(L) Coordinated discharge planning services including the planning of such continuing care as may be Medically Necessary.

11.5 SUBACUTE, TRANSITIONAL INPATIENT, AND SKILLED NURSING FACILITY SERVICES

Members are entitled to receive Medically Necessary subacute, transitional inpatient, and non-acute skilled nursing services in Plan Facilities that are in such Member’s Primary Care Physician’s Network, to the extent prescribed by a Plan Physician and upon Prior Authorization. Non-acute skilled nursing services will be provided up to a maximum of 100 days in any contract year. Covered Services include room and board in semi-private accommodations, meals, services of a diettian, general nursing care and Medically Necessary rehabilitation services. However, Custodial or Domiciliary Care in a skilled nursing facility or any other facility is not a Covered Service. If higher priced accommodations are used without Prior Authorization, the Member will pay the difference between the actual charge incurred and the rate charged by that facility for a room of two or more beds.

11.6 HOSPICE CARE

Members certified for Hospice Care are entitled to receive Medically Necessary Hospice Care upon Prior Authorization by the Medical Director. Hospice Care services include:

(A) Nursing care.
(B) Dietary and Hospice counseling services.

(C) Short term inpatient care for pain control and symptom management in a Hospice or skilled nursing facility that is a Plan Provider.

(D) Durable Medical Equipment.

(E) Medical supplies and drugs and biologicals for pain and symptom control.

(F) Home health aide services.

The Member may change his/her decision to receive hospice care at any time. Once the Member has elected hospice care, the Member is not entitled to any curative treatments for the terminal illness for which he/she has elected Hospice Care; however the Member is entitled to Covered Services not related to the terminal illness.

11.7 EMERGENCY SERVICES

The following Emergency services are provided, subject to the Copayments stated on the Copayment Schedule, except that Copayments for emergency room services will be waived if the Member is admitted to the hospital as an inpatient within 24 hours of receiving Emergency services.

(A) Out-of-Area Emergency Services

(1) If a Member receives Emergency Services care outside the Service Area, the Member will be reimbursed for Medically Necessary Hospital and Medical Services and for emergency transportation. Plan also covers transportation to return the Member to a Plan Hospital, upon Prior Authorization by Medical Director.

(2) Emergency Services received by a Member outside the Service Area are covered only so long as it is medically improper as determined by Plan to return the Member to a Plan Hospital. Plan must be notified by phone within 48 hours of the commencement of such Emergency Services unless it is not reasonably possible to communicate with Plan within such time limits.

(3) Except as provided in subparagraph (A)(1) of this Section 11.7, Members will not be reimbursed for care rendered outside the Service Area. If Emergency Services are provided by an emergency room physician or non-Plan Physicians, follow-up services will be covered only if provided by the Member’s Primary Care Physician or other Plan Provider or if services are Prior Authorized. Payment for services will not be made for a medical screening examination in cases when the Member did not require Emergency Services and care and the Member reasonably should have known that an emergency did not exist.

(B) Out-of-Area Urgently Needed Services

(1) If a Member is outside the Service Area and requires Urgently Needed Services for an unforeseen illness or injury to prevent serious deterioration of the Member’s health which cannot be delayed until the Member returns to the Service Area, the Member will be reimbursed for Medically Necessary Hospital and Medical Services. Follow-up visits require a referral from the Member’s
Primary Care Physician unless such follow-up visits are for Urgently Needed Services. If emergency room visits are made in non-emergency situations, as defined in Section 1317.1 of the Health and Safety Code, the Member will be responsible for the resulting charges. Copayments for Urgently Needed Services are set forth on the Copayment Schedule.

(C) In-Area Emergency Services

(1) If a Member is hospitalized as an inpatient for Emergency Services care in a Plan Hospital, the Member will be covered for Medically Necessary Hospital Services, Medical Services and emergency transportation. Plan also covers transportation to return the Member to a Plan Hospital, upon Prior Authorization by Medical Director, if the Member was hospitalized at a non-Plan Hospital.

(2) Plan also covers Medically Necessary Emergency Services received by Member on an outpatient basis when inside the Service Area.

(3) Plan must be notified by phone within 48 hours of the commencement of such Emergency Services unless it is not reasonably possible to communicate with Plan within such time limits.

(4) Emergency services and benefits received from a non-Plan Hospital are subject to the notification requirements for out-of-area Emergency Services and will be covered so long as such services constitute Medically Necessary Emergency Services.

(5) When emergency room visits are made in non-emergency situations as defined in Section 1317.1 of the Health and Safety Code, Member will be responsible for the entire Charge for the visit.

(D) In-Area Urgently Needed Services

(1) If a Member is within the Service Area and requires Urgently Needed Services for an unforeseen illness or injury to prevent serious deterioration of the Member’s health, the Member will be reimbursed for Medically Necessary Hospital Services and Medical Services obtained from any Plan Provider within the Service Area, for one visit.

(2) Follow-up visits require a referral from the Member’s Primary Care Physician. Urgently Needed Services obtained from a Non-Plan Provider within the Service Area will not be reimbursed by Plan. If emergency room visits are made in non-emergency situations, as defined in Section 1317.1 of the Health and Safety Code, the Member will be responsible for the resulting charges.

(3) Copayments for Urgently Needed Services obtained within the Service Area are set forth on the Copayment Schedule.

(E) Post Stabilization Services

(1) Once the Member’s emergency medical condition is stabilized the treating health care provider may believe that the Member requires additional Medically
Necessary Services prior to the Member being safely discharged. If the hospital is not part of the Plan's contracted network, the hospital will contact the Member's PCP or the Plan to obtain timely Prior Authorization for these post-stabilization services.

(2) If the Plan determines that the Member may be safely transferred to a Plan Hospital, and the Member refuses to consent to the transfer, the hospital must provide the Member with written notice that the Member will be financially responsible for 100% of the cost for services provided to the Member once the Member's Emergency condition is stable.

(3) If the non-Plan hospital is unable to determine the Member's name and contact information at the Plan in order to request Prior Authorization for services once the Member is stable, the non-Plan hospital may bill the Member for such services.

(4) If the Member feels that s/he was improperly billed for services that were received from a non-contracted provider, the Member should contact VHP.

11.8 MEDICAL TRANSPORT SERVICES

If the Member is hospitalized in a non-Plan Hospital for Covered Services, the Member may receive Medically Necessary Prior Authorized medical transport services to return the Member to a Plan Hospital or Plan Facility when such transfer is appropriate, as determined by the Medical Director. Continuing follow-up treatment by Non-Plan Providers for accidental injury or emergency illness is limited to Medically Necessary services required before the Member can, when it is medically appropriate, return to the Service Area.

11.9 PRESCRIPTION DRUGS

Health Plan will cover all Medically Necessary prescription drugs except as excluded below and subject to a Copayment per prescription or refill, as set forth on the Copayment Schedule.

Plan Physicians use a comprehensive drug Formulary that includes FDA-approved drugs (brand name and generic equivalent). VHP delegates the Formulary drug selection process to its Pharmacy and Therapeutics Committee (P&T). The Formulary has been prepared as a reference for all health professionals who share the responsibility for the management of VHP Members health care. The Formulary is prepared for publication by VHP under the direction of the P&T. The Formulary is published online. Additions and deletions to the Formulary, which occur throughout the year by action of the P&T, are conveyed to VHP's pharmacy benefits manager (PBM). The PBM advises the Plan Providers and Members as appropriate. Record of these changes are maintained in the P&T minutes.

To identify whether a specific drug(s) is on the Formulary, members may speak to the Plan PBM at 1.866.682.9492 or go online to www.valleyhealthplan.org

Covered outpatient prescription drugs must be Medically Necessary for treatment of the specific illness or injury for which the drug was prescribed by a physician. Prescription drugs are covered only when prescribed by a Plan Provider (or Non-Plan Provider rendering services with Prior Authorization of Plan) and only when dispensed by a Plan Pharmacy, except when a Member requires Emergency
Services. New prescription(s) prescribed by a Plan Provider can be filled at a Plan Pharmacy. For prescription refill request(s), contact the Plan Pharmacy.

Medically Necessary antibiotics and pain medications prescribed by the Member’s dentist are a Covered Benefit only when filled at a Plan Pharmacy.

Medically Necessary non-Formulary drugs are covered if the Member's Plan Physician obtains Prior Authorization from VHP or PBM designee by faxing a Prior Authorization request form (i.e. via facsimile). This form is received by the Plan PBM. New non-formulary prescriptions will be authorized within 5 business days. Urgent or emergency non-formulary prescriptions will be authorized within 24 hours.

If the Prior Authorization request is denied, the Member will be referred back to the Plan Physician for alternative treatment and/or to contact VHP PBM customer services by calling 1.866.682.9492 for further assistance. In the event Member needs to file Grievance with the Plan the Member must contact VHP Member Services. If VHP denies the Member Grievance VHP will notify the Member in writing of the reason for denial. The notice shall also inform the Member of their right to dispute the decision.

All routine prescription drugs must be filled at/through a Plan Pharmacy. The Member may be financially responsible for lost or misplaced medications. The PBM or pharmacist advises the Member of all charges.

After hours, weekends, holidays, emergent or urgent care prescriptions are also subject to the authorization process. The Member may have the prescriptions filled at any Plan 24-hour pharmacy. If a Plan Pharmacy is not available, VHP will cover the prescription filled at an Out-of-Network Pharmacy.

Drug prescriptions (including non-Formulary drugs) paid for by the Member and obtained from non-Plan providers and filled by non-Plan Pharmacies may be subject to denial of reimbursement upon review by the VHP's Medical Director.

Over the counter (OTC) items are not a Covered Benefit.

11.10 DURABLE MEDICAL EQUIPMENT

Members are entitled to the use of Durable Medical Equipment, upon Prior Authorization by the Medical Director, when Medically Necessary, when, and for the time, prescribed by a Plan Physician and obtained from a provider authorized by Plan. In the discretion of Plan such equipment may be obtained by lease/rental or purchase. Plan will cover only the initial purchase of Durable Medical Equipment. Repair, maintenance and replacement of Durable Medical Equipment are not Covered Services unless Prior Authorized.

11.11 PROSTHETIC AND ORTHOTIC DEVICES

Members are entitled to receive original and replacement Prosthetic and Orthotic Devices when such devices are:

(A) Medically Necessary;
(B) Prescribed by a Plan Physician or other Plan Provider acting within the scope of his/her license; and

(C) Upon Prior Authorization of the type and model of the device by the Medical Director.

The Medical Director will determine whether to repair or replace Prosthetic or Orthotic Devices. Replacement devices are not Covered Services when a device can be repaired. Orthotic appliances are limited to one per year, unless more than one per year is Medically Necessary and Prior Authorization has been obtained.

Medically Necessary Prosthetic Devices or prostheses incidental to surgery, include the following:

(A) Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

(B) Artificial limbs and eyes;

(C) Supplies necessary for the operation of prostheses; and

(D) Initial fitting and replacement after the expected life of the item.

For Medically Necessary surgically implanted and other Prosthetic Devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see “Reconstructive Surgery.”

11.12 HEARING AIDS

Members are entitled to receive hearing aids, up to a maximum cost of one thousand dollars ($1,000), subject to the limitation that a Member shall not be entitled to receive a new hearing aid more frequently than once every thirty-six months, when such hearing aids are:

(A) Medically Necessary;

(B) Prescribed by a Plan Physician or other Plan Provider acting within the scope of his/her license; and

(C) Upon Prior Authorization of the type and model of the device by the Medical Director.

11.13 BEHAVIORAL HEALTH SERVICES

Members are entitled to receive Mental Disorder or Behavioral Health Services/Treatment under the following circumstances:

(A) Outpatient behavioral health services psychiatric and counseling Covered Services for evaluation, including prescribed psychiatric and psychological testing, crisis intervention, and Medically Necessary treatment of a behavioral health condition, in the amount, frequency, or duration which is appropriate for the Member’s condition. Individual and group psychotherapy sessions Covered Services include applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practical, the functioning of an individual with Pervasive Developmental Disorder or Autism. An outpatient behavioral health Covered
Services condition includes treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child or Adolescent.

Post-hospitalization outpatient behavioral health Covered Services treatment(s) only as authorized by a Plan Provider at a Plan Facility.

(B) Inpatient behavioral health Covered Services for evaluation, treatment and crisis intervention, subject to the Inpatient Hospital Services requirements section of the Agreement.

11.14 ALCOHOLISM AND DRUG ABUSE SERVICES

Members are entitled to receive Alcoholism and Drug Abuse Services including methadone maintenance (also includes methadone maintenance for pregnant Members) under the following circumstances:

(A) Outpatient Alcoholism and Drug Abuse Services – Members are entitled to receive outpatient follow up visits after acute inpatient detoxification. Medically Necessary substance abuse services including Prior Authorized transitional residential recovery services based on the clinical level of intensity for outpatient transitional residential services as provided in a Plan Provider facility. Care in a non-medical residential or transitional residential recovery setting is available to a maximum of 60 days per Benefit Period. No more than 120 days of covered care is provided in any 5 consecutive Calendar Year periods.

(B) Inpatient Alcoholism and Drug Abuse Services - Members are entitled to receive Medically Necessary inpatient short-term acute detoxification services in a licensed medical facility that is an alcoholism and drug abuse Plan Provider. Such facility must provide medical management of the Member for detoxification. Prior Authorization is required unless a Member requires Emergency Services. The Member or the Member’s Plan Physician must call 408.885.4647 and contact Utilization Management to request Prior Authorization. Inpatient detoxification services do not include alcohol and chemical dependency rehabilitation services.

Medically Necessary substance abuse services including Prior Authorized residential recovery services based on the clinical level of intensity for inpatient residential services as provided in a Plan Provider facility. Care in a non-medical residential or transitional residential recovery setting is available to a maximum of 60 days per Benefit Period. No more than 120 days of covered care is provided in any 5 consecutive Calendar Year periods.

11.15 HOME HEALTH SERVICES

Members are entitled to receive the following home health services when the Member is homebound for medical reasons, subject to the Copayments stated on the Copayment Schedule. Home health services are subject to Prior Authorization by the Medical Director. Such home health services include:

(A) Skilled nursing services provided by a registered nurse or licensed vocational nurse;
(B) Home health aide services under the supervision of a registered nurse, excluding meals, child care, in-home day care, and housekeeping services;

(C) Physical, respiratory, occupational, and speech therapy; and

(D) Drugs, medicines and laboratory services prescribed by a Plan Physician and administered by a visiting health care professional to the extent the same would have been Covered Services if the Member had received such services in the hospital.

Home health services do not include Custodial or Domiciliary Care or care that the Medical Director determines may be appropriately provided in a Plan Physician’s office, or in a Plan Hospital or Plan skilled nursing facility. If Charges for home health services exceed Charges for room and board in semi-private or ward accommodations in a skilled nursing facility that is a Plan Provider, then Covered Services may be provided in such skilled nursing facility in lieu of home health services.

11.16 SMOKING CESSATION PROGRAM

Upon prior referral by the Member’s Primary Care Physician, Plan covers smoking cessation programs provided by the American Lung Association, the American Cancer Society or a Plan Hospital. Coverage is limited to program design and class availability.

11.17 ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Covered organ, tissue and bone marrow transplant services are subject to the following limitations:

(A) The Medical Director must:

(1) Determine that the Member satisfies medical criteria for receiving the services; and

(2) Provide a written referral for care to transplant facilities selected by Plan.

(B) If the Medical Director determines that the Member does not satisfy the patient selection criteria for the transplant service, Plan will pay only for Covered Services required to make that determination;

(C) Plan does not undertake to furnish or assure the availability of a donor or donor organ;

(D) Except for Medically Necessary ambulance services and Hospital Services, neither transportation nor living expenses are covered for any person, including the Member, donor, or prospective donor;

(E) Plan’s obligation for services to a donor is limited to:

(1) Testing and evaluation of the suitability of the donor and donor organ;

(2) Services necessary to directly effectuate transplant of the organ or tissue; and

(3) Covered Services not covered, provided or payable under any other plan or insurer covering the donor.
11.18 RECONSTRUCTIVE SURGERY

Plan covers surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance, to the extent possible. Surgical services are limited to Reconstructive Surgery that is likely to correct a disfigurement caused by Medically Necessary surgery or by an injury; that will result in improvement in physical function for conditions that are the result of congenital abnormalities, Medically Necessary surgery or accidents; that will correct a physical functional disorder resulting from a disease or congenital anomaly, following an injury or accident; that follows a Medically Necessary mastectomy surgery (including breast implants) which resulted from disease, illness or injury, or is for internal breast prosthesis required incidental to a mastectomy.

Reconstruction surgery, which is not Medically Necessary, as consistent with professional practice, and not in accordance with Sections 1367.01 and 1367.63 of the Health and Safety Code, is not a Covered Benefit.

11.19 PREGNANCY AND MATERNITY CARE

The following Pregnancy and maternity care is provided, subject to the Copayments stated on the Copayment Schedule.

(A) Physician services in the office and in the Hospital including prenatal care, delivery, antepartum and postpartum care, and for any condition resulting from Pregnancy or resulting from childbirth and any complication thereof including therapeutic abortion and miscarriage. This benefit includes prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancies.

(B) Physician services in the hospital for care of the newborn infant during the mother’s confinement in such hospital. However, newborn infant care is not a Covered Service if the mother is enrolled in Plan as a Child of the Subscriber.

(C) Hospital Services for prenatal care, delivery, antepartum and postpartum care, including any condition resulting from Pregnancy and any complications thereof, including therapeutic abortion and miscarriage. These services are subject to the Copayment for Inpatient Hospital Services.

(D) Hospital Services for ordinary nursing care of the newborn infant and such other newborn care during the mother’s confinement in the hospital. However, newborn infant care is not a covered benefit if the mother is enrolled in Plan as a Child of the Subscriber.

(E) Hospital Services for the newborn infant after the mother is discharged from the Hospital are considered a separate hospital admission of the newborn infant. The Copayment for Inpatient Hospital Services applies as if it were a new admission of the newborn. Enrollment of the newborn is required.

(F) Participation in the Expanded Alpha Feto Protein program administered by the State Department of Health Services, provided, however, that such participation shall not be mandatory, nor shall it be a prerequisite to eligibility for, or receipt of, any other service hereunder.
11.20 FAMILY PLANNING SERVICES

Voluntary family planning services through Plan Physicians, including family planning counseling services and examinations, natural family planning services, pregnancy testing.

11.21 INFERTILITY SERVICES

Artificial insemination is limited to the actual basic insemination procedure only (including placement of sperm provided by the Member) for the treatment of infertility when determined necessary by a Plan Physician. Infertility diagnosis and treatment is defined as procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, and any Medically Necessary surgery. Semen analysis will be covered only in conjunction with artificial insemination procedures.

11.22 CHIROPRACTIC CARE

Chiropractic procedures performed in a Plan chiropractor’s office, upon referral by a Member’s Primary Care Physician, and subject to a limitation of 20 prescribed treatments per Calendar Year. Beyond 20 prescribed visits require justification from Plan Provider. Copayments apply.

11.23 HEALTH EDUCATION SERVICES

Members are entitled to receive from Plan or the Member’s Primary Care Physician, subject to the Copayment listed on the Copayment Schedule for Plan Physician office visits, health education services and/or materials including:

(A) Information regarding personal health behavior and health care, and instructions on achieving and maintaining physical and mental health and preventing illness and injury.

(B) Information and recommendations regarding the optimal provision of Covered Services provided by Plan.

(C) Information regarding and referrals to service agencies, including adoption agencies, medical social services, ancillary services for the abuse of or addiction to alcohol and drugs; and family planning services. Services provided by such agencies are not Covered Services.

(D) Medically Necessary diabetic self-management education services from a Plan Provider upon referral by a Plan Physician and Prior Authorization by the Medical Director subject to the Copayment listed on the Copayment Schedule for Plan Physician office visits.

11.24 ACUPUNCTURE SERVICES

Acupuncture services (with or without electric stimulation of needles) performed to prevent, modify or alleviate nausea and/or severe, persistent, or chronic pain resulting from a generally recognized medical condition are Covered Services. Acupuncture Services are limited to 20 prescribed and authorized visits per Calendar Year. Beyond 20 prescribed visits requires justification from Plan Provider. Copayments apply.
11.25 CANCER CLINICAL TRIAL SERVICES

Cancer clinical trial services include routine health care services associated with the Member’s participation in a cancer clinical trial, Phase I through V, however, Covered Services are only available if (i) the Member has been diagnosed with cancer, (ii) has been accepted into a Phase I through V clinical trial for cancer, and (iii) the Member’s Plan Physician has recommended participation in the trials because it will have a meaningful potential benefit to the Member.

Coverage is limited to routine patient care costs as in accordance with State and Federal regulations and is only provided if the clinical trial's endpoints are not defined exclusively to test toxicity, but have a therapeutic intent. Coverage is only provided if treatment is either (a) approved by the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the Veterans Administration or (b) involves a drug that is exempt under federal regulations from a new drug application.

11.26 DENTAL HOSPITAL OR SURGERY CENTER SERVICES

Plan offers limited dental Services, as rendered in a medical hospital or medical surgery center and as when provided, arranged, and coordinated through the Member’s Plan Physician. Prior Authorization is required.

Services include general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting.

Charges for the dental procedure itself, including but not limited to, the professional fee(s) of the dentist, are excluded. Valley Health Plan does not provide dental insurance services such as those dental services covered through an employer dental plan or as purchased through a dental plan carrier.

SECTION 12 – PRINCIPAL EXCLUSIONS

All services and benefits within the following classifications are excluded from Covered Services:

(A) Services furnished by a facility which is primarily a place for rest, a place for the aged, a nursing home or any facility of like character, except as specifically provided as Covered Services;

(B) Services not Medically Necessary. The determination whether a service or supply is Medically Necessary is made by the Medical Director based on an objective review and subject to grievance procedures.

(C) Services rendered by Non-Plan Providers other than Emergency Services, Out-of-Service Area Urgently Needed Services, or upon Prior Authorization by the Medical Director.

(D) Services rendered prior to the Member’s Effective Date of Coverage or after the time coverage ends.
(E) Services that are court ordered or as a condition of incarceration, parole or probation.

(F) Services which exceed the limitations or fail to meet the conditions of Covered Services.

(G) Charges for any treatment for addiction to, or dependency on, tobacco or tobacco products, except for the smoking cessation program that is included in the health education and health promotion services.

(H) Charges for services which the Member would not be obligated to pay in the absence of this Agreement or which are provided to the Member at no cost.

(I) Acupuncture services except as provided in Section 11 (Acupuncture Services).

(J) Administration of prescription legend drugs or injectable insulin.

(K) Anorectics or any other drug used for the purpose of weight control, unless Medically Necessary.

(L) Any service, procedure, or process, which prepares the Member to receive conception by artificial means such as services related to prescription drugs not on Plan Formulary, donor sperm, sperm preservation, or washing or concentration procedures.

(M) Artificial Insemination - any service, procedure, or process which prepares the Member to receive conception by artificial means (except as specified as a Covered Service), such as services related to prescription drugs not on Plan Formulary, donor sperm, sperm preservation, or washing or concentration procedures;

(N) Behavioral Health/Mental Health Services that are court ordered, or as a condition of parole or probation, or when incarcerated, except if a Plan Physician determines that the services are Medically Necessary Covered Services.

(O) Hypnotherapy, vision therapy, and sleep therapy.

(P) Cancer clinical trial services unless specifically listed as Covered Services.

(Q) Classes and equipment that are solely for exercise, recreation, self-help, hygienic, and beautification, except as specifically listed as a Covered Service.

(R) Conception by artificial means, such as in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and gamete intrafallopian transfer (GIFT) or any other process that involves the harvesting or manipulation (physical, chemical, or by any other means) of the human ovum to treat infertility.

(S) Contraceptives, other than oral contraceptives, whether medication or device, unless Medically Necessary. Excluded contraceptives include over the counter methods such as condoms and spermicidal jellies, etc.

(T) Cosmetic surgery or plastic surgery except as specified as a Covered Service.

(U) Cosmetics, herbal products and treatments, dietary supplements, health or beauty aids.
(V) Custodial or Domiciliary Care, except as required under Hospice Care.

(W) Dental Services except authorized: (1) services for treatment or removal of tumors; (2) physicians services or physician X-ray exams for the treatment of accidental injury to natural teeth; (3) surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint disease or other medical disorders; and/or (4) services for intra-oral devices and associated services for the treatment of Temporomandibular Joint Disorders within the limitations of $800; or (5) services in connection with accidental fractures of the jaw.

(X) Dependent coverage for Groups with Subscriber Coverage only.

(Y) Devices or appliances except Medically Necessary Diabetic, Prosthetic and Orthotic Devices. Specifically excluded devices include, but are not limited to, the following: elastic stockings, garter belts, and similar devices, experimental or research equipment, devices not medical in nature, modifications to a home or automobile, deluxe equipment, non-standard equipment, more than one piece of equipment that serves the same function, more than one device for the same part of the body, electronic voice producing machines. Unless Medically Necessary, with Prior Authorization, Orthotic Devices are limited to one device per year.

(Z) Drugs and medications, prescription and non-prescription including over the counter drugs, for Outpatient Care unless specifically listed as a Formulary benefit or Covered Service; non-FDA-Approved Drugs; non-Approved Drug Usage. Exceptions to this exclusion include those Covered Services as expressly provided in the Prescription Drugs Section of this Agreement.

(AA) Drugs, which do not require a prescription by a physician, except as Medically Necessary when used for the monitoring and treatment of diabetes.

(BB) Educational services, which a Member might be eligible under State law, including Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs, except as expressly provided in Health Education Services Section of this Agreement.

(CC) Emergency room services for non-emergency care.

(DD) Eyeglass lenses, frames, and contact lenses including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia), non-implant low vision aides, and correction of visual acuity or refractive errors are excluded from the Benefit Plan.

(EE) Experimental or Investigational Treatment, except as provided in Section 11 (Cancer Clinical Trial Services). However, a Member with a Life-Threatening or Seriously Debilitating condition may request an independent medical review as described in Section 8 (Independent Medical Review).

(FF) Gastric bubble, gastroplasty, gastric bypass, bariatric surgery, Laparoscopic Gastric Band (lap-band) surgery, gastric stapling, liposuction, and HCG injections, except when determined by the Medical Director to be Medically Necessary.
(GG) Hearing examinations to determine the need for hearing correction for Members over 18 years of age (unless Medically Necessary) and the furnishing, fitting, installing, or replacing hearing aids except as expressly provided in Section 11 (Hearing Aids).

(HH) Infertility caused by prior tubal ligation or tubal reanastomosis and complex artificial insemination procedures.

(II) Infertility services required due to tubal ligation, tubal reanastomosis, or vasectomy procedures.

(JJ) Inpatient Behavioral Health Services are subject to the Inpatient Hospital Services limitations of this Agreement.

(KK) Massage therapy.

(LL) Medical and Hospital Services for a Member who is a donor or prospective donor when the recipient of an organ, tissue or bone marrow transplant is not a Member. The Covered Services must be directly related to a covered transplant and are covered up to 12 months from the date of the surgery.

(MM) Military service connected disability care for which a Member is legally entitled to services through a federal government facility, which is reasonably accessible to the Member, or for which coverage is received at no cost from a group entity and the Plan is subsequently requested to reimburse entity.

(NN) Nicorette or any other drug containing nicotine or other smoking deterrent medications not on Formulary.

(OO) Organ, tissue and bone marrow transplants considered Experimental or Investigational Treatment; Medical and Hospital Services of a donor or prospective donor where the recipient of an organ, tissue or bone marrow transplant is not a Member.

(PP) Over the counter (OTC) drugs, orthotics, supplies and equipment.

(QQ) Penile implants and services related to the implantation of penile prostheses, except as Medically Necessary for direct physical trauma, tumor, or physical disease to the circulatory system or the nerve supply.

(RR) Personal or comfort items which are non-medical, environmental enhancements and environmental engineers, modifications to dwellings, property or motor vehicles, adaptive equipment and training in operation and use of vehicles, personal lodging, meals, travel expenses and all other non-medical expenses.

(SS) Physical exams, evaluations and reports including those for employment, insurance, licensing, school, sports, recreation, premarital purposes, or required for or by court proceedings, unless timing and scope coincide with covered periodic health appraisal exams.

(TT) Prescriptions from non-Plan pharmacies, except in connection with Emergency Services or upon Prior Authorization.
(UU) Prescription drugs and accessories not Medically Necessary or not in accordance with professionally recognized standards of care; Non-FDA Approved Drugs; generic equivalents not approved as substitutable by the FDA; Non-FDA approved Treatment Investigational New Drugs; National Cancer Institute Group C cancer drugs that are used for purposes other than those purposes approved by the FDA or the National Cancer Institute.

(VV) Public facility care in which services or care are required by federal, state, or local law. However, Plan will reimburse the Member or the facility for the costs of Medically Necessary Covered Services (upon Prior Authorization by the Medical Director) provided at such facility, if the Member is liable for such services, up to the Charges that Plan would pay for such services to a Plan Provider.

(WW) Residential substance abuse non-medical ancillary services and inpatient alcohol and drug rehabilitation services.

(XX) Reversal of voluntary sterilization or of voluntarily induced infertility.

(YY) Rogaine or any other cosmetic hair growth drug.

(ZZ) Routine foot care, including trimming of corns, calluses and nails, unless Medically Necessary.

(FFF) Temporomandibular Joint (TMJ) Disorders Services that are not Medically Necessary. Intra-oral appliances related to TMJ are limited to one oral splint or appliance and are limited to an $800.00 maximum lifetime benefit. Intra-oral appliance and placement services which cost more than the life time limit of $800.00, for intra-oral positioning devices and related services, are not covered.

(GGG) Transportation services unless Medically Necessary and with Prior Authorization of Medical Director or unless necessitated in connection with Emergency Services.
(HHH) Transsexual surgery, related services and supplies except when Medically Necessary due to congenital defects.

(III) Treatment of alcohol, drug, or chemical abuse or dependency, including non-medical ancillary services and rehabilitation services in a specialized inpatient or residential facility (except as specifically provided in this Agreement).

(JJJ) Vision care except as provided in this Agreement.

(KKK) Vocational Rehabilitation.

(LLL) Weight control, weight loss treatments, weight loss surgery, or related supplies unless Medically Necessary for morbid obesity.
Valley Health Plan

EXHIBIT "A" - RATE SCHEDULE

GROUP: Santa Clara County Office of Education

PREMIUMS EFFECTIVE 11/01/2014 – 10/31/2015

Valley Health Plan – Grandfathered S0 Copayment Plan

Active Employee (without Medicare – no dental) – Monthly Premium Rates

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Monthly Premium Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$987.60</td>
</tr>
<tr>
<td>Subscriber plus one</td>
<td>$1,975.19</td>
</tr>
<tr>
<td>Subscriber plus family</td>
<td>$2,468.99</td>
</tr>
<tr>
<td>Composite Rate</td>
<td>$2,079.39</td>
</tr>
</tbody>
</table>

Early Retirees (without Medicare – no dental) – Monthly Premium Rates

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Monthly Premium Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>$1,264.85</td>
</tr>
<tr>
<td>Subscriber plus one</td>
<td>$2,529.70</td>
</tr>
<tr>
<td>Subscriber plus family</td>
<td>$3,162.12</td>
</tr>
<tr>
<td>Composite</td>
<td>$1,335.12</td>
</tr>
</tbody>
</table>

Retirees on Medicare are not eligible for VHP Early Retiree Rates
EXHIBIT “B”

PLAN: GROUP


Group Plan

- $0 or no Copayments prescription drugs,
- $0 Copayments office visit(s),
- except for:
- $10.00 Copayment for Chiropractic or Acupuncture Care,
- $20.00 Copayment for Weight Watchers Session(s); Weight Watchers benefit is limited to one session per calendar year. Weight Watchers session(s) are available in some workplaces or Weight Watchers session coupons are available from VHP. A second session or second set of coupons may be requested if the Member provides documentation of continuous Weight Watchers meeting attendance.
- Nominal fee for some Health Education classes, materials, and supplies, and
- No Copayments for Preventative Health Services, such as Immunizations and injections, and for Pregnancy/Maternity Care services.

COPAYMENT / COINSURANCE MAXIMUM SCHEDULE

Group Plan:

- No maximum lifetime benefit (overall limit). The only maximum benefit limits are those specifically mentioned.
- No deductibles
- Individual: $1,000 per Calendar Year
- Family: $2,000 per Calendar Year
EXHIBIT “C”

PLAN: GROUP

DOMESTIC PARTNER BENEFIT

By executing this Agreement, Group acknowledges that the definition of “Eligible Dependent” includes:

(a) the Domestic Partner of any Eligible Employee, and

(b) the Children, if any, of the Domestic Partner of any Eligible Employee, with any such Domestic Partner treated as the equivalent of the Eligible Employee’s spouse for eligibility and benefit determination purposes, and with any such children of such Domestic Partner treated as the Children of the Eligible Employee.

As used herein, “Domestic Partner” means an individual who is in a “domestic partnership” as that term is defined in California Family Code Section 297.

Domestic Partner benefits can only be provided under the Plan if status of the domestic partnership is verified by providing the Group with a copy of a Valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 298 of the California Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

Upon termination of the Domestic Partnership, the Plan must also be notified.