

Medicare Supplement Plan G Extra

Evidence of Coverage and Health Service Agreement

Medicare Supplement

An independent member of the Blue Shield Association

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MEDICARE SUPPLEMENT PLAN G EXTRA

EVIDENCE OF COVERAGE AND HEALTH SERVICE AGREEMENT

This Evidence of Coverage and Health Service Agreement (“Agreement”) is issued by California Physicians’ Service dba Blue Shield of California (“Blue Shield”), a health care service plan, to the Subscriber whose name, group number, Subscriber identification number, and Effective Date shall appear on his or her identification card.

In consideration of statements contained in the Subscriber's application and payment in advance of dues as stated in this Agreement, Blue Shield agrees to provide the benefits of this Agreement and any Endorsement to this Agreement.

NOTICE TO BUYER OR NEW SUBSCRIBER

This Agreement may not cover all of your medical expenses. Please read this Agreement carefully. If you have any questions, contact the Blue Shield of California office nearest you or call Customer Service at the telephone number indicated on your Identification Card. If you are not satisfied with the Agreement, you may surrender it by delivering or mailing it with the identification (ID) card(s), within 30 days from the date it is received by you, to Blue Shield of California, 601 12th Street, Oakland, California 94607, or to any Blue Shield of California branch office. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and any dues paid will be refunded. Blue Shield of California is not connected with Medicare.

This contract does not cover custodial care in a skilled nursing care facility.

DURATION OF THE AGREEMENT, RENEWALS, AND RATE CHANGES

This Agreement shall be renewed each billing period so long as dues are prepaid. Such renewal is subject to the right reserved by Blue Shield to modify or amend this Agreement.

Blue Shield reserves the right to change the dues amount. The amount of dues is determined by the Subscriber’s age, and rates will be changed automatically based on attained age.

Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare-determined Deductible and coinsurance amounts. Dues may be modified to correspond with such benefits. Any proposed increase in dues or decrease in benefits including but not limited to covered Services, Deductibles, copayments and any copayment maximum amounts as stated herein will become effective after a period of at least 60 days notice to the Subscriber's address of record with Blue Shield.

Subscriber Bill of Rights

As a Blue Shield Medicare Supplement Plan Subscriber, you have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health Services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your Medicare Supplement Plan, the Services we offer you, and the Physicians and other practitioners available to care for you.
5. Have reasonable access to appropriate medical services.
6. Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
7. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
8. Receive from your Physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Know and understand your medical condition, treatment plan, and expected outcome, and the effects these have on your daily living.
10. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
11. Communicate with and receive information from Customer Service in a language you can understand.
12. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
13. Voice complaints or grievances about the Medicare Supplement Plan or the care provided to you.
14. Participate in establishing Public Policy of the Blue Shield Medicare Supplement Plans, as outlined in your Evidence of Coverage and Health Service Agreement.
15. Make recommendations regarding Blue Shield's Member rights and responsibilities policy.

Subscriber Responsibilities

As a Blue Shield Medicare Supplement Plan Subscriber, you have the responsibility to:

1. Carefully read all Blue Shield Medicare Supplement Plan materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out-of-pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield Medicare Supplement membership as explained in the Evidence of Coverage and Health Service Agreement.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that your Physician and/or Blue Shield need to provide appropriate care for you.
4. Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
8. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield Medicare Supplement Plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address and other health plan coverage.
11. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
12. Treat all Blue Shield personnel respectfully and courteously as partners in good health care.
13. Pay your dues, copayments, and charges for non-covered Services on time.

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MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,556	\$1,556 (Part A deductible)	\$0
61 st through 90 th day	All but \$389 a day	\$389 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$778 a day	\$778 a day	\$0
Once lifetime reserve days are used: • Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
• Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$194.50 a day	Up to \$194.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 Pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment/ Coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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MEDICARE (PART B)

MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts*	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
First 3 Pints (Part B)	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts*	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

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PARTS A & B

* Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$233 of Medicare-approved amounts*	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	\$0	100%	\$0
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC			
	\$0	\$0	\$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at blueshieldca.com/medicareOTC . Limitations may apply. Refer to the OTC Items Catalog for more information.			
Up to two orders per quarter	\$0	Up to \$100 allowance per quarter	All costs above the \$100 allowance per quarter

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Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at blueshieldca.com . Click on <i>Find a doctor</i> .			
Comprehensive eye exam once every 12 months	\$0	In-Network: 100% after the \$20 copayment Out-of-Network: Up to \$50 allowance	In-Network: \$20 copay Out-of-Network: All costs above the \$50 allowance
Eyeglass frame once every 24 months	\$0	In-Network: Up to \$100 allowance Out-of-Network: Up to \$40 allowance	In-Network: All costs above the \$100 allowance Out-of-Network: All costs above the \$40 allowance
Eyeglass lenses once every 12 months <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal 	\$0	In-Network: 100% after the \$25 copayment Out-of-Network Single Vision: Up to \$43 allowance Bifocal: Up to \$60 allowance Trifocal: Up to \$75 allowance Aphakic or lenticular monofocal or multifocal: Up to \$104 allowance	In-Network: \$25 copay Out-of-Network: All costs above the allowance

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Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>VISION SERVICES - Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at blueshieldca.com. Click on <i>Find a doctor</i>.</p>			
<p>Contact lenses (instead of eyeglass lenses) once every 12 months</p> <ul style="list-style-type: none"> • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected 	<p>\$0</p>	<p>Non-elective In-Network: Up to \$500 allowance after the \$25 copayment</p> <p>Non-elective Out-Of-Network: Non-elective (Hard or Soft): Up to \$200 allowance</p> <p>Elective In-Network: Up to \$120 allowance after the \$25 copayment</p> <p>Elective Out-Of-Network: Up to \$100 allowance</p>	<p>Non-elective and Elective In-Network: \$25 copay</p> <p>Non-elective and Elective Out-Of-Network: All costs above the allowance</p>

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Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HEARING AID SERVICES - Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. EPIC Participating Providers are listed at blueshieldca.com/HearingAids. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.</p>			
<p>Hearing aid Benefits every year include:</p> <ul style="list-style-type: none"> • One in-person routine hearing exam 	\$0	100%	\$0
<ul style="list-style-type: none"> • Hearing aid instrument <ul style="list-style-type: none"> o Up to two hearing aids delivered in-person through a network hearing aid provider or directly to the member’s home depending on the hearing aid type and care delivery method selected o Choice of private-labeled Silver (mid-level) or Gold (premium level) technology hearing aid models o Silver technology hearing aids: <ul style="list-style-type: none"> – available in the behind-the-ear hearing aid style only – choice of virtual or in-person delivery o Gold technology hearing aids: <ul style="list-style-type: none"> – available in multiple styles – choice of virtual or in-person delivery – virtual delivery is available for the behind-the-ear and receiver-in-the-ear hearing aid styles – in-person delivery is available for the in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles – standard ear molds and impressions are available in-person as needed o All technology levels include: <ul style="list-style-type: none"> – one consultation – up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase – consultation and follow-up visits are delivered in-person or virtually depending on the hearing aid type and care delivery method selected – charging case for rechargeable battery models or a two-year supply of batteries per hearing aid; and – three-year extended warranty. 	\$0	\$0	<p>Silver Technology Level \$449 per hearing aid</p> <p>Gold Technology Level \$699 per hearing aid</p>

IMPORTANT!

No person has the right to receive the benefits of this plan for Services furnished following termination of coverage except as specifically provided under the extension of benefits, Part I.B. of this Agreement. Benefits of this plan are available only for Services furnished during the term it is in effect and while the individual claiming benefits is actually covered by this Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of this Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply to Services furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Agreement.

I: CONDITIONS OF COVERAGE AND PAYMENT OF DUES

A. ENROLLMENT

1. Enrollment of a Subscriber

An eligible Applicant becomes a Subscriber under this Agreement upon notification by Blue Shield that his or her properly completed application for enrollment has been approved by Blue Shield.

2. Enrollment in Blue Shield's Household Savings Program

Any two individuals living in the same Household, and sharing the same mailing address, who are enrolled for coverage in the same Medicare Supplement Plan are eligible for a 7% monthly savings on the Household's combined premiums. Each Applicant in a Household must be individually eligible and must be at least 65 years old in order to take advantage of the savings program. Applicants need not apply at the same time for the Medicare Supplement Plan in order to qualify for the 7% savings.

a. Limitations and Definitions Applicable to the Household Savings Program

i.) Household means the permanent residence of each Subscriber. The Household Savings Program will no longer apply if one of the two members no longer permanently resides in the same household or shares the same mailing address, or is no longer enrolled in the same Blue Shield Medicare Supplement Plan.

3. Effective Date of Benefits

A Subscriber is entitled to the benefits of this Agreement upon the effective date of coverage. The effective date will be assigned by Blue Shield and is the later of the following dates: 1) on the first day of the month following the date a properly completed application is received,

and if underwriting is required when approved, by Blue Shield or 2) on the date established by Blue Shield if confirmation of a disenrollment from a Medicare Advantage plan or other health plan or policy is required before coverage can begin under this Agreement.

4. No Other Coverage

A Subscriber is only entitled to the benefits of this Agreement, regardless of coverage under any prior Blue Shield plan. No Subscriber under this Agreement shall simultaneously hold coverage under any other Blue Shield plan.

B. TERMINATION/CANCELLATION, REINSTATEMENT, AND SUSPENSION OF THE AGREEMENT

No Subscriber shall be terminated individually by Blue Shield for any cause other than as provided in this section I.B.

This Agreement may be rescinded or terminated, as follows:

1. Termination by the Subscriber

A Subscriber desiring to terminate this Agreement shall give Blue Shield 30-days notice.

2. Rescission by Blue Shield

By signing the enrollment application, you represented that all responses contained in your application for coverage were true, complete and accurate, to the best of your knowledge, and you were advised regarding the consequences of intentionally submitting materially false or incomplete information to Blue Shield in your application for coverage, which included rescission of this Agreement.

For underwritten plans (not guaranteed acceptance) - To determine whether or not you would be offered enrollment through this Agreement, Blue Shield reviewed your medical history based upon the information you provided in your enrollment application,

including the health history portion of your enrollment application and any supplemental information that Blue Shield determined was necessary to evaluate your medical history and status. This process is called underwriting.

Blue Shield has the right to rescind this Agreement if the information contained in the application or otherwise provided to Blue Shield by you or anyone acting on your behalf in connection with the application was intentionally and materially inaccurate or incomplete. This Agreement also may be rescinded if you or anyone acting on your behalf failed to disclose to Blue Shield any new or changed facts arising after the application was submitted but before this Agreement was issued, when those facts pertained to matters inquired about in the application. However, after 24 months following the issuance of the Agreement, Blue Shield of California will not rescind the Agreement for any reason.

If after enrollment, Blue Shield investigates your application information, we will not rescind this Agreement without first notifying you of the investigation and offering you an opportunity to respond.

If this Agreement is rescinded, it means that the Agreement is voided retroactive to its inception as if it never existed. This means that you will lose coverage back to the original Effective Date. If the Agreement is properly rescinded, Blue Shield will refund any dues payments you made, but, to the extent permitted by applicable law, may reduce that refund by the amount of any medical expenses that Blue Shield paid under the Agreement or is otherwise obligated to pay. In addition, Blue Shield may, to the extent permitted by California law, be entitled to recoup from you all amounts paid by Blue Shield under the Agreement.

If this Agreement is rescinded, Blue Shield will provide a 30 day advance written notice that will: (a) explain the basis of the decision and your appeal rights, including your right to request assistance from the California Department of Managed Health Care; (b)

clarify that, in the case of a qualifying applicant utilizing the Household Savings Program whose application information was not false or incomplete is entitled to new coverage without medical underwriting and will explain how that individual may obtain this coverage; and (c) explain that the monthly Dues for that individual will be determined based on that individual's age.

3. Termination by Blue Shield if Subscriber is No Longer Enrolled in Medicare

This Agreement shall terminate on the date the Subscriber is no longer enrolled under Parts A and B or Medicare. Blue Shield shall refund the prepaid dues, if any, that Blue Shield determines will not have been earned as of the termination date. Blue Shield reserves the right to subtract from any such dues refund any amounts paid by Blue Shield for benefits paid or payable by Blue Shield prior to the termination date.

4. Cancellation of the Agreement for Nonpayment of Dues

Blue Shield may cancel this Agreement for failure to pay the required Dues. If the Agreement is being cancelled because you failed to pay the required Dues when owed, the Plan will send a Notice of Start of Grace Period and will terminate the day following the 30-day grace period. You will be liable for all Dues accrued while this Agreement continues in force including those accrued during this 30 day grace period.

Within five (5) business days of canceling or not renewing the Agreement, Blue Shield will mail you a Notice of End of Coverage, which will inform you of the following:

- a. That the Agreement has been cancelled, and the reasons for cancellation;
- b. The specific date and time when coverage for you ended.

5. Reinstatement of the Agreement after Cancellation

If the Agreement is cancelled for nonpayment of dues, Blue Shield will permit reinstatement

of the Agreement or coverage twice during any twelve-month period, without a change in dues and without consideration of your medical condition, if the amounts owed are paid within 15 days of the date the Notice of End of Coverage is mailed to you. If your request for reinstatement and payment of all outstanding amounts is not received within the required 15 days, or if the Agreement is cancelled for nonpayment of dues more than twice during the preceding twelve-month period, then Blue Shield is not required to reinstate your coverage, and you will need to reapply for coverage.

6. Extension of Coverage for Total Disability

If the Subscriber is Totally Disabled at the time this coverage terminates under this Agreement, Blue Shield shall extend the benefits of the Agreement for covered Services provided in connection with the treatment of the Sickness or Accidental Injury responsible for such Total Disability until the first to occur of the following:

- a. the end of the period of Total Disability;
- b. the date on which the Subscriber's applicable maximum benefits are reached; or
- c. a period equivalent in duration to the contract benefit period of three (3) months subject to the following:
 - i) written proof of Total Disability is received by Blue Shield within ninety (90) days of the date on which coverage was terminated; and
 - ii) only a person licensed to practice medicine and surgery as a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.) may certify Total Disability.

If the Subscriber obtains any other Medicare supplement plan or other health plan coverage without limitation as to the Totally Disabled condition during the period he is receiving benefits under this extension of benefits provision, the benefits of the Agreement will

terminate when benefits are payable under such other plan.

7. Suspension of Coverage

a) Entitlement to Medi-Cal

If a Subscriber becomes entitled to Medi-Cal, the benefits of this Agreement will be suspended for up to 24 months. The Subscriber must make a request for suspension of coverage within 90 days of Medi-Cal entitlement. Blue Shield shall return to the Subscriber the amount of prepaid dues for the period after the date of suspension, if any, minus any monies paid by Blue Shield for claims during that period. If the Subscriber loses entitlement to Medi-Cal, the benefits of this Agreement will be automatically reinstated as of the date of the loss of entitlement, provided the Subscriber gives notice to Blue Shield within 90 days of that date and pays any dues amount attributable to the retroactive period.

b) Total Disability While Covered Under Group Health Plan

Blue Shield shall suspend the benefits and dues of this Agreement for a Subscriber when that Subscriber:

- i) is Totally Disabled as defined herein and entitled to Medicare Benefits by reason of that disability;
- ii) is covered under a group health plan as defined in section 42 U.S.C. 1395y(b)(1)(A)(v); and
- iii) submits a request to Blue Shield for such suspension.

After all of the above criteria have been satisfied, benefits and dues of this Agreement for the Subscriber will be suspended for any period that may be provided by federal law.

For Subscribers who have suspended their benefits under this Agreement as specified above, and who subsequently lose coverage under their group health plan, the benefits and dues of this Agreement will be reinstated only when:

- i) the Subscriber notifies Blue Shield within 90 days of the date of the loss of group coverage; and
- ii) the Subscriber pays any dues attributable to the retroactive period, effective as of the date of loss of group coverage.

The effective date of the reinstatement will be the date of the loss of group coverage. Blue Shield shall:

- i) provide coverage substantially equivalent to coverage in effect before the date of suspension;
- ii) provide dues classification terms no less favorable than those which would have been applied had coverage not been suspended; and
- iii) not impose any waiting period with respect to treatment of preexisting conditions.

C. PAYMENT OF DUES

Blue Shield of California offers a variety of options and methods by which you may pay your dues. Please call Customer Service at the telephone number indicated on your Identification Card to discuss these options. Dues payments by mail should be sent to:

Blue Shield of California
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional dues may be charged in the event that a state or any other taxing authority imposes upon Blue Shield a tax or license fee which is calculated upon base dues or Blue Shield's gross receipts or any portion of either.

Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare-determined Deductible and coinsurance amounts. Dues may be modified to correspond with such changes.

Dues are determined based on age of the Subscriber, subject to the right reserved by Blue Shield to modify these dues with at least

sixty (60) days notice as set forth in this Agreement.

II: SERVICE BENEFITS

Benefits provided by this Agreement (but only to the extent they are not hereafter excluded) are for the necessary treatment of any Sickness or Accidental Injury as follows:

A. BASIC BENEFITS

1. Blue Shield will pay the following:
 - a) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
 - b) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used. Each Medicare beneficiary is given sixty (60) lifetime reserve days which begin from the 91st day and after;
 - c) Upon exhaustion of the Medicare hospital inpatient coverage including the sixty (60) lifetime reserve days, coverage for the Medicare Part A Eligible Expenses for hospitalization will be paid at the appropriate standard of payment which has been approved by Medicare, subject to a lifetime maximum benefit of an additional 365 days (except that psychiatric care in a psychiatric hospital participating in the Medicare program is limited to 190 days during the Subscriber's lifetime);
 - d) Room and board charges shall be no more than the charge for a semi-private accommodation in the Hospital of confinement, unless confinement in a subacute skilled nursing facility or private room is certified as medically necessary by an attending Physician.
2. Blue Shield will pay the following:
 - a) Coverage for Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of

packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations. For any additional expenses incurred under Medicare Part B, the Subscriber must pay a Medicare Part B Deductible, after which payment will be made at 20% of the billed charges for Medicare Eligible Expenses;

- b) Blue Shield will provide coverage for the coinsurance amount or, in the case of hospital outpatient Services, the copayment amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible provided the Subscriber is receiving concurrent benefits from Medicare for the same Services.
 - c) Blue Shield will provide coverage for hospice care which includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
3. Benefits for the coverage listed above shall be paid when the Subscriber is not entitled to payment for such Services under Medicare by reason of exhaustion of Medicare Benefits or reductions for coinsurance and Deductibles required under Medicare.

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the “911” emergency response system where available.

B. ADDITIONAL BENEFITS

Blue Shield will pay the following:

- 1. Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible Amount per Benefit Period.
- 2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care, including subacute care, eligible under Medicare Part A.

- 3. One Hundred Percent (100%) of the Medicare Part B Excess Charges after deductible.

After the Medicare Part B deductible has been met, Blue Shield will pay 100% of the difference between the amount paid by Medicare and the amount billed, not to exceed any charge limitation established by Medicare or state law.

The following Services are benefits under this section provided the Subscriber is receiving concurrent benefits from Medicare for the same Services:

- a) Physician's Services;
- b) Services of a registered physiotherapist (other than one who ordinarily resides in the Subscriber's home or is related to the Subscriber by blood or marriage) acting under the direction of a Physician;
- c) Rental or purchase of wheelchairs, hospital beds, iron lungs, and other durable medical equipment (rental costs not to exceed the purchase price);
- d) Artificial limbs, artificial eyes, and colostomy supplies;
- e) Professional ambulance Services when considered medically necessary to or from a Hospital, Skilled Nursing Facility, or the Subscriber's home;
- f) Hospital Services rendered to the Subscriber on an Outpatient basis;
- g) Professional charges for diagnostic X-ray and laboratory tests rendered to the Subscriber;
- h) Speech pathology Services where such Services are provided in clinics participating in the Medicare program;
- i) Home health Services (if not already provided under Medicare Part A) furnished by home health agencies participating in the Medicare program;
- j) Immunosuppressive drugs during the first 36 months of a Medicare covered transplant.

5. Medically Necessary Emergency Care in a Foreign Country.

When a Subscriber requires Emergency Care to which he would be entitled to Medicare benefits while within the United States and to which he loses his entitlement solely by reason of his temporary absence from the United States, Blue Shield will pay, in addition to the other benefits of this Agreement, the benefits that Blue Shield determines he would otherwise have been entitled to from Medicare subject to the following:

- a) Medically necessary Emergency Care which begins during the first 60 consecutive days of each trip outside the United States;
 - b) After a Calendar Year deductible of \$250*, Blue Shield payment is made at 80% of the billed charges for Medicare Eligible Expenses;
 - c) The lifetime maximum Blue Shield payment is \$50,000.
6. SilverSneakers® Fitness. SilverSneakers is your fitness benefit, provided for you with no copayment. The program includes access to 13,000+ fitness locations* nationwide, exercise equipment and other amenities, a support network, online resources and group exercise classes led by certified instructors.

SilverSneakers currently offers the following classes. You can find the full class descriptions at silversneakers.com.

- a. **Signature SilverSneakers classes** designed for all levels and abilities are offered in traditional fitness classrooms inside the gym.
- b. More than 70 **SilverSneakers FLEX®** class options including Latin dance, yoga, tai chi and walking groups are offered in settings outside the traditional gym.
- c. Three **BOOM®** classes, MIND, MUSCLE and MOVE IT, offer more intense workouts inside the gym. The 30-minute classes can be modified to fit individual participants' comfort levels.

To start using the program, simply show your personal SilverSneakers ID number at the front desk of any participating location. You may get your SilverSneakers ID number and find fitness locations and classes at silversneakers.com. If you have additional questions about the program, call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.

When you go to the fitness location of your choice, the staff will assist you with enrolling. You may also ask for a tour of the location to see all the amenities and where the classrooms are located. You may use any participating fitness location in the nation.

*At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound.

7. NurseHelp 24/7: Subscribers may call a registered nurse via 1-877-304-0504, a 24-hour, toll-free telephone number to receive confidential advice and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics. There is no charge for these services.
8. Hearing aid services: Blue Shield hearing aid services benefits are administered by EPIC Hearing Healthcare (EPIC). EPIC is a hearing care service plan which contracts with Blue Shield to administer delivery of hearing aid examinations, instruments and services related to the hearing aid instruments covered under this hearing aid services benefit.

The Summary of Benefits sets forth the Member's share-of-cost for covered services under the benefit plan. This benefit is designed for Members to obtain covered services from participating providers within the EPIC network. EPIC Participating Providers may be located online at blueshieldca.com/HearingAids or by contacting EPIC directly at 1-888-370-8949, TTY: 711 Monday through Friday, 6:00 a.m. to 6:00 p.m. PT. If you choose to use EPIC Non-

Participating Providers, those services will not be covered.

Hearing aid benefits every year include:

- a) routine hearing aid exam – one in-person hearing examination. Evaluation/screening includes a pure tone audiometry (threshold) test also referred to as an air conduction test for the appropriate type of hearing aid.
- b) hearing aid instruments – up to two hearing aids delivered in-person through a network hearing aid provider or directly to the Member’s home depending on the hearing aid type and care delivery method selected. Choice of hearing aids include:
 - i. Private-labeled Silver (mid-level) technology.
 - ii. Private-labeled Gold (premium level) technology.
- c) hearing aid services - provided when hearing aid devices are obtained from participating providers as follows:
 - i. one hearing aid consultation.
 - ii. up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase.
 - iii. consultation and follow-up visits are delivered in-person or virtually depending on the hearing aid type and care delivery method selected.
 - iv. charging case for rechargeable battery models or a two-year supply of batteries per hearing aid.
 - v. three-year extended warranty which includes coverage for loss, damage and servicing. Sixty day hearing aid device evaluation period subject to a restocking fee of \$175 (if applicable) which is the Member’s responsibility for returned hearing aids.
 - vi. Silver technology level hearing aids include:

- available in the behind-the-ear hearing aid style only.
 - choice of virtual or in-person delivery.
- vii. Gold technology level hearing aids include:
- available in multiple styles.
 - choice of virtual or in-person delivery.
 - virtual delivery is available for the behind-the-ear and receiver-in-the-ear hearing aid styles.
 - in-person delivery is available for the in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles.
 - standard ear molds & impressions are available in-person as needed.

Note: Once you choose in-person or virtual delivery of your hearing aid instrument(s), all follow-up care will be delivered in the same manner. So, if you choose virtual delivery, then your follow-up care will also be delivered virtually.

9. Vision: Blue Shield’s vision benefits are administered by Vision Service Plan (VSP), a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this vision benefit. VSP also contracts with Blue Shield to serve as a claims administrator for the processing of claims for covered services.

Choice of Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM AND WHAT CARE MAY BE OBTAINED.

This Blue Shield vision benefit is designed for Members to obtain covered services from VSP

Participating Providers within the VSP network. A Directory of VSP Participating Providers is available on Blue Shield's internet site located at www.blueshieldca.com. You may also obtain this information by calling VSP Customer Service at 1-800- 877-7195.

A Member may select any licensed ophthalmologist, optometrist, or optician to provide covered services hereunder, including such providers outside of California when available.

However, Members may choose to seek covered services from VSP Non-Participating Providers. Covered services obtained from VSP Non-Participating Providers will result in a higher share of cost for the Member.

Please be aware that a provider's status as a VSP Participating Provider may change. It is the Member's obligation to verify whether the provider chosen is a VSP Participating Provider prior to obtaining coverage.

VSP Participating Providers

VSP Participating Providers include licensed ophthalmologist, optometrist, or opticians that have a contractual relationship with VSP to provide covered services to Blue Shield Members of this vision plan. VSP Participating Providers agree to accept the plan's payment plus the Member's payment of any applicable copayments and amounts in excess of specified benefit maximums as payment-in-full for covered services. This is not true of VSP Non-Participating Providers.

If a Member receives covered services from a VSP Non-Participating Provider, the plan's reimbursement for those services will be substantially less than the amount billed. The Subscriber is responsible for the difference between the amount the plan pays and the amount billed by the VSP Non-Participating Provider.

The Member should contact Customer Service if the Member needs assistance locating a provider in the Member's service area. Blue Shield will review and consider a Member's

request for services that cannot be reasonably obtained in network. If a Member's request for services from a VSP Non-Participating Provider is approved at an in-network benefit level, the plan will pay for covered services at a VSP Participating Provider level.

The Member should call Customer Service or visit www.blueshieldca.com to determine whether a provider is a VSP Participating Provider and is in the Member's service area.

Benefits

The plan will pay for covered services rendered by VSP Participating Providers as indicated in the Summary of Benefits. For covered services rendered by VSP Non-Participating Providers, the plan will pay the Allowable Amount as shown in the Summary of Benefits. The Member will be responsible for all charges in excess of those amounts along with any applicable copayments.

Covered Services and Supplies

Covered services under this vision benefit are limited to the following:

- a) One comprehensive eye examination in a 12 consecutive-month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service but need not be performed at one session. The service may include history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

The comprehensive examination benefit does not include the contact lens exam

service; however, the contact lens Allowance may be used towards a contact lens fit and evaluation. You are responsible for requesting this information from your provider.

- b) One frame in a 24 consecutive-month period. Frames are covered in full, less any copayment, up to the Allowance as described in the Summary of Benefits. The Member is responsible for the additional costs above the Allowance.

Note: The difference between the Allowable Amount under the Summary of Benefits and the charges for more expensive frame styles or unusual lenses, such as oversize, no-line bifocal, or a material other than ordinary plastic, will be the Member's responsibility, whether dispensed by a VSP Participating Provider or a VSP Non-Participating Provider. VSP Participating Providers allow a selection of frame styles that retail up to the Allowance with lenses that fit an eye size less than 61 millimeters. If a more expensive frame is selected, the Member is responsible for the additional retail cost above the Allowance. If the lenses are 61 millimeters or over, any difference between the Allowance and the provider's charge is the Member's responsibility.

- c) One pair of eyeglass lenses in a 12 consecutive-month period. Lenses are covered in full, less any copayment, up to the Allowance as described in the Summary of Benefits. Each pair of eyeglass lenses includes Pinks #1 and #2 tints in the Allowance and up to 60 mm in size.
- d) Contact lenses (instead of eyeglass lenses) in a 12 consecutive-month period as follows:
 - i. One Pair of non-elective (medically necessary) contact lenses, which are lenses covering the following conditions: aphakia, aniridia, anisometropia, corneal transplant, high

ametropia, nystagmus, keratoconus, heredity corneal dystrophies and other eye conditions that make contact lenses necessary. Prior authorization from the contracted VSP provider is required.

- ii. Up to a three to six-month supply of elective (chosen for cosmetic reasons or for convenience) contact lenses for each eye based on the lenses selected up to the benefit Allowance.

General Exclusions

Unless exceptions to the following are specifically made elsewhere in this booklet, no benefits are provided for:

- a) Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses.
- b) Replacement or repair of lost or broken lenses or frames except as provided under this Agreement. However, VSP does offer a discount on replacement or additional frames.
- c) Any eye examination required by an employer as a condition of employment.
- d) Medical or surgical treatment of the eyes.
- e) Services and materials for which the Subscriber is not legally obligated to pay, or services or materials for which no charge is made to the Subscriber.
- f) Comprehensive examination benefit does not include a fit and evaluation exam for contact lenses.

Payment of Benefits

Prior to service, the Member should consult their benefit information for coverage details. The Member should make an appointment with a VSP Participating Provider identifying themselves as a Blue Shield / VSP Member. The VSP Participating Provider will submit a claim for covered services online or by claim form.

VSP Participating Providers will accept the plan's payment as payment in full except as noted in the Summary of Benefits. When services are provided by a VSP Non-Participating Provider, the Provider may submit the claim or the Member can follow the "How to Submit a Member Reimbursement Form" found on www.VSP.com or contact VSP Customer Service at 1-800- 877-7195. The claim can be submitted via the online portal or submitted to the following address:

Vision Service Plan
Attn: Claims Services
P O Box 385018
Birmingham, AL 35238-5018

If the Member receives services from a VSP Non-Participating Provider, payment will be made directly to the Subscriber, and the Member is responsible for payment to the VSP Non-Participating Provider.

Every VSP Participating Provider's contract stipulates the Member shall not be responsible to the VSP Participating Provider for compensation with respect to any services to the extent they are provided in this vision benefit. When services are provided by a VSP Non-Participating Provider, the Member is responsible for any amount the plan does not pay. However, if a Member is receiving services from a VSP Participating Provider as of the date that such provider's contract is terminated, the Member's responsibility to that provider for services rendered subsequent to that termination date shall be no greater than it was for services rendered immediately prior to that termination date, until the first to occur of the following:

- a) The date that the services being rendered by such providers are completed;
- b) The date that Blue Shield makes reasonable and appropriate provision for the assumption of such services by another VSP Participating Provider; or
- c) The date that coverage for such Member is terminated.

VSP Participating Providers submit claims for payment after their services have been received. If you receive services from a VSP Non-Participating Provider, you or your provider may also submit claims for payment after services have been received.

Customer Services

If the Member has a question about these vision benefits, providers, services, or concerns regarding the quality of care or access to care that the Member has experienced, the Member may contact:

Blue Shield of California
P. O. Box 272540
Chico, CA 95927-2540

The Member may also contact Blue Shield Customer Service.

10. Teladoc: Teladoc provides Physician consultations by phone or online. Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication. Teladoc is a supplemental service that is not intended to replace care from your Physician. You may contact Teladoc by phone at 1-800-Teladoc 24/7 or by secure online video at www.teladoc.com/bsc, from 7 a.m. to 9 p.m. Pacific Time.
11. Over-the-counter (OTC) items: You are entitled to a two-time use per quarter Allowance for OTC drugs and supplies, as shown in the Summary of Benefits.

Items such as aspirin, vitamins, cold and cough preparations, and bandages are covered under this benefit. Items such as cosmetics and food supplements are not covered under this benefit.

The OTC Items Catalog and ordering instructions are available online at www.blueshieldca.com/medicareOTC. You can order items by phone at 1- 888-628-2770 (TTY: 711) from Monday to Friday between 9 a.m. and 8 p.m. or online at www.blueshieldca.com/medicareOTC.

You cannot roll over your unused Allowance into the next quarter. Additional limitations

may apply. Refer to the OTC Items Catalog for more information.

C. MEDICARE ASSIGNMENT

If a provider accepts the assignment method of payment under Medicare, Blue Shield's payment is limited to the difference between the amount paid by Medicare and the approved charge under Medicare.

D. SECOND MEDICAL OPINION POLICY

If you have a question about your diagnosis or believe that additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, you may make an appointment with another Physician for a second medical opinion. Your attending Physician may also offer to refer you to another Physician for a second opinion.

Remember that the second opinion visit is subject to all benefit limitations and exclusions.

E. TRAVELLING OUTSIDE THE UNITED STATES

There are advantages to being a member of a Blue Shield plan. If you need urgent care while out of the country, contact the Blue Cross Blue Shield Global Core services through the toll-free BlueCard Access number at (800) 810-2583 or call collect at 1-804-673-1177 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. You should also always call us at the Customer Service number on the back of your Plan ID card. As part of this service, for inpatient hospital care, you can contact the Blue Cross Blue Shield Global Core Services Center to arrange for cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Before traveling abroad, you may want to call Customer Service for the most current listing of participating providers or you can go on-line at

www.bcbs.com and select "Find a Doctor" "Outside of the United States" or "Blue Cross Blue Shield Global Core."

III: BENEFIT PAYMENTS

Blue Shield may pay the benefits of this Agreement directly to the Physician, Hospital, or Subscriber. Providers do not receive financial incentives or bonuses from Blue Shield of California.

Claims are submitted for payment after Services are received. Requests for payments must be submitted to Blue Shield by the Physician, Hospital or the Subscriber within one (1) year after the month in which Services are rendered or the date of processing of Medicare Benefits. The claim must include itemized evidence of the charges incurred together with the documentary evidence of the action taken relative to such charges by the Department of Health and Human Services under Medicare.

Benefits for Services not covered by Medicare (Part II.B.5.) are payable upon receipt of properly completed claim forms for medically necessary emergency care in a foreign country.

All requests for payments and claim forms are to be sent to Blue Shield of California, P.O. Box 272540, Chico, California, 95927-2540.

No sums payable hereunder may be assigned without the written consent of Blue Shield. This prohibition shall not apply to ambulance Services or certain Medicare providers as required by section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) for which Blue Shield shall provide payment directly to the provider.

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

An individual Subscriber may select any Hospital or Physician to provide covered Services hereunder, including such providers outside of California that meet similar requirements as shown in the definitions of these terms.

IV: EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS

The following Services are excluded from all benefits unless otherwise stated in this Agreement or any endorsements:

1. Services incident to hospitalization or confinement in a health facility primarily for Custodial, Maintenance, or Domiciliary Care; rest; or to control or change a patient's environment.
2. Dental care and treatment, dental surgery and dental appliances.
3. Services for cosmetic purposes.
4. Services for or incident to vocational, educational, recreational, art, dance or music therapy; and unless (and then only to the extent) medically necessary as an adjunct to medical treatment of an underlying medical condition, prescribed by the attending physician, and recognized by Medicare; weight control programs; or exercise programs (with the exception of SilverSneakers® Fitness).
5. Blood and plasma, except that this exclusion shall not apply to the first three (3) pints of blood the Subscriber receives in a Calendar Year.
6. Acupuncture.
7. Physical examinations, except for a one-time "Welcome to Medicare" physical examination if received within the first 12 months of the Subscriber's initial coverage under Medicare Part B, and a yearly "Wellness" exam thereafter; or routine foot care.
8. Routine immunization except those covered under Medicare Part B preventive services.
9. Services not specifically listed as benefits.
10. Services for which the Subscriber is not legally obligated to pay, or Services for which no charge is made to the Subscriber.
11. Services for which the Subscriber is not receiving benefits from Medicare unless

otherwise noted in this booklet as a covered service.

See the Grievance Process for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your right to independent medical review.

B. EXCLUSION FOR DUPLICATE COVERAGE

In the event that an individual is both enrolled as a Subscriber under this Agreement and entitled to benefits under any of the conditions described in paragraphs 1. through 4. of this section IV.B, Blue Shield's liability for Services provided to the Subscriber for the treatment of any one (1) Sickness or Accidental Injury shall be reduced by the amount of benefits paid, or the reasonable value or the amount payable to the provider under the Medicare Program, whichever is less, of the Services provided without any liability for the cost thereof, for the treatment of that same Sickness or Accidental Injury as a result of the Subscriber's entitlement to such other benefits.

This exclusion is applicable to:

1. Benefits provided under Title XVIII of the Social Security Act (commonly known as "Medicare").
2. Any Services, including room and board, provided to the Subscriber by any federal or state governmental agency, or by any municipality, county, or other political subdivision, except that benefits provided under Chapters 7 and 8 of Part 3, Division 9 of the California Welfare and Institution Code (commonly known as Medi-Cal) or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are not subject to this paragraph.
3. Benefits to which the Subscriber is entitled under any workers' compensation or employers' liability law, provided however that Blue Shield's rights under this paragraph will be limited to the establishment of a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of the Sickness or Accidental Injury which was the basis of the Subscriber's claim for benefits under such

workers' compensation or employers' liability law.

4. Benefits provided to the Subscriber for Services under any group insurance contract or health service plan agreement through any employer, labor union, corporation or association, or under any individual policy or health service plan agreement.

C. MEDICAL NECESSITY

Unless otherwise stated in the Agreement, the benefits of this Agreement are provided only for Services which are medically necessary.

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished in accordance with generally accepted professional standards to treat Sickness, Accidental Injury, or medical condition, and which, as determined by Blue Shield, are:
 - a) consistent with Blue Shield medical policy; and
 - b) consistent with the symptoms or diagnosis; and
 - c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
 - d) furnished at the most appropriate level which can be provided safely and effectively to the patient.
2. Hospital Inpatient Services which are medically necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician's office, the Outpatient department of a Hospital, or another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient Services which are not medically necessary include hospitalization:
 - a) for diagnostic studies that could have been provided on an Outpatient basis;
 - b) for medical observation or evaluation;

- c) for personal comfort.

3. Blue Shield reserves the right, at its option, to waive this provision.

D. CLAIMS REVIEW

Blue Shield reserves the right to review all claims to determine whether any exclusions or limitations apply.

E. UTILIZATION REVIEW

NOTE: The Utilization Review process does not apply to Services that are not covered by Blue Shield because of a coverage determination made by Medicare.

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care services under the plan. Blue Shield has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the document describing this Utilization Review process, call the Customer Service Department at the telephone number indicated on your Identification Card.

V: GENERAL PROVISIONS

A. IDENTIFICATION CARDS

An Identification (ID) Card will be issued by Blue Shield to the Subscriber for presentation to Physicians and to Hospitals in order that they may bill Blue Shield directly.

B. GRIEVANCE PROCESS

Blue Shield of California has established a grievance procedure for receiving, resolving and tracking Subscribers' grievances with Blue Shield.

Customer Service

A Subscriber who has a question about Services, providers, benefits, how to use this plan, or concerns regarding the quality of care or access to care that he has experienced, may call Blue Shield's Customer Service Department at the telephone number indicated on your Identification Card.

The hearing impaired may contact Blue Shield's Customer Service Department through Blue Shield's toll-free TTY number, 711.

Customer Service can answer many questions over the telephone.

Note: Blue Shield has established a procedure for our Subscribers to request an expedited decision.

The Subscriber, physician, or representative of the Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. Blue Shield shall make a decision and notify the Subscriber and physician within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other healthcare Services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Customer Service Department.

Blue Shield may refer inquiries or grievances to a local medical society, hospital utilization review committee, peer review committee of the California Medical Association or a medical specialty society, or other appropriate peer review committee for an opinion to assist in the resolution of these matters.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or Service. Subscribers may contact Blue Shield at the telephone number noted in this Agreement. If the telephone inquiry to Customer Service does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may

request this Form from Customer Service. The completed form should be submitted to Customer Service Appeals and Grievance, P. O. Box 5588, El Dorado Hills, CA 95762-0011. The Subscriber may also submit the grievance online by visiting our web site at <http://www.blueshieldca.com>.

Blue Shield will acknowledge receipt of a grievance within five (5) calendar days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. Grievances are normally resolved within 30 days.

External Independent Medical Review

NOTE: The following Independent Medical Review process does not apply to Services that are not covered by Blue Shield because of a coverage determination made by Medicare.

If your grievance involves a claim or Services for which coverage was denied by Blue Shield in whole or in part on the grounds that the service is not medically necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service.

The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent

determination of whether the care is medically necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is medically necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid.

This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

C. DEPARTMENT OF MANAGED HEALTH CARE REVIEW

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 the telephone number indicated on your Identification Card 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

(1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's internet website (<http://www.dmhca.gov>) has complaint forms, IMR application forms and instructions online.

In the event that Blue Shield should cancel or refuse to renew your enrollment and you feel that such action was due to reasons of health or utilization of benefits, you may request a review by the Department of Managed Health Care Director.

D. REDUCTIONS – THIRD PARTY LIABILITY

If the Subscriber is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to Services required as a result of that injury, provide the benefits of this Agreement and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to the Subscriber on a fee-for-service basis from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

Blue Shield's right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other judgment, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. Blue Shield's right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due Blue Shield for the Benefits it paid in connection with such injury or illness, calculated in accordance with California Civil Code section 3040.

The Subscriber is required to:

- 1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Subscriber expects to bring or has brought**

against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate with Blue Shield to execute any forms or documents needed to enable Blue Shield to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

A Subscriber's failure to comply with 1 through 5, above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

E. INDEPENDENT CONTRACTORS

Providers are neither agents nor employees of the plan but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts or omissions of any person receiving or providing Services, including any physician, hospital, or other provider or their employees.

F. ENDORSEMENTS

Endorsements may be issued from time to time subject to the notice provisions of the section entitled Duration of the Agreement, Renewals and Rate Changes (on the front page). Nothing contained in any endorsement shall affect this

Agreement, except as expressly provided in the endorsement.

G. NOTIFICATIONS

Any notices required by this Agreement may be delivered by United States mail, postage prepaid. Notices to the Subscriber may be mailed to the address appearing on the records of Blue Shield. Notice to Blue Shield may be mailed to Blue Shield of California, P.O. Box 272540, Chico, California, 95927-2540.

H. COMMENCEMENT OR TERMINATION OF COVERAGE

Wherever this Agreement provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective as of 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

I. STATUTORY REQUIREMENTS

This Agreement is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such laws shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

J. LEGAL PROCESS

Legal process or service upon Blue Shield must be served upon a corporate officer of Blue Shield.

K. ENTIRE AGREEMENT: CHANGES

This Agreement, including the appendices and any endorsements, is the entire agreement between parties. Any statement made by a Subscriber shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by an executive officer of Blue Shield and unless a written endorsement is issued. No representative has the

authority to change this Agreement or to waive any of its provisions.

L. PLAN INTERPRETATION

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of this Agreement, to determine the benefits of this Agreement, and to determine eligibility to receive benefits under this Agreement. Blue Shield shall exercise this authority for the benefit of all Subscribers entitled to receive benefits under this Agreement.

M. NOTICE

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Blue Shield of California (hereafter referred to as "Blue Shield"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an Association of independent Blue Cross and Blue Shield plans, permitting Blue Shield to use the Blue Shield Service Mark in the State of California and that Blue Shield is not contracting as the agent of the Association.

The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Blue Shield and that neither the Association nor any person, entity, or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of Blue Shield's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Shield, other than those obligations created under other provisions of this Agreement.

N. GRACE PERIOD

After payment of the first Dues, the Subscriber is entitled to a grace period of 30 days for the payment of any Dues due. During this grace period, the Agreement will remain in force. However, the Subscriber will be liable for payment of Dues accruing during the period the Agreement continues in force.

O. CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the telephone number indicated on your Identification Card, or by accessing Blue Shield of California's internet site located at <http://www.blueshieldca.com> and printing a copy.

If you are concerned that Blue Shield may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:

Blue Shield of California Privacy Official
P.O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone:

1-888-266-8080

Email Address:

blueshieldca_privacy@blueshieldca.com

P. ACCESS TO INFORMATION

Blue Shield may need information from medical providers, from other carriers or other entities, or from you, in order to administer benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Blue

Shield that information that is reasonably needed by Blue Shield. You agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in your possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Q.PUBLIC POLICY PARTICIPATION PROCEDURE

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (Health and Safety Code, Section 1369).

At least one-third of the Board of Directors of Blue Shield is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interest in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
601 12th Street
Oakland, CA 94607
Phone: (510) 607-2065

1. Your recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.

2. Your name, address, phone number, subscriber number, and group number should be included with each communication.
3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.
4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within ten (10) business days after the minutes have been approved.

VI: DEFINITIONS

Whenever any of the following terms are capitalized in this booklet, the terms will have the meaning as indicated below:

Accidental Injury means accidental bodily injury sustained by the covered person.

Agreement means this Evidence of Coverage and Health Service Agreement, any endorsements issued by Blue Shield to this Agreement, and the Subscriber's application.

Allowable Amount (Allowance) means the total amount Blue Shield allows for covered service(s) rendered, or the provider's billed charge for those covered services, whichever is less. The allowable amount, unless specified for a particular service elsewhere in this Evidence of Coverage, is:

1. For a participating provider: the amount that the provider or contract administrator and Blue Shield have agreed by contract will be accepted as payment in full for the covered service(s) rendered.
2. For a non-participating provider: the amount Blue Shield would have allowed for a participating provider performing the same service in the same geographical area.

Applicant means the person who seeks to contract for health coverage benefits.

Benefit Period means the total duration of all successive confinements, including those that

occurred before the Effective Date of the Agreement, that are separated from each other by less than 60 days.

Calendar Year means a period beginning on January 1 of any year and ending on January 1 of the next year.

Confinement means that period of time beginning with a Subscriber's admission to a Hospital or a Skilled Nursing Facility as an Inpatient and ending with the Subscriber's discharge as a registered Inpatient from that institution.

Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility means those same terms as defined in the Medicare program.

Custodial or Maintenance Care means care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care, and/or supervisory care by a Physician); or care furnished to a person who is mentally or physically disabled, and:

1. who is not under specific medical, surgical, or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or
2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible means the amount paid by the Subscriber for specific covered Services before Original Medicare or the Blue Shield Medicare Supplement Plan begins to pay.

Domiciliary Care means care provided in a Hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

EPIC Non-Participating Provider means a licensed audiologist or Otorhinolaryngology (ENT) who has not certified and not accepted the terms of the Agreement.

EPIC Participating Provider means a licensed audiologist or Otorhinolaryngology (ENT) who has certified his willingness to accept the terms and

conditions and compensations as payment in full for covered services as set forth in the EPIC contract.

Emergency Care means care needed immediately because of Accidental Injury or a Sickness of sudden and unexpected onset.

Hospital means an institution operated pursuant to law which is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis, and which provides such facilities under the supervision of a staff of Physicians and 24-hour a day nursing service by registered graduate nurses. In no event, however, shall such term include an institution which is principally a rest home, nursing home or home for the aged.

Inpatient means a Subscriber who has been admitted to a Hospital or a Skilled Nursing Facility as a registered bed patient and is receiving Services under the direction of a Physician.

Medicare means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Medicare Benefits means those benefits actually provided under Part A (hospital benefits) or Part B (medical benefits) of Medicare to an individual having entitlement thereto, who made claim therefore, or the equivalent of those benefits.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Part A and B to the extent recognized as reasonable and medically necessary by Medicare.

Outpatient means a Subscriber receiving Services under the direction of a Physician, but not as an Inpatient.

Physician means any practitioner as defined under Medicare.

Services means medically necessary health care services and medically necessary supplies furnished incident to those services.

Sickness means an illness or disease of a covered person which first manifests itself after the

effective date of the Agreement and while coverage is in effect.

Skilled Nursing Facility means a facility which participates in the Medicare program and is licensed by the California Department of Health Services as a "Skilled Nursing Facility," or a similar institution licensed by another state, a United States Territory, or a foreign country.

Subacute Care means skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services, physical, occupational, or speech therapy; a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility, or home for the aged is not included.

Subscriber means a person whose status is the basis for eligibility for membership in this Medicare Supplement Plan, who is enrolled by Blue Shield, and maintains coverage in accordance with this Agreement.

Total Disability (or Totally Disabled) means the incapability of self-sustaining employment by reason of mental retardation or physical handicap.

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

VSP Non-Participating Provider means a licensed ophthalmologist, optometrist, or dispensing optician who has not certified and not accepted the terms of the Agreement.

VSP Participating Provider means a licensed ophthalmologist, optometrist, or optician who has certified his willingness to accept the terms and conditions and compensations as payment in full for covered services as set forth in the VSP contract.

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Officer, to take effect on the Subscriber's Effective Date.

A handwritten signature in black ink, appearing to read 'L. Saadzi', written in a cursive style.

Lina Saadzi
Vice President & General Manager, Medicare
Blue Shield of California

For information, please direct correspondence to:

Blue Shield of California
P. O. Box 272540
Chico, CA 95927-2540

You may call Customer Service toll free at: 1-800-248-2341.

The hearing impaired may call
Blue Shield of California's toll-free TTY number:
711

NOTES

MEDSUPPLANG Extra (1-23)

Pending Regulatory Approval

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