

**Valley Health Plan Individual Conversion Plan
Membership Agreement and
Evidence of Coverage & Disclosure Form**

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Introduction

About this Agreement

This *Individual Plan Membership Agreement and Evidence of Coverage (Agreement)* and any amendments describe the health care coverage of "Valley Health Plan Individual Conversion Plan" (a Knox Keene licensed plan), and constitute the legally binding contract between the County of Santa Clara, DBA Valley Health Plan (Health Plan), and you (Subscriber). For benefits provided under any other Health Plan program, refer to that plan's *Evidence of Coverage*. In this *Agreement*, Valley Health Plan, is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *Agreement*; please see the "Definitions" section for terms you should know.

Health Plan provides Services directly to our Members through an integrated medical care program, rather than reimbursing expenses on a fee-for-service basis. Please read the following information so that you will know from whom or what group of providers you may obtain health care. It is important to familiarize yourself with your coverage by reading this *Agreement* completely, so that you can take full advantage of your Health Plan Benefits. Also, if you have special health care needs, please read the sections applicable to you carefully.

The term of this *Agreement* initially is from July 1, 2006 through June 30, 2007 and automatically renews annually thereafter on July 1 unless amended. New sales are issued through the end of June of any year. All accounts renew annually on July 1.

Definitions

While VHP is dedicated to making its services easily accessible and understandable, the language of health care and managed care organizations can sometimes be very confusing. To help you understand some of the words and terms you may encounter in this booklet and accompanying materials, the following definitions are available for your reference. You will find that these definitions are identified easily because they are capitalized or indicated by an "Initial Uppercase."

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.
2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

Acute Care is the care provided on an inpatient basis at an intensive level by a facility licensed and accredited to provide such services.

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.

Advance Directive means a formal document, signed by you in advance of a severe illness or

injury, which will guide your physician(s) when providing treatment if you become so incapacitated that you cannot make an informed decision.

Agreement means the Individual Conversion Agreement, including but not limited to this Combined Evidence of Coverage and Disclosure Form, any and all applications and information submitted by the Members in applying for Coverage, attachments, addenda, and any amendments that may be added in the future.

The Agreement contains the exact terms and conditions of your Coverage. It incorporates all of the contracts, promises, and agreements exchanged by the Subscriber and VHP. 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.

Benefits or Covered Services means the Medically Necessary health care services, supplies and products including the exclusions and limitations to which you are entitled as a Member under your Individual Conversion Agreement and which are described in this Combined Evidence of Coverage and Disclosure Form.

Benefit Plan means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form.

Any date referenced in this Benefit Plan begins at 12:01 a.m., Pacific Standard Time.

Calendar Year means a twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Coinsurance is the Member's share of cost of Covered Services, which are represented as percentages. The coinsurance will be calculated based on contracted rates, if any, between VHP and its Plan Providers.

Coordination of Benefits (COB) means when you are covered by two (2) or more insurance plans, COB:

- eliminates duplicate payments,
- specifies the order in which coverage will be paid (the primary plan, the secondary plan, etc.), and
- ensures that the benefits paid under both plans do not total over 100% of the charges.

Copayment is an additional fee, which you are required to pay in order to receive a particular Benefit. This is the Member's share of the cost of Covered Services.

Copayments paid for eyeglasses, Dental Services, or any other supplementary benefit(s) that are not covered under this Benefit Plan are not counted against the Copayment Maximum.

Copayment Maximum is the maximum amount you are required to pay for Covered Services during a Calendar Year.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Coverage means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form.

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).

Covered Service(s) means the Benefits as covered under the Benefit Plan.

Custodial Care 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. Custodial 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; or
- 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.

Department of Managed Health Care (DMHC) is the State regulatory agency responsible for the regulation or oversight of health care plans in California.

Dependent means any member of a Subscriber's family who is an Eligible Dependent and meets the applicable eligibility requirements set forth in this Agreement, and who has enrolled in the Plan in accordance with its enrollment requirements.

Disenrollment is the voluntary process of ending your membership in the Benefit Plan.

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.

Durable Medical Equipment (DME) means the Medically Necessary medical supplies, equipment, and devices which:

- are intended for repeated use over a prolonged period,
- are not considered disposable, with the exception of ostomy bags and diabetic supplies,
- are ordered by your Plan Physician,
- do not duplicate the function of another piece of equipment or device covered by VHP,
- are generally not useful to the Member in the absence of illness or injury,
- primarily serve a medical purpose, and
- are appropriate for use in the home.

Effective Date of Coverage means the date that your Coverage under the Benefit Plan begins.

Your precise Effective Date of Coverage may be obtained by calling a Member Services Representative.

Eligible Dependent is a person who resides or works continuously within the Service Area, who was previously enrolled as a Member under a Group Service Agreement on the effective date of termination from the Group (except newborns and newly adopted children) and who is:

1. a Subscriber's lawful spouse; or
2. a Subscriber's domestic partner as eligible and as defined in the Subscriber's Group Service Agreement; or
3. the unmarried child of a Subscriber or the Subscriber's spouse/domestic partner who is defined as:
 - a. a natural child or stepchild; or
 - b. a child placed in the physical custody of the Subscriber or the Subscriber's spouse/domestic partner for adoption, and who is covered from and after the date on which there exists evidence of the Subscriber or Subscriber's spouse's right to control the health care of the child placed for adoption (documentation of placement by an adoption agency and/or court will be required) with a permanent residence within the Service Area; or
 - c. a legally adopted child (documentation by an adoption agency and/or court will be required); or
 - d. a ward or child under the guardianship of the Subscriber or the Subscriber's enrolled spouse/domestic partner pursuant to a valid court order (proof of legal guardianship will be required).

and the unmarried child must be:

- i. under the age of nineteen (19); or
- ii. age nineteen (19) to age twenty-four (24) (i.e. from 19 through 23) and enrolled as a full-time student (taking at least twelve [12] semester units) at a high school, an

accredited college, university, vocational, or secondary school (proof of which VHP may require at any time); or

- iii. nineteen (19) 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 nineteen (19) and covered under the Benefit Plan prior to his or her nineteenth (19th) birthday. The Subscriber must furnish proof of incapacity and dependency to VHP within thirty-one (31) calendar days following the date of the request.

VHP has the right to require such proof of eligibility status as may be required, but no more frequently than annually after the initial two (2) year period. Such proof will be without cost to VHP, and VHP's determination of eligibility will be conclusive.

Eligible Dependent children may retain eligibility and be employed under the following conditions:

- summer employment, or
- part-time work while a student.

Eligible Dependent children may reside outside the Service Area, but will only be covered for Emergency or Prior Authorized Urgently Needed Services when Out-of-Network. All follow-up or routine care must be received in Network through the Member's PCP.

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.

EOC or Combined Evidence of Coverage and Disclosure Form means this Combined Evidence of Coverage and Disclosure Form(s) or this booklet.

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 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:

1. The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;
2. The Office of Technology assessment of the U.S. Congress;
3. The National Institute of Health;
4. The Food and Drug Administration (FDA); or
5. 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.

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.

Formulary is the broad list of prescription drugs that have been reviewed and selected by VHP Plan Providers in accordance with professionally recognized medical standards for their medical and cost effectiveness. The Formulary includes both brand name and generic drugs, all of which are approved by the Food and Drug Administration (FDA).

Grievance means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, denial of a service or payment of a claim (in whole or part) made by a Member or the Member's representative.

Group means the employer that has entered into the Agreement with the Plan.

Group Service Agreement means the Group Medical and Hospital Service Agreement between an employer and VHP.

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

Hospital Services means all services provided by the hospital while occupying a hospital bed or visiting a licensed facility provider for a procedure or treatment, within the capability of the facility.

Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV or AIDS) 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.

Individual Conversion means VHP Coverage for an individual who is no longer a part of the employer group coverage but still works or resides in Santa Clara County and is not eligible for other health insurance.

Infertility means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medications and any medically necessary surgery.

Initial Eligibility Period is the:

1. sixty-three (63) day period following the date your Group coverage ends during which all Subscribers and their Eligible Dependents may enroll in this Plan, or
2. thirty-one (31) day period after your dependent is no longer an Eligible Dependent under this Agreement and he/she may enroll in the Individual Conversion Plan as a Subscriber , or
3. thirty-one (31) day period after your newborn or newly adopted child becomes an Eligible Dependent and may enroll in this Plan.

Inpatient Hospital Services are those services that are provided on an inpatient basis to Member while staying in the hospital over a twenty-four (24) hour period of time, excluding long term non-Acute Care.

Life-Threatening means either or both of the following:

- Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Lock-In means that Covered Services are available only through Plan Providers in the VHP Network you select (unless such care is rendered as worldwide Emergency Services or is Prior Authorized).

If you seek routine care, elective medical services, or Urgently Needed Services from Non-Plan Providers without a VHP-approved referral, VHP will not pay for your care and you will be required to pay for the full cost of such services.

Medical Director means the Medical Director of VHP who is a physician or designee with the responsibility for the medical administration of VHP and authorizing care when required. The Plan Medical Director is a manager of the utilization and quality of health care.

Medical Services means those professional services of physicians and other health care professionals, which are performed, prescribed or directed by a Primary Care Physician or Specialist Physician.

Medically Necessary or Medical Necessity means the services which are:

- appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition, and
- within recognized standards of medical practice, and
- not primarily for the convenience of you, your family, caretaker, or any provider, and
- the most appropriate supply or level of service which can safely be provided.

Member is any Subscriber or Eligible Dependent who is enrolled in the Benefit Plan in accordance with the applicable eligibility requirements.

Member Services Representative means any VHP Member liaison who is available to answer your questions about Coverage, help you with any service issues, and assist you with special situations.

Mid Levels means health care professional supervised by a physician, who include medical attendants such as nurse practitioners.

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

Non-Experimental Procedures are those procedures for which the medical safety and efficacy have been demonstrated and are no longer investigational, as determined by VHP in accordance with generally accepted medical practice and professionally recognized standards in the medical community.

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 VHP to deliver services to Members.

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.

Out-of-Network means any Plan Provider or Non-Plan Provider that is not part of your VHP Network.

Outpatient Care means medical treatment that does not require an overnight stay.

Outpatient Hospital Services or Outpatient Care means the medical services received by an Individual under the direction of a Plan Physician and they are not staying in the hospital overnight.

Plan or VHP means the Valley Health Plan. VHP is the DBA (doing business as) name of the County of Santa Clara, a California corporation licensed under the Knox-Keene Health Care Service Plan Act.

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

Plan Hospital means Santa Clara Valley Medical Center or any other duly licensed hospital, that at the time care is provided to a Member, has a contract with VHP to provide Hospital Services to Members.

Plan Pharmacy means a pharmacy that has contracted with VHP to provide you with medication(s) prescribed by your Plan Provider.

Plan Physician is a duly licensed PCP, physician, or physician group who at the time of care is provided, has contracted with VHP to deliver health care services to Members.

Plan Provider means any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State to deliver or furnish health care services. Such person or facility is located within the Service Area or which, at the time care is provided has a contract with VHP to deliver services to Members.

Plan Specialist means a physician whom practices in a medical specialty and has contracted with

VHP to deliver health care services to Members.

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

Prescription Unit means the maximum amount (quantity) of medication that may be dispensed per prescription. For most chronic condition oral medications, the Prescription Unit represents a one hundred (100) day supply of medication. The Prescription Unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for your protection and safety.

Primary Care Physician (PCP) means a Plan Physician who has contracted with VHP to deliver primary care services to Members.

Primary Care Physicians practice in a wide range of medical disciplines and can be family or general practitioners, pediatricians, or internists. In addition, obstetricians/gynecologists (OB/GYNs) may serve as Primary Care Physicians within selected Networks if they meet VHP criteria for the delivery of primary care.

A Primary Care Physician is medically trained to take care of your routine health care needs and is primarily responsible for the coordination of your care. Coordinating your care includes responsibilities such as supervising continuity of care, record keeping, and initiating referrals for specialist Plan Physicians.

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

Rehabilitation Services means the Covered Services included in your Benefit Plan. These Benefits are provided in a prescribed, organized, multidisciplinary rehabilitation program, whether in a hospital, Skilled Nursing Facility, physician's office or other facility.

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:

- to improve function, or
- to create a normal appearance, to the extent possible.

Routine Care means the provision of Medically Necessary services which are required for:

- screening purposes,
- the prevention of disease,
- the diagnosis and treatment of new or ongoing illnesses or injuries, or
- the evaluation and treatment of signs or symptoms which a prudent lay person or physician might reasonably be concerned to represent a deterioration in health status.

Such Routine Care does not pose an immediate risk requiring either urgent or emergency care.

"Santa Clara Valley Health & Hospital System" or "SCVHHS" is a VHP Plan Provider, which includes the Valley Medical Center (VMC), VMC physicians, and Valley Health Center clinics.

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:

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

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 eighteen (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.

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

Service Area means Santa Clara County and/or the geographic area, established by VHP and approved by the Department of Managed Health Care (DMHC), where VHP provides health care services to Members.

Severe Mental Illness means a mental disorder:

- which is severe in degree and persistent in duration,
- which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and
- 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 Illness 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.

Skilled Nursing Facility (SNF) means a facility where inpatient services provided at a less intensive level than an Acute Care hospital but still requiring services by a licensed health care professional.

Standing Referral means a referral by a PCP to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.

State means the state of California.

Subscriber means the person who is enrolled and responsible for payment to VHP or whose terminated employment or other status is the basis of eligibility for membership in the Benefit Plan.

Termination means the involuntary process of ending your membership in the Benefit Plan.

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

VHP ID Card is an identification card (ID card) issued to Members by VHP to identify membership in VHP. Your VHP ID Card must be presented whenever and wherever care is received.

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

Eligibility & Enrollment

Becoming a VHP Member

Before applying for VHP Individual Conversion membership you must be eligible to enroll and you or your Eligible Dependents must meet certain eligibility and enrollment requirements. After you have enrolled in the VHP Individual Conversion Plan it will be necessary for you to continue to meet these requirements.

The following sections outline who is eligible to enroll, how enrollment is done, how to retain membership, and when coverage begins. If you have any questions regarding individual conversion eligibility, enrollment, or changes to your enrollment, contact a VHP Member Services Representative.

Individual Conversion Eligibility

You are eligible to apply for Coverage under the Benefit Plan as long as you meet the definition of Subscriber or Eligible Dependent as described in the “*Definitions*” section and you:

- live or work in the VHP Service Area,
- were previously enrolled as a Member under a Group Service Agreement issued by VHP to an employer Group or enrolled as a Member under an Individual Conversion agreement issued by VHP to a Subscriber,
- were continuously covered during the three-month period immediately preceding termination from Group coverage,
- are not eligible for any other group health coverage, and
- written application and first premium payment must be received no later than sixty-three (63) days after termination from Group. (Coverage becomes effective the first day following termination from Group coverage.)

VHP may verify eligibility, other health plan eligibility (including Medicare) status and dependent status. Services are not covered prior to the Member’s Effective Date of Coverage or after the Member’s coverage ends.

If you or your Dependent(s) are eligible for Medicare, you are not eligible to continue to membership under this Agreement.

Unmarried enrolled Eligible Dependent children under the age of nineteen (19) who reside outside the Service Area, may be eligible for Coverage, but will only be covered for Emergency or Prior Authorized Urgently Needed Services when Out-of-Network. All follow-up or routine care must be received in Network through the Member’s PCP.

Unmarried, enrolled Dependent children under the age of twenty-four (24) who are enrolled full-time in an accredited school or institution of higher education as defined by the school or institution, while residing outside the approved Service Area may be eligible for Coverage, but will only be covered for Emergency or Prior Authorized Urgently Needed Services when Out-of-Network. All follow-up or Routine Care must be received in SCVHHS Network through the Member’s PCP.

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

If an Eligible Dependent child’s Coverage is terminated for failure to maintain full-time student status, and he/she re-enrolls full-time in an accredited or licensed educational institution, he/she will not be eligible to re-enroll under the Benefit Plan.

In the event that a Subscriber works and resides outside the Service Area for more than ninety (90) consecutive days (with no intention of returning) he/she is not eligible, or is no longer eligible, for Coverage under the Benefit Plan.

You or any one of your dependents may not be eligible to enroll, if you or your dependents have ever had membership in VHP terminated for a reason stated in the section entitled “*Termination of Benefits—Cancellation of Membership for Cause*” and/or “*Termination for Nonpayment*.”

Children of your Dependents are not eligible for enrollment.

If you or your Dependents are subsequently found to be ineligible, VHP will not provide Benefits during the period of ineligibility and will be entitled to reimbursement from you for any services rendered and claims paid during such period you were ineligible for membership.

If you and your Dependents are otherwise eligible to enroll, VHP will not refuse to enroll you or your Eligible Dependents because of you or your dependent(s) pre-existing health condition.

Enrollment

A completed and signed Individual Conversion enrollment application and health statement, if applicable, must be received by VHP within sixty-three (63) days of your loss of Group coverage in order for you and/or your Eligible Dependent(s) to apply for Coverage.. A completed and signed Individual Conversion enrollment application and health statement, if applicable, must be received by VHP within thirty-one (31) days of loss of your dependent's Individual Conversion coverage in order for the dependent to apply for continued Coverage. A completed and signed Individual Conversion enrollment application must be received within thirty-one days of the birth or your child or the adoption of a child.

To enroll, you, the Subscriber, must contact the VHP Member Services Department to request an enrollment application and other VHP materials for your enrollment and reference. Upon your request, VHP will provide you with a copy of the VHP Combined Evidence of Coverage and Disclosure Form. You are responsible for submitting your properly completed application for membership and applicable premiums to the Plan. Following receipt, VHP will process all eligible enrollments and distribute a Member packet and Identification Card(s) to your current address in VHP records.

Enrolling Initially

You must apply for membership for you and your Eligible Dependents by submitting an enrollment application to VHP within the Initial Eligibility Period. Contact VHP for information on the application process, when you are eligible to enroll, and your Effective Date of Coverage.

If you or your Dependents do not enroll when you first become eligible, you may not enroll in the VHP Individual Conversion Plan at a later date.

Adding Dependents

You must submit an enrollment or status change request to VHP to add your newborn or newly adopted dependent(s). The request must be received by VHP within thirty-one (31) days after they become your Eligible Dependent(s). Proof of dependent status (e.g. birth certificate or adoption paperwork) must also be provided at the time that you add a Dependent to your Coverage.

It is your responsibility to notify VHP of any changes in status that affect your own or your enrolled Dependent's ability to meet the eligibility criteria. If you do not enroll your Eligible Dependents when they are first eligible, you will not be able to enroll them.

Enrolling Late or During Open Enrollment

Late enrollment means that you or your Eligible Dependents do not enroll when you first become eligible. If you do not enroll when you first become eligible, you are no longer eligible for enrollment in the Individual Conversion Plan

There is no open enrollment period for this Plan, you may enroll during your Initial Eligibility Period.

It is your responsibility to ensure your enrollment application for the Individual Conversion Plan is received by VHP during the Initial Eligibility Period.

When Coverage Begins

If we accept your application, Covered Services begin for you, the Subscriber, and your Dependents at 12:00 A.M. on the Effective Date of Coverage established by VHP if you enroll:

- When you or your Eligible Dependents first became eligible, and
- Within the Initial Eligibility Period which includes the sixty-three (63) days period following the loss of Group or within thirty-one (31) days of loss of your dependent's Individual Conversion coverage.

Covered Services begin for your Dependent:

- Newborn natural child—at the moment of birth (a newborn child is automatically covered from the moment of birth through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later); or
- Adopted child—on the date you obtain adoptive custody or when you receive the legal right to control the adopted Eligible Dependent child's health care; or
- Ward that is an Eligible Dependent child—on the commencement date of legal guardianship.

However, to ensure continued Coverage you must enroll your new Eligible Dependent(s) within 31 days after birth, custody, or legal guardianship.

Continuing Coverage for Dependents

Health Coverage may continue for your Eligible Dependents as follows:

1. Physically or mentally handicapped unmarried Eligible Dependent(s) who is incapable of self-sustaining employment and is dependent upon you for support and maintenance can continue Coverage providing the child was a VHP Member on the day before reaching age nineteen (19) and proof of such incapacity and dependency is furnished to VHP within thirty-one (31) days of the child reaching that age.

Verification of disability and dependency may be required as often as deemed necessary by VHP. However, the Plan will not request verification more often than once a year after the first two years the child has reached age nineteen (19).

2. Newborn, newly adopted, or new legal ward child can continue Coverage after the first thirty-one (31) days provided you enroll your child within the first thirty-one (31) days following the child's birth, adoption, or guardianship. After this period, you will not be able enroll your child.
3. Your or your spouse's unmarried natural child, step-child, legally adopted child, or a child under your court-ordered legal guardianship, residing with you or with your present or former spouse, can be covered under the Plan until age nineteen (19). The child must be chiefly dependent on you for support. Membership can continue beyond age nineteen (19) for an unmarried child who is a full-time student at a certified educational institution, provided proof of the child's status is furnished to VHP within thirty-one (31) days of the child reaching age nineteen (19). Verification of student status may be requested by VHP on a periodic basis.

Renewal Provisions

The Agreement renews automatically as long as premiums have been properly paid. Reapplication is not necessary unless changes are needed. Monthly premiums may change at the time of renewal or upon 60 day notice from VHP. If Coverage for you or your Dependents is terminated and there is a lapse of Coverage, you or your Dependents are not eligible to re-enroll and your membership will not be reinstated.

Contract Period of this Evidence of Coverage

The Agreement is revised when the contract between you and VHP is changed. Any future changes to the Agreement will affect this Combined Disclosure Form and Evidence of Coverage. The description of Benefits discussed in this booklet are applicable after September 2003. If your Individual Conversion Agreement renews at a later date, the description is applicable during that contract period.

VHP revises its EOC on an annual basis, however EOCs are not distributed annually. You may request a copy of the most recently published Individual Conversion EOC by calling a Member Service Representative at 1-888-421-8444.

Periodically VHP also distributes member communications regarding Benefits. If you would like copies of the most recent Member communications, such as the VHP Member newsletter "Perspectives," call the VHP Member Services Department.

Choice of Physicians & Providers

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Valley Health Plan is a non-profit health plan that contracts with its Primary Care Physicians (PCPs) and other Plan Providers who are responsible for providing and coordinating Covered Services or Benefits for its Members. As a Member of Valley Health Plan, you must receive all of your care for Covered Services from these Plan Providers. The use of Plan Providers is necessary except in the event of an Emergency or if VHP has pre-authorized the services.

At the time of enrollment, a Primary Care Physician needs to be selected for each Member. The PCP is responsible for providing all basic medical care, for all specialty and hospital services referrals, and for coordinating any necessary Prior Authorization.

You will be given information in your Member packet regarding the VHP's Primary Care Physicians and facilities, which includes pharmacies and clinics, and laboratories. Although the list(s) of VHP Plan Providers is subject to change, we recommend that you keep this information and other additional information together with this Combined Evidence of Coverage and Disclosure Form. Call a Member Service Representative at (408) 885-4760 or 1-888-421-8444 if you need an updated Plan Provider list.

To understand the meaning of important definitions, such as Plan Providers and Service Area, refer to the "Definitions" section of this EOC. Additional important information regarding our Plan Network is located in the "Provider Payments" section below.

Provider Payments

The Valley Health Plan contracts with its Plan Providers to provide Covered Services to its Members. VHP's Network primarily is the Santa Clara Valley Hospital & Health System (SCVHHS). This Network includes the Valley Medical Center (VMC), VMC physicians, and Valley Health Center satellite clinics. VHP also contracts with other Service Area providers to augment the SCVHHS. Under the terms and conditions of your membership with VHP, you must obtain services from these Plan Providers unless you are authorized to receive services out of the contracted Network or in the event of an Emergency situation.

VHP's financial arrangements with our physicians and providers are reviewed and approved by the DMHC. No financial incentives are utilized for any provider.

The SCVHHS physicians are salaried physicians and all revenues collected by VHP are paid directly to the Santa Clara Valley Health & Hospital System less any fee for service provider

payments made directly to individually contracted Plan Providers and less the cost of VHP administration. The payment to the SCVHHS is a certain amount per member per month (PMPM), based on the prepaid premiums collected (and received by VHP) for all Members. In exchange for the PMPM payment the SCVHHS is responsible to provide all Covered Services to those Members that SCVHHS has received payment. VHP administrative responsibilities include the processing of all Covered Services claims to contracted and non-contracted providers.

Additional information regarding provider payments may be requested from your provider or VHP. For information regarding claims processing and other reimbursement responsibilities refer to the "Payment & Reimbursement Responsibilities" section of this booklet.

Choosing Your Primary Care Physician

VHP encourages you and your Dependents to choose your own personal VHP Primary Care Physician (PCP). If you do not select a PCP, VHP will assign one for you and your enrolled Dependents.

To choose your own VHP PCP:

1. Select a Primary Care Physician, which is located near your home or work, from the list of VHP PCPs. You may choose a different PCP for each Dependent,
2. Indicate your PCP and your Dependent's PCP on the pre-paid pre-addressed "postcard form" (received in your new Member packet) or form provided, and return the form to VHP's office as soon as possible to avoid a PCP being assigned by VHP or, call a VHP Member Services Representative at (408) 885-4760 or 1-888-421-8444 to make a PCP selection.

VHP will make every effort to assign you with the PCP of your choice, however, if this is not possible, VHP will contact you with details on how to make another selection.

If you need any assistance in selecting a VHP PCP, please call a Member Services Representative at (408) 885-4760 or 1-888-421-8444 who will be happy to assist you.

In addition, VHP encourages you to identify your baby's Primary Care Physician during the last few months of pregnancy. Please contact a Member Service Representative to help you with your selection.

Changing Your Primary Care Physician

You can change your PCP at any time by calling the Member Services Department or by requesting the change in writing. The effective date of the change will be first of the next month after your request is received, provided you are not receiving hospital or other institutional care at the time of your request. In the event you are institutionalized, discuss your effective date with the Member Services Department.

If needed, a new VHP Identification Card (VHP ID Card) will be mailed to you.

Access To Care

Scheduling Appointments

It's easy—simply call "Valley Connection" at 1-888-334-1000, Monday through Friday, 8 a.m. to 9:30 p.m. or on Weekends/Holidays 8:30 a.m. to 5 p.m. to make or cancel a doctor's appointment at any of the Valley Health Centers. The "Valley Connection" also provides free 24-hour medical advice over the telephone.

Dial 1-888-334-1000

Press 1 for English

2 for Spanish

3 for Vietnamese

If your PCP is a Plan Provider that is not at one of the Valley Health Centers, simply call that PCP directly. If you need help in making an appointment with your PCP call VHP Member Services at (408) 885-4760.

VHP recommends you call in advance when scheduling your doctor's appointments. Be prepared to provide information such as your name, medical record number on your VHP ID Card, a daytime telephone number where you can be reached, and the reason for the visit so that adequate time can be scheduled for your appointment. To keep wait times at a minimum and to allow the physician office sufficient time to prepare for your visit, we suggest that when you call:

- For routine visits, call at least 48 hours in advance;
- For health evaluation appointments, such as your yearly physical, call at least 2 weeks in advance; or
- For more immediate or urgent care attention, advise the nurse of the urgency of your call and request the next available appointment.

If you need to cancel an appointment, be sure to contact the "Valley Connection" or your Plan Provider immediately so another patient can be scheduled. Whenever possible, you should give at least twenty-four (24) hours notice when canceling an appointment.

At the time of your doctor's appointment, you will be asked to show your VHP ID Card. VHP suggests that you bring your VHP ID Card with you when you go to all appointments.

Receiving Primary Health Care and Self-Referrals

The PCP you or your Dependent(s) have chosen will provide or arrange for the majority of your general medical, pediatric, and OB/GYN Covered Services from VHP Plan Providers. To ensure quality health care, you should regularly schedule general checkups and office visits.

Any woman Member may receive Covered Services through direct access (self refer) from a Plan OB/GYN and/or through direct access from a Plan family practice physician and surgeon (Plan Provider).

Any Member may self refer to a Plan Provider Dermatologist for dermatology Covered Services or to a VHP Optometrist for eye service Benefits.

Any Member may also call VHP at (408) 885-4080 option #3 to receive information on how to receive an authorization for direct access for Mental Health Services with a VHP Plan Provider.

Receiving Specialty Care and Referrals

Your PCP will coordinate all specialty care or other Covered Service health care needs:

- Before you receive specialty services from a VHP Plan Physician, (such as general surgery, orthopedic surgery or cardiology), you must receive a referral from your PCP. Self-referral care is an exception.
- Your PCP will request specialty services for you from one of the Plan Specialists. This service is arranged through the VMC Referral Center or the Plan Provider who will establish an appointment(s) with you for your specialty care. The Referral Center has been authorized by Valley Health Plan to approve two initial visits. Should it be necessary for you to receive specialty services from a physician outside of the Plan Provider Network, your PCP will submit his request in writing to Valley Health Plan, this is referred to as a request for specialty services through an authorization process (Prior Authorization).

Valley Health Plan Medical Director will review this request. Provided all necessary referral information is available, VHP will inform you and the physician of its decision within two (2)

business days.

Your Primary Care Physician will discuss the specialty visits with you and you will be provided with any other special instructions. You may also call a VHP Member Service Representative for more information.

- If you have a Serious Chronic Condition, including HIV or AIDS, that may require a Standing Referral for more than two (2) visits, your PCP will involve your Plan Specialist and discuss the coordination of your care with you. The Prior Authorization process through VHP is needed to obtain these services. Your PCP is responsible for requesting and coordinating these services to ensure continuum of care. You will be advised of the decision by VHP within two (2) business days.
- If you require mental health/behavioral health services, refer to the “Benefits Description” section under “Mental Health Services.”

To receive more information about referrals and Prior Authorization simply call a VHP Member Service Representative at (408) 885-4760 or refer to the “Authorization and Denial of Services” section below in this booklet.

You should be aware that the “Lock-In” provision of your Benefit Plan requires you to obtain all Covered Services from Plan Providers in your PCP’s Network. Except in an Emergency situation, if you seek and receive services outside of your Plan Network without an authorized referral and/or Prior Authorization you will be responsible for the charges.

Receiving Hospital or Other Facilities Care

Your selection of VHP means the primary hospital at which you the Member will receive all hospital services is the Santa Clara Valley Medical Center (SCVMC) located at 751 South Bascom Avenue, San Jose, CA 95128.

The “Valley Connection” appointment and advice nurse services are available 24 hours a day by calling 1 888 334-1000. To receive any Medically Necessary hospital or facilities Covered Services:

- Your Primary Care Physician will arrange for all Covered Services in a Plan Hospital or Facility, including inpatient, transitional, and/or care provided in a sub-acute or Skilled Nursing Facility. Authorization is required for all facilities care and VHP should be notified of any such care either prior to admission or, as in the event of an emergency, as soon as possible thereafter.
- In the rare event Covered Services are not available at the SCVMC or Plan Facilities, your Primary Care Physician will arrange with VHP for a Prior Authorized referral. If you receive services without a Prior Authorization, or if you receive services outside of the VHP Plan Provider Network you will be responsible for the charges.
- **In the event of an Emergency and you can not safely come to SCVMC, you should call 9-1-1 or seek care at the closest hospital. Please refer to the “Emergency Services” section in this booklet.**

Receiving Out-of-Network Care

Before leaving your Network, it’s important that you obtain any care (such as Routine Care or foreseeable care for Serious Chronic conditions) that you know will be needed before you return. For example, if you require routine dialysis or oxygen therapy and know that you will require a treatment during your absence, you should either make arrangements to obtain the necessary therapy prior to leaving your Network or work with your Primary Care Physician to obtain Prior Authorization for this care from a Non-Plan Provider while you are outside your Network.

Services that you receive while Out-of-Network that can be foreseen and have not been Prior Authorized, are not considered Urgently Needed Services or Emergency Services. If you delay

receiving or arranging for this care until you are Out-of-Network, VHP will not pay for your care and you will be financially responsible for the full cost of such services.

In the event of Urgently Needed Services, call Valley Health Plan at 1-888-421-8444, follow instructions or leave a message and go to the nearest urgent care center. Refer to the *“Urgent Care”* section.

In the event of an Emergency, call 911 or go to the nearest emergency room. Refer to the *“Emergency Services”* section.

Receiving Health Care as a Dependent While Out-of-Area

Enrolled Dependents residing Out-of-Area will only be covered for Emergency or Prior Authorized Urgently Needed Services when Out-of-Network. All follow-up or Routine Care must be received in Network through the Member’s PCP. Refer to the section above.

Authorization and Denial of Services

Valley Health Plan contracts with its Primary Care Physicians and Plan Providers who are responsible for providing and coordinating Covered Services or Benefits for its Members. Except in the event of an Emergency or if VHP has authorized the services in advance, you must receive all of your care from these contracted providers. Services not received from the Member’s PCP require a referral (unless such services are eligible for self-referral as defined in this EOC) or Prior Authorization. Timelines regarding authorization and denial of Services are outlined in the *“Access to Care”* section *“Receiving Specialty Care and Referrals.”*

All Member Covered Services are provided, arranged for, or coordinated by your PCP. In order for Members to receive Covered Services that require a referral or Prior Authorization:

- a VHP PCP must initiate such a referral to a specialist on behalf of the Member;
- as needed, the referral is submitted to the Santa Clara Valley Health & Hospital System Referral Center or VHP’s Utilization Review Department for approval or denial; and
- in the event that the referral requires Prior Authorization, VHP’s Medical Director must also give authorization prior to a Member receiving Benefits.

If you would like more details regarding the referral provision of your Benefit Plan or the authorization process, you may contact VHP Member Services at (408) 885-4760 or 1-888-421-8444. Also refer to *“Access to Care”* sections in this EOC, including *“Receiving Specialty Care and Referrals.”*

Members are generally notified of authorizations from the PCP or by telephone. Members are notified of denials in writing. Except in an Emergency or Urgent Care situation (Refer to the section *“Emergency and Urgently Needed Services”*), if you receive services without a referral or Prior Authorization, or if you receive services outside of the VHP Provider Network you will be responsible for the charges.

If you believe that your Primary Care Physician or other VHP Provider has improperly denied a request for treatment or services, you may request a reconsideration of that decision by calling Member Services (408) 885-4760. You should file this request for reconsideration within 30 days of the initial denial. If the service you requested is still denied; you may file a formal grievance by following the procedures described in the section entitled *“Grievance Review Process.”*

Requests involving an imminent and serious threat to your health will receive an expedited review as may be required by the urgency of the situation.

In the event that you are dissatisfied with any action or adjustment by your Plan Provider or VHP, you should follow the *“Member Grievances”* procedure sections as outlined in this EOC. In addition, you may also contact the California Department of Managed Health Care. Refer to the *“DMHC Consumer Help-Line”* section for more details.

Second Medical Opinions

A second medical opinion is a medical evaluation that you seek from a provider other than your current VHP treating provider. Second medical opinions within the VHP Plan Provider Network are a Covered Service. Second medical opinions outside the VHP Plan Provider Network are not covered unless VHP's Medical Director or Utilization Department has given Prior Authorization. You have the right to request and receive a second medical opinion. Reasons to request a second opinion, include:

- If you question the reasonableness or necessity of recommended surgical procedures;
- If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, such as a Serious Chronic Condition;
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or your Plan Provider is unable to diagnose the conditions, and you request an additional diagnosis;
- If your treatment plan in progress is not improving your condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment; and
- If you have attempted to follow the plan of care or consulted with your initial provider concerning serious concerns about the diagnosis or plan of care.

When you want to obtain a second medical opinion, your VHP PCP or VHP Member Services Representative will help you make the necessary arrangements. They will help you select which VHP Plan Provider to call. Decisions regarding Second Medical Opinions (SMO) requests will be determined and notification to the Member and Provider will be given within the following time limits:

- Emergency Services SMO requests — within 2 – 6 hours
- Urgently Needed Services SMO requests — within 24 hours
- Routine SMO requests — within 5 business days

If you are calling VHP after business hours and it is an Emergency Services Second Medical Opinion request, simply call the Valley Connection at 1-888-334-1000 and request a second medical opinion. Then call VHP during regular business hours and advise the Utilization Department of your request.

As needed, providers will provide services of an expedited second medical opinion within 72 hours as appropriate for your condition. Providers will render services for all other second medical opinions within 30 calendar days as appropriate for your condition.

If you are not satisfied with how your request or determination or the way a second medical opinion has been handled, you can call a Member Services Representative at (408) 885-4760. VHP representatives will help resolve your concern or if necessary, assist you in filing a grievance as outlined in the "Member Grievances" procedure sections of this EOC. In addition, you may also contact the California Department of Managed Health Care's Health Plan Division, refer to the "DMHC Consumer Help-Line" section for more details.

Continuity of Care

If you or your Dependents have an Acute Condition, a Serious Chronic Condition, a Pregnancy, a terminal illness, or your newborn child between birth and age 36 months is under medical care, you may be eligible to continue to receive treatment from your physician:

- at the time of his/her termination as a VHP Plan Physician, or
- from a non-participating physician at the time of your enrollment in VHP Plan.

This section describes the Covered Services of this continuity of care. You have the right to request a copy of the Plan's Continuity of Care policy. To request a copy of this policy, call Member Services at (408) 885-4760 or 1-888-421-8444.

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. 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.

Completion of Covered Services following termination of a Plan Provider or enrollment in the Plan:

- for an Acute Condition shall be provided for the duration of the Acute Condition.
- for a Serious Chronic Condition shall be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to a Plan Provider. Completion of Covered Services shall not exceed 12 months.
- for a Pregnancy shall be provided for the duration of the Pregnancy.
- for a terminal illness shall be provided for the duration of the terminal illness. Terminal illness for continuity of care is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less.
- for the care of a newborn child between birth and age 36 months. Completion of Covered Services shall not exceed 12 months.
- for the performance of a surgery or other procedure that is authorized by the Plan as part of a documented course of treatment and has been recommended and documented by the current provider at the time of enrollment or Plan Provider termination. Completion of such surgical Covered Services must occur within 180 days.

To receive continuation of care from your physician, you must obtain a written Prior Authorization from VHP. This authorization shall state the predetermined amount of time you will be able to continue to receive care from your current provider.

In addition, if you are a new enrollee or your physician is a terminated VHP Provider, a written referral is only provided when:

- delay in the provision of services or loss in continuity of care,
- the services for the condition are otherwise Medically Necessary covered Benefits under the terms of your Coverage with VHP when provided by Plan Provider Physicians,
- the services are provided within the Service Area,
- your coverage with VHP is in effect,
- the terminated Provider or Out-of-Network Provider signs a new temporary contract with VHP, and the terminated Provider was not terminated by VHP for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination, and
- your coverage with VHP does not include an Out-of-Network option.

To apply for this continuity of care coverage, call Member Services at (408) 885-4760 or 1-888-421-8444 within 30 days from your Effective Date of Coverage with VHP.

Independent Medical Review

One of VHP principal exclusions includes services that are not Medically Necessary. The determination whether a service or supply is Medically Necessary is made by the Plan Medical Director based on an objective review and subject to the Plan grievance procedures. However, if VHP denies you health care services on the basis that the service is not Medically Necessary, you, your designee, or your doctor can request an Independent Medical Review (IMR). You must have completed the VHP grievance process or have participated in the grievance process regarding a Disputed Covered Service for at least 30 days.

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

You must submit a request for an IMR to the DMHC within 6 months of receiving a denial from the Plan. You must request an IMR only for a service that is a Covered Benefit. You can obtain more information on the IMR process by accessing the Department of Managed Health Care's web site at www.dmhc.ca.gov/imr or by calling a Member Services Representative at (408) 885-4760 or 1-888-421-8444.

If services are denied because they are Experimental or Investigational Treatment(s), which are non-Covered Benefit(s), you have the right to request an IMR from the DMHC. You may request the IMR without participating in the VHP's Member Grievances Process. Also refer to the "External Independent Review" section in this booklet for additional important information regarding Experimental or Investigational Treatment review.

For additional information on the "DMHC Consumer Help-Line" or the Plan's "Member Grievances Process" refer to the Member Services Assistance section of this booklet. For the External Independent Review process refer to the section below.

External Independent Review

A drug, device, procedure, or other therapies, which are Experimental or Investigational Treatments, are not VHP Covered Benefits. However, if you or your Plan Physician requests an Experimental or Investigational Treatment for you or your Dependents and VHP denies the request, you have the right to a review by an External Independent Review Organization (EIRO) of this denial, free of charge. Such a request must be Life-Threatening and Seriously Debilitating or due to a terminal condition that has a high probability of causing death within two years and standard therapies used have not been effective, are not medically appropriate, or there is no other beneficial standard therapy available.

A Member or the Member's Plan Physician on the Member's behalf, may submit a request for this review regarding the Coverage Decision denying the Experimental or Investigational Treatment. If the request for an EIRO requires an expedited review due to a Life-Threatening and Seriously Debilitating medical condition, the decision for the expedited review will be rendered and delivered to an EIRO within 24 hours of the approval of the request for review. The request and any additional supporting information and documentation should be sent to:

Valley Health Plan
Attention: Grievance
2325 Enborg Lane, Suite 290
San Jose, CA 95128.

A panel of independent medical experts will review the initial determination and provide VHP with their analyses and recommendations. VHP will notify you of the panel's decision within thirty (30) calendar days of receiving your request.

If the Plan Physician determines that a decision needs to be made on a more urgent basis, the review will be rendered within seven (7) calendar days of receiving the request for an expedited

review.

At the request of the panel expert, the deadline can be extended by up to three (3) business days (to obtain relevant documents).

If the experts on the panel recommend providing the proposed treatment, VHP will provide Coverage for the services required subject to the terms and conditions generally applicable to other Benefits under the Benefit Plan.

VHP Web site: www.valleyhealthplan.org

Valley Health Plan has a Web site. Please log on to www.valleyhealthplan.org. This site provides information such as Covered Services/Benefits, VHP Network Providers and their locations, and wellness information which includes prevention guidelines and recommended immunizations. There will also be a listing of phone numbers for you to call for appointments with your Primary Care Physician (PCP), to reach a VHP Network Pharmacy, to make appointments with a self-refer clinic (Optometry, Dermatology & OB/GYN) or to reach VHP Member Services. Another important phone number to have is, Valley Connection (1 888-334-1000). This is a 24-hour a day medical advice line. Valley Connection can also make an appointment for you if your PCP practices at a Valley Health Center location. Updates to this Web site will be made periodically.

VHP Newsletter – Perspectives

Valley Health Plan publishes a quarterly newsletter, called “Perspectives.” This publication includes many interesting articles that provide its Members with legislative changes, access to care advice, health tips, doctor profiles, and other information that is important to VHP members. For copies of VHP’s most recent publications contact the VHP Member Services Department at (408) 885-4760 or 1-888-421-8444.

Using Your VHP ID Card

After enrolling, you will receive a VHP Identification (ID) Card for yourself and one for each covered Dependent. Keep your VHP ID Card handy when you call to make an appointment, or go to a medical facility for care.

Please note ... Your VHP ID Card is for identification only. To receive Covered Services, you must be a Member. Anyone who is not a VHP Member will be charged for any services received. If you let someone else use your card, your membership may be terminated.

Benefit Descriptions

You and your Dependents are eligible to receive a comprehensive range of medical and hospital Benefits when you need them. This section describes the standard Covered Services that are available through your Benefit Plan.

Please take a few moments to read these descriptions, and the “*Emergency & Urgently Needed Services*” and the “*Exclusions & Limitations*” Sections to fully understand the extent of your Benefits.

Your Member’s share of cost (e.g. Copayments) responsibility and the particular costs due to exclusions and limitations that apply to a specific Benefit are your responsibility. Most VHP Individual Conversion Benefits have a \$0 Copayment. There is a \$10 Copayment for Chiropractic Care office visits and nominal fees for health education classes.

Except for Emergency Services or Prior Authorized services, Covered Services must be:

- provided, prescribed, arranged for, and/or directed for authorization by your PCP or a Plan Physician,
- obtained from Plan Provider(s) within the VHP Network, and
- rendered to a Member for the treatment of illness or injury, (unless specifically covered as preventive or routine health services).

Mid Levels may be involved in your care if you are admitted to Santa Clara Valley Medical Center for certain specialty services. The Mid Level will participate in your care only under the direct supervision of an attending physician and all health care decisions will be made by consultation with the attending physician. You will be informed of the involvement of any Mid Levels by the individuals themselves or upon your admission to the hospital.

Certain definitions of terms used to describe your Benefits can be found in the “Definitions” section of this booklet. If you have additional questions about your Covered Services, *please call a VHP Member Services Representative at (408) 885-4760 or 1-888-421-8444.*

Ambulance and Transportation Services

Arrangements will be made and/or authorized by your PCP or Plan Medical Director for non-emergency medical transportation when Medically Necessary. In the event of an emergency medical condition that requires an emergency response you are encouraged to use appropriately the “9-1-1” emergency response system in areas where the system is established and operating. In the event of an emergency where no “9-1-1” response service is available, go to the nearest hospital by the most appropriate means available to you. Ambulance services are Covered Services with Prior Authorization or when used in accordance with the services as outlined in this EOC under the section titled “*Emergency Services.*”

Professional Services

Professional services include physician services that are covered under your Benefit Plan. Covered Services are received from your PCP or Plan Specialist (or other Plan Providers) and include:

- Inpatient Hospital Services;
- Outpatient Care; and
- Outpatient Hospital Services.

Outpatient Services

Outpatient Care is covered under your Benefit Plan when received from your Plan Providers. Routine Care or urgent care is arranged or provided through your PCP or Plan Physician and includes many of the common preventive and diagnostic services you will need. There is no limit to the number of visits (except for defined limitations). You may self-refer directly to a Plan Physician for OB/GYN, dermatology, and optometry services.

Because VHP believes that preventive services are important in maintaining your health and the health of your Dependents many preventive and diagnostic services require no Copayment. Copayments do apply to certain outpatient care, as applicable these amounts are indicated in the appropriate sections of this EOC.

Outpatient Covered Services include:

- Pediatric/Well-Child Care – including periodic office visits, diagnostic laboratory services, immunizations, and the testing and treatment of phenylketonuria (PKU). The age, health status, and medical needs of the child determine the frequency of these examinations;
- Periodic Health Examinations – including diagnostic laboratory services, Pap smears, Prostate Specific Antigen (PSA) tests, and all generally medically accepted cancer screening tests;

- Physical Examinations for Routine Care – including diagnostic laboratory services and testing and treatment of PKU. Vision and hearing screening examinations to determine the need for vision or hearing correction as provided by your PCP. Hearing aid benefits are limited to once every 36 months and up to a coverage maximum of \$1,000. Eyeglasses and contact lenses are excluded;
- Well Woman Examinations – including diagnostic laboratory services, a pelvic and breast examination, Pap smear, and other simple diagnostic tests. Annual cervical screening includes PAP tests and the option of any cervical cancer screen test approved by the FDA (i.e. liquid based prep test);
- Mammography Screening for Routine Care – including radiological procedures and interpretation of the results, frequency is determined based on Medical Necessity, age, and demographic characteristics;
- Allergy Testing and Treatment – including serum and injection services;
- Dermatology Services for Routine Care – including diagnostic, laboratory, and dermatological preparations;
- Diagnostic Laboratory Services – including outpatient diagnostic X-ray, nuclear medicine, and laboratory services (including tests performed on an outpatient basis at your Plan Facility);
- House Calls – including visits by a Plan Physician or nurse (when you are not on a VHP home health care program);
- Immunizations and Injections– including flu shots, tetanus and diphtheria boosters, Hepatitis A and B vaccines, pneumococcal pneumonia vaccines, and immunizations as recommended by the U.S. Preventative Services Task Force, including travel immunizations;
- Optometry Services – for Routine refraction examinations. Eyeglasses, contact lenses, low aides, and correction of visual acuity or refractive errors by any means, including eye surgery such as radial keratotomy are excluded;
- Podiatry Services – for the treatment of injuries and diseases of the feet. Coverage is limited to a medical condition affecting the fee, such as diabetes, systemic foot disease, trauma, or accidental injury to the foot, requiring care by a medical professional;
- Physical, Occupational, Speech, and Respiratory Therapy Services – are limited to treatment provided in the amount, frequency, or duration, as the Plan Physician deems medically appropriate. Occupational therapy is limited to care that will allow you to achieve and maintain improved self-care;
- Outpatient Hospital Services – including outpatient surgery and procedures in a hospital or outpatient centers such as, but not limited to, angiograms and brochoscopies, chemotherapy and medically appropriate materials. Outpatient services also include surgical assistant and anesthesiologist, drugs, X-ray, supplies and blood, and blood derivatives, and transfusions (blood bank);
- Urgently Needed Services – when you are temporarily out of your Service Area Network. The provision of medically necessary services for an illness or injury which, treatment cannot be delayed until the Member returns to the Service Area and, in the view of a prudent lay person or physician, is likely to lead to a serious deterioration in the patient's health or significant disability. Authorization for care must be received from VHP prior to treatment; and
- Ambulance and Transportation Services. – including emergency ambulance transportation and inter-facility medical transportation transfers

Facilities (Hospitalization & Skilled Nursing)

When Medically Necessary, your Plan Physician will make arrangements for you to be admitted to your Plan Hospital. Inpatient Hospital Services are covered under your Benefit Plan when your Plan Physician has admitted you, or Prior Authorization has been obtained, or Emergency or Urgently Needed Services result in your hospitalization.

There is no limit to the number of inpatient days, when provided at a Plan Hospital by Plan Providers.

You must notify VHP if you are confined in a facility, hospital, or Skilled Nursing Facility on your Effective Date of Coverage so that VHP can arrange for care to be provided in your Plan Facility or Plan Hospital as soon as your condition has stabilized sufficiently to permit transfer.

Inpatient Hospital Service Benefits include:

- Semi-private room (unless Medically Necessary and ordered by your Plan Physician) and board, intensive care, operating room, inpatient drugs, X-ray lab, supplies, acute rehabilitation, dialysis, and blood, blood derivatives, and transfusions (blood bank);
- Ancillary services, such as laboratory, pathology, radiology, radiation therapy, cathode ray scanning, inhalation and respiratory therapy, physical therapy, occupational therapy, and speech therapy;
- Diagnostic and therapeutic services;
- Discharge planning services and the coordination and planning of such continuing care;
- Surgical and anesthetic supplies furnished by the hospital as a regular service;
- Physician and surgeon care; and
- Inpatient skilled nursing care.

Skilled Nursing Facilities (SNF) care is provided to you when authorized by a Plan Physician. VHP provides up to one hundred (100) days per Calendar Year of prescribed and authorized skilled nursing services in a Plan Facility

Skilled nursing care (inpatient) provided in a SNF or a skilled nursing bed in a Plan Facility, including semi-private room and board, general and skilled nursing, social services, drugs, X-ray, lab, supplies, blood, blood derivatives, and transfusions (blood bank), and durable medical equipment ordinarily furnished by the SNF. Care is limited to care which: is skilled and required on a daily basis, is not Custodial Care, and as a practical matter, can only be provided on an inpatient basis.

Skilled nursing care is limited to conditions which are long term or chronic in nature. SNF care which requires ongoing inpatient skilled nursing care are excluded from your Benefit Plan after you receive 100 days of care for each Calendar Year. Rehabilitation services are limited to treatment provided in the amount, frequency, or duration, as the Plan Physician deems medically appropriate.

Prescription Drugs

When you receive a prescription from your Plan Physician, have it filled at any Plan Pharmacy or to request refills, simply call the "Automated Refill System" at the telephone number on your prescription label and as needed the Plan Physician will be telephoned. You can pick your prescription up at your convenience. If you are prescribed a specific drug from a non Plan Provider, including dentists, you must contact your PCP or VHP for authorization.

Plan Physicians use a comprehensive drug Formulary that includes both FDA-approved brand name and generic drugs. Unless otherwise written by the Plan Physician on the prescription with the words, "Do Not Substitute", generic drug equivalents may be dispensed by the Plan Pharmacies. Valley Health Plan delegates the Formulary drug selection process to the Santa Clara Valley Health and Hospital System (SCVHHS) Pharmacy and Therapeutics Committee (P&T). The SCVHHS Formulary has been prepared as a reference for all health professionals who share the responsibility for the management of patient care, including VHP Members. The Formulary is prepared for publication by the SCVHHS Pharmacy Department under the direction of the P&T. The Formulary is published annually. Additions and deletions to the Formulary, which occur throughout the year by action of the P&T, are conveyed to the medical staff by the

summary of the P&T minutes.

Your Plan Physician coordinates your health care to determine when you need medication and the proper dosage to be prescribed. Although a drug may be on the Formulary, it does not guarantee that your Plan Physician will prescribe the drug. All medications are dispensed in Prescription Unit quantities. To identify whether a specific drug(s) is on the Formulary or to obtain a copy of the formulary, call a VHP Services Representative at 1-888-421-8444.

When you fill a prescription at your Plan Pharmacy, present your VHP ID Card and the prescription to the pharmacist. There are no limits on the number of prescriptions you may have filled as long as your Plan Physician prescribes them. However, no more than a one hundred (100) day supply, for Serious Chronic medical conditions, can be obtained per prescription from your Plan Pharmacy. When applicable, you may be required to pay a Prescription Unit copayment. The Pharmacy will advise you of all charges.

Non-formulary drugs, which are medically necessary, are covered if your Plan Physician obtains Prior Authorization by sending an authorization request form or placing a telephone call to VHP. For a new prescription or in case of urgent or emergency care, authorization can be obtained within 24 hours. For refills, authorization can be obtained within 48 hours. If you are completely out of your prescription, authorization for refill can be obtained within 24 hours. Your Plan Physician will advise you of the authorization.

Anytime a request for prior authorization cannot be obtained or the process cannot be completed within the times specified, your prescription, (including non-formulary prescriptions) can be processed for you to receive either:

- A 5-day short supply pending authorization for full prescription by the Plan Medical Director.
- The full prescription.

If the request for authorization is denied, VHP will notify you and your Plan Physician in writing, within two (2) working days, of the reason for the denial. You will be referred back to your Plan Physician for alternative treatment. The notice will also inform you of your right to dispute the denial. If you have questions, speak with your Plan Pharmacist, Plan Provider or a VHP Member Services Representative.

If you are taking prescription drugs at the time you enroll, please make an appointment with your Primary Care Physician for evaluation of your current medication and your continuing care. If your doctor determines that you need a prescription, you will receive either a prescription for your current medication or a new prescription for a drug(s) from the SCVHHS Formulary that is equally as effective.

VHP and the SCVHHS Pharmacies maintain an expeditious treatment authorization process. All routine prescriptions must be filled by Plan Pharmacies. When your Plan Pharmacy is closed (during and after regular business hours, on weekends and holidays) or for urgent or emergency care, you may have your prescription filled at any 24-hour pharmacy. Prescription drugs (including non-formulary drugs) obtained from providers and filled by pharmacies outside of the VHP network are subject to the authorization process. Upon review by the Medical Director, reimbursement may be denied.

Routine Medically Necessary medications prescribed by your dentist are a Covered Benefit only when filled at a Plan Pharmacy.

Over the counter (OTC) drugs, medications, and supplies are not a Covered Benefit.

Inpatient hospital and other facility drugs and supplements are provided in accordance with your Plan Physician's prescription and Plan formulary. Covered Services include drugs, supplies, and supplements. Applicable Copayments and other Member charges apply. Refer to the "*Schedule of Benefits Table*" for additional Covered Services information.

Emergency Services prescription drugs are provided in accordance with the attending physician's prescription. However, should you need to obtain a prescription associated with Out-of Network Emergency Services or Urgent Care that is not filled by the hospital, take your prescription to a

pharmacy and either you or the pharmacist can contact VHP by calling 1-888-421-8444 to obtain authorization. If after normal business hours, a message can be left advising the Utilization Department of the type of prescription and the name of the attending physician. Once authorized, VHP will reimburse directly to you or the pharmacy. Refer to “*Reimbursement Provisions*” for reimbursement procedures.

Durable Medical Equipment, Medical Supplies and Equipment

Medical Supplies and Equipment are covered under your Benefit Plan through Plan Providers. Your Plan Physician will prescribe when Medically Necessary. If Prior Authorization is required (e.g. DME and prosthetic devices) your PCP or Plan Physician will arrange it. Covered Services include:

- Durable Medical Equipment;
- Corrective appliances;
- Prosthetic and orthotic devices; and
- Oxygen and oxygen equipment.

VHP or your Plan Provider will determine whether to repair, rather than to replace prosthetic devices.

DME Diabetic supplies include blood glucose monitors and blood glucose testing strips; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; ketone urine testing strips; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; podiatric devices to prevent or treat diabetes-related complications; insulin syringes; and visual aides, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

DME asthmatic supplies and equipment include pediatric asthmatic inhaler spacers, nebulizers (including facemasks and tubing) and peak flow meters. Over the counter items are excluded.

Orthotic and prosthetic appliances are limited to Medically Necessary to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or alleviate severe pain. Over the counter items are excluded.

Medical Supplies are limited to equipment and devices which: are intended for repeated use over a prolonged period, are not considered disposable (with the exception of ostomy bags and diabetic supplies), are ordered by your Plan Physician, do not duplicate the function of another piece of equipment or device covered by VHP, are generally not useful to you in the absence of illness or injury, primarily serve a medical purpose, and are appropriate for use in the home.

Formulas and special food products for the treatment of phenylketonuria (PKU) are Covered Services provided that such items are part of a diet prescribed by Plan Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Prior Authorization is required.

Any customization of living environment or automobile are excluded from your Benefit Plan.

Mental Health Services

Outpatient mental health services are available through VHP mental health Plan Providers when pre-authorized by VHP. Coverage includes therapy utilizing individual, couple, family, or group sessions. To obtain authorization call the VHP Utilization Department at (408) 885-4080-option #3 or call your PCP for a referral.

Mental Health Services (Outpatient Psychiatric and Counseling) for evaluation including prescribed psychiatric and psychological testing, crisis intervention (Emergency and Urgently Needed Services), and therapy are Covered Benefits. Services include prescription drugs, medications, and pharmacy services. Includes treatment for Severe Mental Disorders and

Serious Emotional Disturbances of a Child or Adolescent. Services are limited to Medically Necessary treatment in the amount, frequency, or duration up to the point in which you are no longer clinically determined to require treatment. Prior Authorization from VHP is required. Post-hospitalization Outpatient Behavioral Health Services treatment(s) only as authorized by a Plan Provider at a Plan Facility. Applicable \$10.00 Copayments apply. Copayments are waived for Severe Mental Illnesses or Serious Emotional Disturbances of a Child or Adolescent as determined by your VHP Provider and identified by the State of California.

Mental health services that are court ordered, or as a condition of parole or probation or when incarcerated are excluded from your Benefit Plan.

Covered Services for Inpatient mental health psychiatric care is available at a mental health Plan Provider when such care has been Prior Authorized. Hospital alternative treatment services are available if a Member would benefit from treatment in a structured multidisciplinary mental health program as an alternative to inpatient hospitalization.

To obtain a list of Mental Health Plan Providers call VHP Member Services at (408) 885-4760.

Chemical Dependency Services

Outpatient diagnosis and counseling for alcohol or drug dependency and medical treatment for withdrawal symptoms are Covered Services when authorized by VHP and arranged through a Plan Provider. Prior Authorized inpatient detoxification services for alcohol and drug addictions are available for short-term confinement when provided in a Plan Facility.

Coverage includes prescribed methadone maintenance for pregnant Members during pregnancy and for two (2) months after delivery, in a licensed treatment center approved by Plan Providers.

Home Health Services

When you are confined to your home for medical reasons, your Benefit Plan covers you for home health services from Plan Providers. Your Plan Physician must arrange Prior Authorization. Home health care will be provided under the direct care and supervision of a Plan Physician and administered by visiting Plan Provider health care professionals.

Home Health Services are only covered inside our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. Coverage is limited to care which is not Custodial Care, and may not be appropriately provided in a Plan Provider's office, hospital or skilled nursing facility. Coverage excludes meals, childcare, in-home day care, and housekeeping services.

Hospice Care

Should you be diagnosed as having a terminal illness with a life expectancy of twelve (12) months or less you may elect home-based hospice care. Such care will be arranged through a certified hospice program with Prior Authorization from VHP and your Plan Physician. Hospice care is provided within the Service Area.

You may change your decision to receive hospice care at any time, however, once you have elected hospice care, you are not entitled to any other Benefits for the terminal illness while your hospice election is in effect, however you are entitled to Covered Services not related to the terminal illness. Coverage is limited to 5 consecutive days of inpatient respite care (to provide relief for family members or others who might be caring for you) and a maximum of 366 days of hospice care. Other Benefits for the terminal illness are excluded while your hospice election is in effect.

Dialysis and Transplants

Dialysis services for acute renal failure and chronic renal disease, including equipment, training and medical supplies required for home dialysis are covered under your Benefit Plan. Plan Providers must render Covered Services. Prior Authorization must be received before evaluation and treatment.

Tissue and Human Organ Transplantation for Non-Experimental Procedures (such as, but not limited to, heart, liver, and kidney transplants) including the reasonable medical and hospital expenses of a donor or individual identified as a prospective donor if such expenses are directly related to the transplant, other than corneal transplants. Benefits include Medically Necessary ambulance services. Services for organ, tissue, and bone marrow transplants are subject to the limitations and exclusions as outlined in the *"Limitations and Exclusions"* section. Plan Physician(s) must:

- determine that you meet certain medical criteria developed for patients needing transplants,
- refer you, in writing with the approval of the VHP Medical Director, to transplant facilities selected by VHP, and
- the Plan referral facility must determine that you satisfy the patient selection criteria for the transplant.

If denied, Covered Services include those services received before such decision(s) is made. Anti-rejection drugs, biological products, and other procedures are limited to Non-Experimental Procedures.

Cancer Clinical Trial Services

Cancer Clinical Trial Services include routine health care services associated with your participation in a cancer clinical trial, Phase I through V. The clinical trial's: i) endpoints must not be defined exclusively to test toxicity, but have a therapeutic intent, and ii) treatment must be either be (a) approved by the National Institutes of Health, the Federal Food and Drug Administration, the Department of Defense, or the Veterans Administration or (b) involve a drug that is exempt under federal regulations from a new drug application. Covered Services are only available if: you have been diagnosed with cancer, you are accepted into a Phase I through V clinical trial for cancer, and your Plan Physician has recommended your participation in the trials because it will have a meaningful potential benefit to you. Coverage is limited to routine patient care costs as in accordance with State and Federal regulations.

Chiropractic Care and Acupuncture Services

Chiropractic care is available through the Plan's Chiropractic Network and is obtained by PCP referral only. Your Benefit Plan covers twenty (20) visits per Calendar Year. Applicable \$10.00 Copayments apply.

Acupuncture services are available through authorized Plan Providers and are obtained by PCP or VHP referral only. Prior to Covered Services, treatment by all other modalities must have been exhausted. Coverage is limited to a maximum of twenty (20) prescribed visits per calendar year. Acupuncture services that are not acupuncture related are not covered. Applicable \$10.00 Copayments apply.

Dental Hospital or Surgery Center Services

Your Benefit Plan offers limited dental Services, as rendered in a medical hospital or medical surgery center and as when provided, arranged, and coordinated through your 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.

Covered Services are available if Members meet the following requirements:

- Are under seven years of age,
- Are developmentally disabled, regardless of age, or
- Whose health is compromised and for whom general anesthesia is medically necessary, regardless of age,

Charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist, are excluded.

Family, Sterilization and Abortion Services

Your Benefit Plan offers a wide selection of family services when provided, arranged, and coordinated through your Plan Physician.

- Family Services Benefits include family planning services, genetic counseling services, and Prior Authorized artificial insemination services.
- Sterilization services including Prior Authorized sterilization procedures.
- Abortion services and abortion procedures.

Some Plan Hospitals and other Plan Providers do not provide one or more of the following services that may be covered under your plan benefits and that you or your Eligible Dependents might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective Plan Provider or call Valley Health Plan Member Services at 408 885-4760 to ensure that you can obtain the health care services that you need.

Infertility Services

Infertility diagnosis and treatment including evaluation, diagnostic operative procedures, and Medically Necessary treatment when provided, arranged, and coordinated through your PCP and Prior Authorized by VHP Medical Director. Infertility services required due to tubal ligation, tubal reanastomosis, or vasectomy procedures are excluded.

Artificial Insemination Services including family planning counseling, pre-abortion and post-abortion counseling, and information on birth control. Medical services in a physician's office for the diagnosis and treatment of involuntary infertility. Artificial insemination is limited to the actual basic insemination procedure only for the treatment of infertility when determined necessary by a Plan Physician and as Prior Authorized by VHP Medical Director. Conception by artificial means (e.g. IVF, ZIFT, GIFT) or any other process that involves the harvesting or manipulation of the human ovum to treat infertility are excluded. Any service, procedure, or process which prepares you to receive conception by artificial means that is not a Covered Benefit are excluded.

Health Education and Health Promotion Services

VHP is committed to promoting and enriching the health of our Members. The primary purpose of providing health education and health promotion is to help you live a healthy lifestyle. Health education programs and materials are available to VHP Members. Call the VHP Health Education Department at (408) 885-5957 to obtain more information.

Health education programs and materials, related to disease management are available. Contact your PCP or the VHP Health Education Department to discuss your needs for this service. Topics include asthma and diabetes.

Health promotion services are designed to improve your health as well as prevent illness. Classes include childbirth preparation, prenatal education, smoking cessation, CPR, first aid, and fitness.

These health education and promotion classes are offered to Members at low-cost or at no cost. VHP maintains an updated list of health education classes available throughout Santa Clara County. In addition to SCVHHS classes, other community organizations, hospitals, health centers, and voluntary health agencies sponsor these classes. Class/program fees may be reimbursable to Members. Please contact the VHP Health Education Department at (408) 885-5957 for information on class availability, schedules, fees, and reimbursement options.

The array of health education resources encourages our Members to make changes for better health and emphasize active participation, informed decision-making and self-care skills. VHP publications (e.g. the Member's newsletter) will be sent to your home as well. These publications communicate the latest information on health topics and available programs. In addition, a current copy of the Healthwise Handbook is distributed with each new Member's packet.

Coverage is limited to program design and class availability. Weight management at "Weight Watchers," is limited to one 12 week session per Calendar Year. A \$20.00 Copayment applies for the Weight Watchers session.

Maternity Services

Maternity care is provided through your Plan Physician. Maternity services include maternity care and newborn circumcision.

Keeping your prenatal appointments, making healthy lifestyle changes, and following the advice of your physician are important to assure the good health of you and your baby.

You and your newborn child are entitled to at least forty-eight (48) hours of inpatient hospital care following a normal vaginal delivery or ninety-six (96) hours following a delivery by Cesarean section. An earlier discharge may be arranged when the decision is made jointly by you and your attending physician. Inpatient Hospital Services for your baby after you are discharged are considered a separate hospital admission. Enrollment of the newborn is required.

If you are released from the hospital early, you and your baby are entitled to a follow-up visit within forty-eight (48) hours of discharge. You and your Plan Physician will determine whether the visit will occur at your Plan Facility, your Plan Physician's office, or at home. The visit will include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

Mastectomies & Lymph Node Dissections

Your coverage includes Medically Necessary mastectomies and lymph node dissections including hospitalization, office visits, and physician and surgeon costs. Covered Services include prosthetic devices and Reconstructive Surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. When necessary, your Plan Physician will make arrangements for you to receive Covered Services.

Emergency & Urgently Needed Services

Emergency Services and Urgently Needed Services are available from Plan Providers within your Network 24 hours a day, 7 days a week.

Although all necessary care is available from and should be obtained through Plan Providers in your Network, VHP also covers you for all Covered Services received from Non-Plan Providers for:

- Emergency Services when you can not safely come to the Santa Clara Valley Medical Center, and
- Urgently Needed Services when you are temporarily out of the Service Area and obtain Prior Authorization for care from your Plan Medical Director in advance of treatment.

Be sure to carry your VHP ID Card with you at all times to access care.

Emergency Services

In an emergency, call 911 for assistance, go to the nearest emergency room, or seek care from your Plan Facility or Plan Hospital.

Emergency Services are covered when furnished either by:

- Plan Providers or
- Non-Plan Providers when the time required to reach your Plan Facility or Hospital is such that a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, Active Labor and psychiatric condition) such that the absence of immediate medical attention could reasonably expect the delay to result in serious impairment to your bodily functions, serious dysfunction of any bodily organ or part, or placing your health or psychological wellbeing in serious jeopardy.

The final determination as to whether such services were rendered in connection with Emergency Services will be determined by VHP.

Should it be necessary to receive Emergency Services from a Non-Plan Provider, present your VHP ID Card and ask the provider or someone acting on your behalf to call VHP at 1-888-421-8444. After normal business hours, a message can be left advising VHP of the emergency. VHP must be notified within 48 hours or as soon as reasonably possible after receiving the care.

Covered Services are considered to be Emergency Services only until your condition has stabilized sufficiently to permit either discharge or transfer.

Urgent Care

Valley Health Centers offer extended hours for urgent care. For the urgent care hours in your Network consult your VHP list of providers. If you need to receive medical care for Urgently Needed Services call the advice nurse at "Valley Connection" at 1-888-334-1000. If you require care, you will either be given a same-day appointment with a Plan Physician or other instructions. Follow the instructions given, and present your VHP ID Card to receive care.

Should it be necessary to receive Urgently Needed Services outside your Service Area, call VHP's Utilization Department at 1-888-421-8444 to receive authorization for care required. If you are unable to reach VHP, call the advice nurse at "Valley Connection" at 1-888-334-1000, explain the situation, and follow his/her instructions. If authorized, contact the closest provider to receive treatment. **Present your VHP ID Card and call VHP Utilization Department representative within 48 hours to advise him/her of your urgent care visit.** As necessary, he/she can help coordinate your care. Failure to notify VHP within this time frame may result in the denial of your claim.

Urgent care services are covered by VHP if:

- your condition meets the definition of Urgently Needed Services, and
- you make an urgent care appointment with the "Valley Connection" advice nurse by calling 1-

888 334-1000, or

- you make an urgent care appointment with your VHP Network Provider, or
- you obtain Prior Authorization from VHP Utilization Department (or advice nurse) before seeking treatment from a Non-Plan Provider when you are temporarily out of your Service Area and medical care cannot be delayed until you return.

Follow-Up Care for Emergency or Urgently Needed Services

Your Coverage includes Medically Necessary follow-up care to Emergency and Urgently Needed Services if that care cannot be delayed without adverse medical effects.

Follow-up care to any Emergency Service or Urgently Needed Service should be obtained through your Primary Care Physician. However, follow-up care by Non-Plan Providers will be covered as long as the care required continues to meet the definition of an Emergency or Urgently Needed Service as set forth in this EOC.

Should it be necessary to receive Urgently Needed Services outside your Network, call VHP to receive Prior Authorization before care.

Remember, if you seek routine or elective medical services that are not emergent or urgent from Non-Plan Providers without a Prior Authorization, VHP will not pay for your care and you will be required to pay for the full cost of such services.

Limitations & Exclusions

This section describes the limitations and exclusions generally affecting services that are not available through the Benefit Plan. For specific Benefit limitations and exclusions please also refer to your Benefit Plan "Benefits Descriptions" section in this EOC booklet.

VHP will not be financially responsible for such limited or excluded services. Whenever the word "service" is used, it refers to any drug, equipment, device, treatment, or therapeutic or diagnostic procedure.

Except for Emergency or Urgently Needed Services when a particular service is excluded, all services that are necessary for that excluded service are also excluded, even if they would otherwise be covered.

Principal Limitations

The following items, procedures, benefits, services, drugs, supplies, and equipment are limited under your Benefit Plan:

1. Covered Services are available only through Plan Providers in the Network (unless such care is rendered as worldwide Emergency Services or is Prior Authorized);
2. Covered Services provided by Non-Plan Providers are limited to those services rendered as worldwide Emergency Services or for which you have obtained Prior Authorization before services are rendered;
3. If you seek routine care or elective medical services from Non-Plan Providers without a VHP approved referral, VHP will not pay for your care and you will be required to pay for the full cost of such services;
4. In the event of major disasters, epidemic, labor disputes, war, and other circumstances beyond our control, VHP Plan Providers will provide benefits to the extent practical, according to their best judgment within the limitations of available facilities and personnel. We will have no liability to you for delay or failure to provide services under such conditions. The Plan will use its best efforts to provide Covered Services, however if Plan Providers are unable to

provide services in these, the above note circumstances, Member(s) should seek Emergency Services from the nearest facility, and the Plan will later provide reimbursement for Covered Services;

5. You may refuse, for personal reasons, to accept procedures or treatment recommended by your Plan Physician. If you refuse to follow a recommend treatment or procedure, your Plan Physician will inform you whether he or she believes there is no acceptable alternative treatment. You may seek a second medical opinion from another VHP Plan Provider. If you still refuse the recommended treatment or procedure, then we have no further responsibility to provide care to you for the condition involved. However, as needed, the Plan will continue to provide Covered Services for medical conditions or complications arising from such refusal to receive care;
6. VHP reserves the right to Coordination of Benefits Reimbursement as outlined in the Agreement. Your Benefits are limited to such extent. As a member, you have an obligation to cooperate and assist us to coordinate Benefits by providing information to all health service providers on any other coverage you and your Dependent(s) have;
7. VHP reserves the right to seek Third Party Reimbursement as outlined in the Agreement. Your Benefits are limited to such extent. As a Member, you have the obligation to cooperate fully in our efforts by signing any forms necessary to assist us in obtaining this recovery.

Principal Exclusions

The following items, procedures, benefits, services, drugs, supplies, and equipment are excluded under your Benefit Plan:

1. 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;
2. Services rendered by Non-Plan Providers except in an Emergency or upon Prior Authorization by the Medical Director;
3. Services rendered prior to the Member's effective date of coverage or after the time coverage ends;
4. Services which exceed the limitations or fail to meet the conditions of Covered Services;
5. Charges for services which the Member would not be obligated to pay in the absence of the Agreement or which are provided to the Member at no cost;
6. Charges for any treatment for addiction to, or dependency on, tobacco or tobacco products, except for the smoking cessation programs that are Benefits of the health education and health promotion services;
7. Acupuncture services unless specifically listed as a Covered Service;
8. Behavioral Health Services that are court ordered, or as a condition of parole or probation, except if a Plan Physician determines that the services are Medically Necessary Covered Services.
9. Behavioral training and modification including but not limited to hypnotherapy, education, vision therapy, play therapy, and sleep therapy;
10. Cancer clinical trial services except specifically listed as a Covered Service in the *"Benefit Descriptions"* under the *"Cancer Clinical Trial Services"* section of this EOC;
11. Chiropractic services are limited to 20 visits per Calendar Year or unless specifically listed as a Covered Service;
12. Cosmetic Surgery, plastic or Reconstructive Surgery except as specified as a Covered Service the *"Definitions"* and *"Benefit Descriptions"* under the *"Mastectomies & Lymph Node Dissections"* sections of this EOC;
13. Cosmetics, herbal products and treatments, dietary supplements, health or beauty aides;
13. Custodial or Domiciliary Care, except as required under Hospice Care;

14. Dental Services except: (1) services for treatment or removal of tumors; (2) Physicians' services or 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; or (4) services in connection with accidental fractures of the jaw;
15. 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;
16. Educational Services, except as expressly provided as Covered Benefits (health education and promotion services);
17. Emergency room services for non-Emergency care;
18. Exercise, recreation, self-help, hygienic, and beautification classes and equipment;
19. Experimental or Investigational Treatment except as expressly provided as a Covered Service. Independent Medical Review of denial of coverage by a Plan for Experimental and Investigational Treatment is available; refer to "*Benefit Descriptions*," "*Cancer Clinical Trial Services*," and "*Access to Care*" under the "*External/Independent Medical Review*" sections of this EOC;
20. Gastric bubble, gastroplasty, gastric bypass, and gastric stapling unless determined to be Medically Necessary by the Plan Provider;
21. Hearing examinations to determine the need for hearing correction for Members over eighteen (18) years of age (unless Medically Necessary) and the furnishing, fitting, installing, or replacing hearing aids unless specified as a Covered Service;
22. Human Chorionic Gonadotropin (HCG) Injections, unless Medically Necessary with the appropriate Prior Authorization;
23. Human Growth Hormone (HGH), unless Medically Necessary with the appropriate Prior Authorization, and except for members with confirmed HGH deficiency;
24. Infertility services unless specified as a Covered Service;
25. Liposuction;
26. Massage therapy;
27. Military service connected disability care for which a Member is covered or is eligible for such care through another group, whether insured or self-insured;
28. 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. Independent Medical Review of denial of coverage by a Plan for Experimental and Investigational Treatment is available; refer to the "*Access to Care*" under the "*Independent Medical Review*" section of this EOC;
29. Over the counter (OTC) drugs, items, orthotics, supplies and equipment;
30. 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;
31. Personal or comfort items which are non-medical, environmental enhancements and environmental adaptations, 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;
32. 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;
33. Prescription drugs and accessories not deemed Medically Necessary and in accordance with

professionally recognized standards of care. Non-prescription drugs or medications, including over the counter drugs. Non-FDA Approved Drugs. Generic equivalents not approved as substitutable by the FDA. Non-FDA approved Treatment Investigational New Drugs. Independent Medical Review of denial of coverage by a Plan for Experimental and Investigational Treatment is available; refer to the "Access to Care" under the "*Independent Medical Review*" section of this EOC;

34. Reversal of voluntary sterilization or of voluntary induced infertility;
35. Routine foot care, including trimming of corns, calluses and nails, unless Medically Necessary;
37. 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 Benefits;
39. Transportation services unless Medically Necessary and with Prior Authorization of Medical Director or unless necessitated by an Emergency;
40. Transsexual surgery, related services and supplies except when Medically Necessary due to congenital defects;
41. 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 as Covered Benefit);
42. Vision care except as provided in the Agreement (i.e. vision screening examinations only), including eyeglasses, contact lenses, low aides, and correction of visual acuity or refractive errors by any means, including eye surgery such as radial keratotomy;
43. Vocational Rehabilitation;
44. Weight control or weight loss treatments or supplies unless Medically Necessary or except as specifically provided as Covered Benefits.

Payment & Reimbursement Responsibility

Prepayment Fees (Premiums)

You are responsible for submitting your monthly membership fees or premiums to VHP. You will be required to make payments directly to the VHP office at 2325 Enborg Lane, Suite 290, San Jose, CA, 95128.

You must prepay the required dues or premiums for each month on or before the last day of the preceding month. Only Members for whom we have received the appropriate premiums are entitled to coverage under this *Agreement*, and then only for the period for which we have received payment. If you have questions regarding information on the method, amount, or frequency of your premiums, please contact VHP Member Services.

Changes in Fees, Benefits, and Charges

VHP may change the premiums and benefits, to the extent permitted by law, during the term of the Agreement. VHP will notify Members who are in the Individual Conversion Plan in writing sixty (60) days before any change in the rates.

If there are changes or modification to your Benefits, to other charges, such as Copayments, or to the cost of contribution to your Membership Premiums VHP will notify you of the change and reason(s) why.

Other Charges

When you receive medical care, you may be responsible for paying certain Copayments or other charges. These charges are also referred to as the Member's share of cost. Such charges may include:

- Copayment is a minimal charge. Payment can be requested at the time of service.
- ■ Deductible, which is a defined amount that you are responsible to pay prior to the Plan paying for any Covered Services.

Annual Copayment or Other Charges Maximum

There is a limit to the Copayments and other charges that you must pay in any Calendar Year for services. The Copayment and other charges limit for the Individual Conversion Benefit Plan is:

- \$1,500 for an individual, or
- \$3,000 for a family.

You should retain your records of all Copayments and premiums paid by you during the year. When the applicable limit has been reached, advise VHP. Once you have demonstrated to VHP that you have reached the Member's share of cost limit, you will not be required to pay any additional copayments or other charges for the remainder of the Calendar Year.

If you have any questions regarding your Copayment and other charges annual maximum limits, call a Member Services Representative at (408) 885-4760 or 1-888-421-8444.

Provider Payments

The Valley Health Plan contracts with its Plan Providers to provide Covered Services to its Members. VHP's Network primarily is the Santa Clara Valley Hospital & Health System (SCVHHS). This Network includes the Valley Medical Center (VMC), VMC physicians, and Valley Health Center satellite clinics. VHP also contracts with other Service Area providers to augment the SCVHHS providers. Under the terms and conditions of your membership with VHP, you must obtain services from these Plan Providers unless you are authorized to receive services out of the contracted Network or in the event of an Emergency situation.

VHP's financial arrangements with our physicians and providers are reviewed and approved by the DMHC. No financial incentives are utilized for any provider.

The SCVHHS physicians are salaried physicians and all revenues collected by VHP are paid directly to the Santa Clara Valley Health & Hospital System less any fee for service provider payments made directly to individually contracted Plan Providers and less the cost of VHP administration. The payment to the SCVHHS is a certain amount per member per month (PMPM), based on the prepaid premiums collected (and received by VHP) for all Members. In exchange for the PMPM payment the SCVHHS is responsible to provide all Covered Services to those Members that SCVHHS has received payment. VHP administrative responsibilities include the processing of all Covered Services claims to contracted and non-contracted providers.

Additional information regarding provider payments may be requested from your provider or VHP.

Reimbursement Provisions (Claims)

VHP has designed coverage in a way to minimize the need for you to file a claim. If for some reason you are billed or have paid for services that are Covered Services, submit the itemized bill and/or your original receipt showing proof of payment with your request for reimbursement within ninety (90) days after you receive those Covered Services to:

Valley Health Plan
Claims Department
P.O. Box 26160
San Jose, CA 95159-6160

Be sure your name, the Subscriber's Social Security Number, date and type of service, your PCP's name, and any other pertinent information are included in your request. VHP will consider your request for reimbursement after 90 days, provided you can demonstrate good cause for such delay.

VHP will process the request for reimbursement within 30 days of receiving complete information. If a request for reimbursement is denied or partially denied, you will receive written notice of the decision, including specific reasons for the decision. VHP reviews all services received outside of the Plan Network for appropriateness of care. If the services are from a non-VHP Plan Provider for either an Emergency or for authorized services, VHP will reimburse you or the provider for those Covered Services. Payment for Covered Services will be made at the reasonable and customary or Medicare allowable amounts as defined within the Service Area. If the services from the Non-Plan Provider are non-Covered Services or you have exceeded the Benefits limits, VHP will not make payment.

In the event that VHP fails to pay a Plan Provider, you will not be liable to the Plan Provider for any sums owed by VHP. As required by California law, every contract between VHP and a Plan Provider contains a provision to this effect. However, in the event that VHP fails to pay a Non-Plan Provider, you could be liable to the Non-Plan Provider for the cost of services.

For inquiries regarding reimbursement of your claim, please call our Member Services at (408) 885-4760 or 1-888-421-8444. You may also obtain information about reimbursement by writing or visiting the VHP office at 2325 Enborg Lane, Suite 290, San Jose, CA 95128.

Liability of Subscriber or Enrollee for Payment

Plan Members are not liable for charges for Covered Services authorized by their PCP or VHP, which are covered under the your Benefit Plan. A Copayment or other charges may be required for some services. The specific Copayment or other charges for your Benefit Plan can be found in this Agreement.

If you obtain care that is not performed or authorized by your PCP or VHP, you will be financially responsible for the cost of care provided. (This does not apply if you receive Emergency Services that are Covered Services and you have notified your PCP or VHP.)

If you obtain care from your PCP that is a non-Covered Service or if you are referred to services of a non-VHP Provider that have not been Prior Authorized by VHP, you will be liable for such non-Covered Services. Non-Covered Services that are not covered are listed in the "*Exclusions and Limitations*" and in the "*Benefits Descriptions*" sections of this booklet.

Third Party Reimbursement

It is your responsibility to inform VHP or your provider when services performed are covered through workers' compensation laws, automobile, accident or other liability coverage. The Plan will not duplicate coverage for such services. VHP and/or its Plan Providers will seek reimbursement for up to the amount VHP has paid for any services rendered which duplicate such coverage. In the case of a monetary award, VHP or its Plan Providers must be reimbursed immediately after the award is received. VHP also has the option to be subrogated to your rights to the extent of the cost of Benefits provided by the Plan.

If you wish to release a third party from liability or settle a claim against a third party for which you receive compensation for medical care provided through VHP, you must obtain prior written consent from VHP if such acts would limit VHP's right to reimbursement.

Member Services Assistance

Member Services Representative

Valley Health Plan's top priority is to provide quality service and health care to its Members. Everyone at VHP shares responsibility for assuring your satisfaction. Our Member Services Representatives will be happy to assist you with your questions, complaints or to hear how VHP and its Plan Providers are doing.

Member Services is available to assist you over the phone Monday through Friday from 9:00am to 5:00pm at (408) 885-4760 or 1-888-421-8444. Walk-in office hours are Monday through Friday 8:00am - 5:00pm. Valley Health Plan is located at 2325 Enborg Lane, Suite 290, San Jose, CA 95128.

You can ask our representatives how to obtain medical care, how to interpret your covered health benefits, what to do if you move, how to add dependents, how to obtain a new VHP ID Card, how to submit claims or file grievances, or to help you with any other service issues. You can also request an updated VHP Primary Care Physician List, which includes clinic address and appointment line information.

If a representative is not available, please leave a message, a representative will return your call on the next business day. VHP's toll free number, 888.421.8444 is available to leave a message 24-hours a day.

If you need to notify VHP of an emergency or urgent care situation, please leave a telephone number where you can be reached.

Membership Records

Membership records contain information about you and other family Members. These records are very important because they identify you as a Member and determine where you and your enrolled Dependents can receive services. Incorrect records can delay medical care, create problems in Coverage, and possibly cost you money.

It is important to keep your Member records updated with your and your Dependent(s)' current personal information. To change your membership records or to receive a new identification card with your new records, call the VHP Member Services office at (408) 885-4760 or 1-888-421-8444.

VHP must be notified upon your death or the death of your Dependent(s), entitlement to other health coverage, or entitlement to Medicare.

Member Grievances

At Valley Health Plan (VHP) we take pride in being a member focused health plan. We suggest that you allow our Member Services Department to assist you in resolving your concerns. You may call a VHP Member Services Representative at (408) 885-4760 or 1-888-421-8444, they are available Monday through Friday between 9:00am - 5:00pm. You may request that a formal Grievance be filed on your behalf or you can complete a Grievance form and submit it to VHP. Grievance forms are available through VHP, at your provider's office and on our web-site at <http://vhp.sccgov.org>. **Send your Grievance to Valley Health Plan, Attention: Grievance Department, 2325 Enborg Lane, Suite 290, San Jose, CA 95128. Alternatively, you may also submit your grievance online at <http://vhp.sccgov.org>.** You have one hundred and eighty (180) days from the date of the event, which caused a grievance.

It would be helpful to include all pertinent information from your VHP ID Card and the details and circumstances surrounding your concern or problem. Providing as much information as possible

may eliminate the time required to collect such data. Pertinent information should include any medical records or physician opinions in support of your Grievance; otherwise your medical records may need to be obtained from your Plan Physician or you may need to obtain them from a Non-Plan Physician. Your Grievance will be acknowledged within five (5) calendar days of receipt.

After the Grievance Review Committee makes its decision, VHP will notify you in writing of the outcome within thirty (30) calendar days of receiving your Grievance.

If the Grievance involves an imminent and serious threat to your health or the health of your Dependents, including but not limited to, severe pain, psychological wellbeing, potential loss of life, limb or major bodily function you will be entitled to an expedited review. The Grievance must state that you are requesting an expedited review. You will be notified of the outcome or status within three (3) working days of receipt of the Grievance.

If you are not satisfied with the decision of the Grievance Review Committee, you may contact the California State Department of Managed Health Care (DMHC) by following the procedures outlined below in the section titled "DMHC Consumer Help-Line

DMHC Consumer Help-Line

"The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against your health plan, you should first telephone your health plan at (408) 885-4760 or 1-888-421-8444 and use your health 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 you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health 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 urgent medical services.

The department also 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 Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online."

Public Policy Committee

You may assist VHP to establish public policy through VHP's Advisory Group. The findings and recommendations of this public policy committee or Advisory Group are regularly reported to VHP's governing body. A minimum of 51% of the committee must be Members of VHP. "Public Policy" means acts performed by VHP and its employees to assure the comfort, dignity, and convenience of Members who rely on VHP providers to provide services. Please contact a VHP Member Services Representative at (408) 885-4760 or 1-888-421-8444 if you are interested in becoming an Advisory Group member or would like more information.

Your Health Care Choices (Advance Directives)

An Advance Directive is a formal document, signed by you in advance of a severe illness or injury, which will guide your physician(s) when providing treatment. Notwithstanding this document, you still have the right to make medical and other health care decisions for yourself so long as you can give informed consent regarding the particular decision. As long as you can speak for yourself, Plan Providers will honor your wishes. But, if you become so incapacitated that you cannot make an informed decision, this directive will guide your health care treatment based on the directions you set out in the Advance Directive.

There are two basic types of Advance Directives in California that provide legal protection for your physicians if a disagreement results about following your wishes. They are:

- Durable Power of Attorney for Health Care Decisions (DPAHCD), and
- Natural Death Act Declaration.

The preferred document is the DPAHCD. Blank Advance Directive Forms of either type can be purchased in most stationary stores or a VHP Member Services Representative can direct you on where you can obtain one.

The policies involving your right to make medical treatment decisions may vary from facility to facility. For example, it is typical in operating rooms to suspend Advance Directives and provide all appropriate resuscitative and life-prolonging treatment during surgery and recovery.

It is your responsibility to inquire about and comply with the policies of your hospital or other health care facility on carrying out Advance Directives. Provide copies of your completed Advance Directive to your physician, your representative (if designated), and your family. Be sure to keep a copy for yourself and take one with you when you are hospitalized.

You are not required to have an Advance Directive. If you do not have an Advance Directive, you can and will still be treated.

If you have any questions regarding your health care choices or need more information, please contact your Primary Care Physician or Member Services Representative.

Termination Of Benefits

Once enrolled, your coverage may be canceled only for the Disenrollment and Termination of Benefits reasons identified below. If you voluntarily disenroll by contacting Member Services Representative to complete and sign a Disenrollment, you may request a copy of the disenrollment with the effective date of termination. If you or your Dependents coverage is terminated involuntarily, notification of the date of termination will be distributed to you.

Until the effective date of your Disenrollment or Termination date, you will remain a VHP Member and are responsible to:

- continue to receive all Covered Services from Plan Providers (except in the event of an Emergency),
- pay for all applicable Membership Premiums, and
- continue to adhere to all requirements of your membership with VHP.

Once your Disenrollment or Termination from the Benefit Plan becomes effective, your Identification Card will no longer be valid for obtaining health care.

You may not be reinstated automatically if coverage is canceled or terminated.

Fraudulent use of your Identification Card, the services or facilities of VHP or its Plan Providers, and/or fraud or misrepresentation on the enrollment application form will result in an investigation and appropriate legal action.

If you have additional questions about the Disenrollment or Termination process, please review the following sections and/or a VHP Member Services Representative at (408) 885-4760 or 1-888-421-8444.

Loss of Eligibility

If you cease to meet VHP eligibility requirements, then your and your Dependent's coverage will involuntarily terminate. (Subject to the provisions for continuation or coverage or conversion of benefits.)

You agree to notify VHP immediately if you or your Dependents cease to meet the eligibility requirements. (Refer to "Eligibility" section.)

You lose eligibility if:

- You work and reside outside the Service Area for an uninterrupted period of more than ninety (90) consecutive days with no intention of returning.

Your legal spouse loses eligibility if:

- Upon dissolution of the marriage, Coverage for a Subscriber's spouse will automatically terminate. In addition, the enrollment of all of the spouse's Dependents who are not also Eligible Dependents of the Subscriber will terminate. Coverage will terminate on the last day of the month of the dissolution of marriage.
- He/she moves out of the service area, he/she is covered for Emergency Services only.

Your domestic partner (if applicable, and as defined by your former employer's Group Service Agreement or as in accordance with State and federal requirements) loses eligibility if:

- Upon dissolution of the relationship as certified by you, Coverage for a Subscriber's domestic partner will automatically terminate. In addition, the enrollment of all of the domestic partner's Dependents who are not also Eligible Dependents of the Subscriber will terminate. Coverage will terminate on the last day of the month of the dissolution of relationship.
- He/she moves out of the service area, he/she is covered for Emergency Services only.

Your Eligible Dependent child(ren) lose eligibility and coverage automatically terminates when they:

- Marry, regardless of age.
- Reach the age of nineteen (19) unless:
 - they are unmarried and attending a recognized college, university, trade school or secondary school on a full-time basis (as determined by the applicable educational institution and agreed to by VHP), then once they reach age twenty-four (24); or
 - are incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred before age nineteen (19) and are chiefly dependent on you for support and maintenance, then coverage will discontinue the earlier of the date the child recovers from the handicap or the date the child is no longer chiefly dependent on you for support and maintenance.
- Move out of the service area, he/she is covered for Emergency Services only. Non-emergent services as provided or arranged through Plan Providers are available in the Service Area.

Your Dependent(s) may also lose eligibility in the event of your death.

- If the Subscriber dies, Dependent Member(s) must contact VHP for details on Disenrollment or continued Coverage for Members.

Disenrollment by Member

If you or your Dependents elect coverage under another health benefits plan available to you or your Dependents, then your Coverage terminates automatically at the time and date the alternate coverage becomes available or effective. You agree to notify VHP immediately that you or your Dependents have elected coverage or you or your Dependents have the option of enrolling in other coverage elsewhere.

You or your Dependents may voluntarily disenroll from VHP at any time and for any reason. You may disenroll by notifying VHP in writing of your intent to cancel your membership. Your Coverage terminates at midnight on the last day of the month in which payment or notification from you was received.

Cancellation of Members for Cause

VHP may terminate your membership and the membership of your Dependents, effective immediately upon written notice to you, if:

1. You knowingly give us incorrect or incomplete material information in any document or if you fail to notify us of material changes in your family status or Medicare coverage that may affect eligibility for membership or Benefits; or
2. You or your Dependent(s) knowingly misrepresents membership status; or
3. You or your Dependent(s) knowingly presents an invalid prescription; or
4. You or your Dependent(s) misuse a VHP ID Card by:
 - using someone else's VHP ID Card, or
 - using an invalid VHP ID Card, or
 - allowing someone else to use your VHP ID Card, or
 - engaging in fraud or deception in the use of the services or facilities of VHP, Plan Providers, or Non-Plan Providers; or
5. After repeated efforts to educate you, or your Dependent(s) repeatedly use Non-Plan Providers for unauthorized care (unless such care is rendered as worldwide Emergency Services); or
6. You or your Dependent(s) is abusive or disruptive to the extent that it threatens the safety of employees, providers, members and/or patients or the Member's repeated behavior substantially impairs the Plan's ability to furnish or arrange services for the Member or other members or a Provider's ability to provide services to other patients. Cancellation of a Dependent for cause will solely apply to the Dependent involved and will not affect the enrollment of the Subscriber or any other Dependents.

Termination for cause as a result of (5), and/or (6) above is made after VHP has:

- Made a good faith effort to resolve the problem, or
- Made attempts to re-educate you on how to use VHP services, or
- Considered all circumstances, and
- Documented all problems, efforts, and medical conditions.

You may use the Grievance procedure to contest an involuntary Disenrollment or Termination for cause. (Please refer to the "Member *Grievances*" section for details.)

Termination for Nonpayment

VHP will terminate or cancel your and/or your Dependent(s) membership as of the last day of the month for which full payment has been received subject to compliance with the following notice requirements. VHP will request payment on the first of the month preceding the month in which payment is due (e.g. invoice will be sent June 1 for a July 1 due date). If payment is not made within at least 15 days prior your premium due date, a notice of non-receipt of payment including a notice of cancellation will automatically be sent. The notice of nonreceipt of payment/cancellation will be sent to the Subscriber's address of record. If payment is not received within 15 days from the date of mailing of the notice, all rights of the Subscriber and Dependents shall terminate as of the first of the month at 12:00 a.m. for which no payment has been received. If the notice of nonreceipt of payment/cancellation is not mailed on the 15 days prior to the first of the month for which no payment has been received, termination will take place 15 days following the date of mailing.

After the effective date of Termination for non-payment, you and your Dependent(s) may not reinstate membership. If your payment is received more than fifteen days after issuance of the notice of cancellation, the Plan will refund your payment within 20 business days.

Medicare Enrollment

VHP will terminate your membership or the membership of your Dependents if you or your Dependent(s) who is/are eligible to be covered by Medicare. Please call VHP to discuss your termination and/or your options for continuation of coverage.

Enlistment in Uniformed Services

VHP may terminate your membership or the membership of your Dependent(s) if you or your Dependent(s) enter full-time service in any branch of the armed forces (enlistment) and you become eligible for and become covered by other health coverage.

If you or your Dependents enlist, please call VHP to discuss your termination and/or your options for continuation of coverage.

State Review of Termination

If you believe your membership was terminated because of your ill health or your need for health care, you may request a review by the California Department of Managed Health Care by calling 1.888.466.2219. For additional information, telephone numbers, or e-mail address, please refer to the "DMHC Consumer Help-Line" section of this EOC.

Cessation of Coverage

VHP will not cover any services or supplies provided after the effective date of termination of coverage regardless of whether you were seeing a physician or other provider for a condition or course of treatment. The only exceptions are, where applicable, the following circumstances:

- You are or your Dependent is a registered bed patient in a Plan Hospital at the date of termination of the Agreement by VHP. You or your Dependent may receive all the Benefits of your VHP coverage for the condition confining you to the hospital, subject to your payment of the premium and applicable co-payments, until those Benefits expire or you are discharged from the facility, whichever occurs first;
- You are or your Dependent is receiving inpatient obstetrical care in a Plan Facility at the date of termination, and there has been no default in premiums. You will continue to receive Coverage of inpatient obstetrical care only through discharge.

Effective Date of Termination

If VHP terminates your Coverage, VHP will notify you of the cause and effective date of your Termination. Your coverage will cease as of the date of Termination or cancellation. If you are undergoing treatment for a medical condition, services provided beyond the date of Termination or cancellation will be your financial responsibility.

Refunds in the Event of Cancellation

If your Coverage terminates, payment of premiums for any period after the termination date and any other amounts due to you will be refunded to you within thirty (30) days. Refunds are minus any amounts due to VHP or VHP Providers. If your Coverage terminates due to fraud or deception in the use of health services or facilities or you knowingly permitted such fraud or deception by another, refunds will not be made.

Conversion of Membership

If you no longer qualify as a Dependent described under "Eligibility & Enrollment" section, you may be eligible to convert to a Subscriber status under an Individual Conversion Plan. However, you are not eligible to convert if your membership ends because we terminated your membership under "Cancellation of Members for Cause" or "Termination for Nonpayment" above. You must apply to convert your membership within 31 days after your coverage ends. During this period, no medical review is required, and your conversion coverage begins when your coverage under this Agreement ends. You will have to pay premium dues, and the benefits and Copayments under the new coverage may differ from those under this Agreement.

For information about converting your membership, call our Member Services Department at (408) 885-4760.

General Information

Your Rights and Responsibilities

As a Member you have the right to:

- Exercise these rights without regard to race, disability, sex, religion, age, color, sexual orientation, creed, family history, marital status, veteran status, national origin, handicap, or condition, without regard to your cultural, economic, or educational background, or source(s) of payment for your care;
- Be treated with dignity, respect, and consideration;
- Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs;
- Be provided with information about VHP, its services, and Plan Providers;
- Know the name of the Primary Care Physician who has primary responsibility for coordinating your health care and the names and professional relationships of other Plan Providers you see;
- Actively participate in your own health care, which to the extent permitted by law, includes the right to receive information so that you can accept or refuse recommended treatment;
- Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment or procedure. Except for Emergency Services this information will include a description of the procedure or treatment, the medically significant risks involved, alternative courses of action and the risks involved in

- each, and the name of the Plan Provider who will carry out the treatment or procedure;
- Full consideration of privacy concerning your course of treatment. Case discussions, consultations, examinations, and treatments are confidential and should be conducted discreetly. You have the right to know the reason should any person be present or involved during these procedures or treatments;
 - Confidential treatment of information in compliance with state and federal law including HIPAA (including all communications and medical records) pertaining to your care. Except as is necessary in connection with administering the Agreement and fulfilling State and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written permission from you or your authorized representative;
 - Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand;
 - Give informed consent before the start of any procedure or treatment, unless medically inadvisable;
 - Refuse health care services to the extent permitted by law and to be informed of the medical consequences of that treatment, unless medically inadvisable;
 - Readily accessible and ready referral to Medically Necessary Covered Services;
 - A second medical opinion, when medically appropriate, from another Plan Physician within your VHP Network;
 - Be able to schedule appointments in a timely manner;
 - Reasonable continuity of care and advance knowledge of the time and location of your appointment(s);
 - Reasonable responses to any reasonable requests for Covered Services;
 - Have all lab reports, X-rays, specialist's reports, and other medical records completed and placed in your files as promptly as possible so that your Primary Care Physician can make informed decisions about your treatment;
 - Change your Primary Care Physician;
 - Review your medical records, unless medically inadvisable;
 - Be informed of any charges (Copayments) associated with Covered Services;
 - Be advised if a Plan Provider proposes to engage in or perform care or treatment involving experimental medical procedures, and the right to refuse to participate in such procedures;
 - Leave a Plan Facility or Hospital, even against the advice of Plan Providers;
 - Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals;
 - Be informed of, and if necessary, given assistance in making a medical Advance Directive;
 - Have rights extended to any person who legally may make decisions regarding medical care on your behalf;
 - Know when Plan Providers are no longer under a contractual arrangement with VHP;
 - Examine and receive an explanation of any bill(s) for non-Covered Services, regardless of the source(s) of payment;
 - File a Grievance without discrimination through VHP or appropriate State or federal agencies;
 - Know the rules and policies that apply to your conduct as a Member;
 - Adhere to behavior that is reasonably supportive of therapeutic goals and professional supervision as specified;
 - Behave in a manner that doesn't interfere with your Plan Provider or their ability to provide care;
 - Safeguard the confidentiality of your own personal health care as well as that of other Members;

- Accept fiscal responsibility associated with non-Covered Services. Covered Services are available only through Plan Providers in your VHP Network (unless such care is rendered as worldwide Emergency Services or is Prior Authorized);
- Cooperate with VHP or a Plan Provider's third party recovery efforts;
- Participate in your health care by scheduling and keeping appointments with Plan Providers. If you cannot keep your appointment, call in advance and reschedule or cancel;
- Report any changes in your name, address, telephone number, or your family's status to a Member Services Representative immediately.

Governing Law

VHP is subject to State and federal laws, including the Knox-Keene Health Care Service Plan Act, and the regulations issued by the DMHC. The terms and provisions of the Agreement may be amended or modified if the law requires such amendments or modifications. Any provisions required in this Combined Evidence of Coverage and Disclosure Form by the above regulations will bind you and VHP whether or not expressly provided for in this document.

Suspension of Services

In the event of an emergency or circumstances not within the control of VHP, suspension of services may occur. Suspension of services may result in the facilities, personnel, or resources of VHP or its Plan Providers becoming unavailable to provide or arrange for health care services pursuant to the Agreement. Taking into account the nature of the event, VHP's obligation will be limited to the requirement that it make a good-faith effort to provide or arrange for Covered Services.

Privacy Practices & Protected Health Information (PHI)

VHP adheres to HIPAA and protects PHI as required by law. VHP agrees to maintain and preserve the confidentiality of any and all Protected Health Information. VHP also requires its contracting providers to protect your PHI in your medical records and such information from Plan Providers will be kept confidential in accordance with State and federal law. PHI is health information that includes your name, Social Security number, or other information that reveals who you are.

Except as is necessary in connection with administering the Agreement and fulfilling State and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written consent from you or your authorized representative. However, by the terms of the Agreement you authorize the release of information and access to any and all of your medical records. Such release of your medical records without your written consent include the purposes of utilization review, quality assurance, processing of any claim, financial audit, or any other purpose reasonably related to the provision of Coverage to VHP, its agents and employees, your Primary Care Physician, and appropriate governmental agencies.

As a member of VHP, you may request a copy of VHP's Notice of Privacy Practices by contacting VHP's Member Services, or view this information on VHP's Web site at <http://vhp.sccgov.org>.