

# **PLAN F**

## **MEDICARE SUPPLEMENT PLAN**

### **EVIDENCE OF COVERAGE AND HEALTH SERVICE AGREEMENT**

This HEALTH SERVICE 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 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 Service Agreement carefully. If you have any questions, contact the Blue Shield of California office nearest you. **IF YOU ARE NOT SATISFIED WITH THE SERVICE AGREEMENT, YOU MAY SURRENDER IT BY DELIVERING OR MAILING IT WITH THE IDENTIFICATION CARDS, WITHIN 30 DAYS FROM THE DATE IT IS RECEIVED BY YOU, TO BLUE SHIELD OF CALIFORNIA, 50 BEALE STREET, SAN FRANCISCO, CALIFORNIA 94105, OR 100 N. Sepulveda Blvd., El Segundo, California 90245, OR TO ANY BLUE SHIELD OF CALIFORNIA BRANCH OFFICE.** Immediately upon such delivery or mailing, the Service Agreement shall be deemed void from the beginning, and any dues paid on it 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. Blue Shield reserves the right to change the dues amount. The amount of dues is determined by the Subscriber's age, and rate increases are automatic based on attained age. Such renewal is subject to the right reserved by Blue Shield to modify or amend this Agreement.

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 stated herein may be effected after a period of at least 30 days' notice from date of postage paid mailing to the Subscriber's address of record with Blue Shield.

## Subscriber Bill of Rights

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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.

## Subscriber Responsibilities

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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 the plan need to provide appropriate care for you.
4. 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.
5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
6. Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
7. Communicate openly with the Physician you choose so you can develop a strong partnership based on trust and cooperation.
8. Offer suggestions to improve the Blue Shield Medicare Supplement Plan.
9. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address and other health plan coverage.
10. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
11. Treat all plan personnel respectfully and courteously as partners in good health care.
12. Pay your dues, copayments, and charges for non-covered services on time.

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**APPENDIX A - DUES**

## 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 1.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 for Services furnished on or after the effective date of the modification. There is no vested right to receive the benefits of this Agreement.**

## HEALTH EDUCATION AND HEALTH PROMOTION

Health education and health promotion services provided by Blue Shield include the Better Living Member Newsletter.

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## **I: CONDITIONS OF COVERAGE AND PAYMENT OF DUES**

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### **A. ENROLLMENT**

#### **1. ENROLLMENT OF A SUBSCRIBER —**

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

#### **2. ENROLLMENT OF A SUBSCRIBER AND SUBSCRIBER'S SPOUSE/DOMESTIC PARTNER IN A TWO-PARTY AGREEMENT**

An individual and his spouse or Domestic Partner who meets the definition of Dependent as defined in this section, may apply for coverage together under a two-party Agreement (Subscriber and Dependent). Each applicant must be individually eligible to apply for a Medicare supplement plan in order to be approved for coverage, and must be 65 years of age or older.

If accepted for coverage under a two-party Agreement, the older Applicant will be designated as the Subscriber and the second Applicant will be designated as the Dependent. A two-party Agreement is issued by and between Blue Shield and the Subscriber; however, the Dependent is entitled to the benefits and provisions of this Agreement, and the term, "Subscriber," shall be read to include the term, "Dependent," throughout this Agreement, except as follows: the preamble, Sections I.B, I.C, III., VI.A, and VI.F.

##### **a. Two-Party Rate (Dues)**

The two-party rate (dues) will be based on the age of the Subscriber, as of the effective date of the two-party Agreement.

##### **b. Termination of a Two-Party Agreement**

In addition to Section I.B., a two-party Agreement will terminate upon any of the following events:

- The Dependent spouse or Domestic Partner no longer meets the definition of Dependent.
  - The Dependent spouse or Domestic Partner terminates coverage under this Medicare Supplement plan. In such instance, the Subscriber may continue coverage under this Medicare Supplement plan under a Subscriber only Agreement.
  - The Subscriber terminates coverage under this Medicare Supplement plan. In such instance, the Dependent spouse or Domestic Partner may transfer this Medicare Supplement plan coverage to a Subscriber only Agreement.
- c. Definitions Applicable to a Two-Party Agreement
- 1) **Dependent** - A Subscriber's legally married spouse (who is not legally separated from the Subscriber) or Domestic Partner who has been enrolled and accepted by Blue Shield as a Dependent in the Agreement and has maintained his coverage in accordance with this Agreement.
  - 2) **Domestic Partner** - An individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:
    - a) Both partners are 65 years of age or older and of the same or different sex;
    - b) The partners share an intimate and committed relationship of mutual caring and the same principal residence;
    - c) The partners are not currently married and not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
    - d) Both partners were mentally competent to consent to a contract

when their domestic partnership began.

3. **EFFECTIVE DATE OF BENEFITS** — An Applicant is entitled to the benefits of this Agreement on the later of the following dates: 1) on the first day of the month following the date his properly completed application is received by Blue Shield or 2) on the effective 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** — Regardless of his coverage under any prior Blue Shield Plan, an Applicant for enrollment under this Agreement shall be enrolled only for the benefits of this Agreement. No Subscriber under this Agreement shall simultaneously hold coverage under any other Blue Shield Plan.

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

**1. TERMINATION**

Blue Shield of California may terminate this Agreement together with all like Agreements by giving 90 days' written notice. This Agreement shall terminate on the date the Subscriber is no longer enrolled under Parts A and B of Medicare. No Subscriber shall be terminated individually by Blue Shield of California for any cause other than as provided in this section B. A Subscriber desiring to terminate this Agreement shall give Blue Shield of California 30 days' written notice.

This Agreement may be terminated by Blue Shield for false representations to, or concealment of material facts from, Blue Shield of California in any health statement, application, or any written instruction furnished to Blue Shield of California by the Subscriber at any time before or after issuance of this Agreement, or fraud or deception in enrollment. The Agreement may also be terminated if the Subscriber fails or refuses to provide access to documents and other information that

was provided in the application for coverage. Termination in such instances shall be effective as of the original Effective Date of coverage, without prior notice to the Subscriber.

Blue Shield of California may terminate this Agreement for cause immediately upon written notice for the following:

- a. Material information that is false or misrepresented information provided on the enrollment application or given to the plan;
- b. Permitting use of your Subscriber identification card by someone other than yourself to obtain Services;
- c. Obtaining or attempting to obtain Services under this Agreement by means of false, materially misleading, or fraudulent information, acts, or omissions;
- d. Abusive or disruptive behavior which: (1) threatens the life or well-being of Blue Shield of California personnel and providers of Services; or (2) substantially impairs the ability of Blue Shield of California to arrange for Services to the Subscriber; or (3) substantially impairs the ability of providers of Service to furnish Services to the Subscriber or to other patients.

Blue Shield of California shall, within 30 days of the notice of termination, return to the Subscriber the amount of prepaid dues, if any, minus any monies paid by Blue Shield of California for incurred claims that Blue Shield of California determines will not have been earned as of such termination date. However, Blue Shield of California reserves the right to recoup all payments from the Subscriber for incurred charges which exceed the dues paid by the Subscriber, if this Agreement is terminated for fraud or deception.

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:

- (1) the end of the period of Total Disability; or
- (2) the date on which the Subscriber's applicable maximum benefits are reached; or
- (3) a period equivalent in duration to the contract benefit period of three (3) months subject to the following:
  - (a) written proof of Total Disability is received by Blue Shield within ninety (90) days of the date on which coverage was terminated; and
  - (b) 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 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.

## **2. TERMINATION/CANCELLATION OF THE AGREEMENT FOR NON-PAYMENT OF DUES**

- a) If the Agreement is being cancelled because you failed to pay the required dues when due, then coverage will end retroactively back to the last day of the month for which dues were paid. This retroactive period will not exceed 60 days from the date of mailing of the Notice Confirming Termination of Coverage. Blue Shield will notify you in a Prospective Notice of Cancellation if your dues have not been received. This notice will provide you with the following information:
  - (1) That dues due have not been paid and that the Agreement will be cancelled if you do not pay the required dues within 15 days from the date the Prospective Notice of Cancellation is mailed;

- (2) The specific date and time when coverage for you will end if dues are not paid;
- (3) Information regarding the consequences of any failure to pay the dues within 15 days.

- b) Within five (5) business days of canceling or not renewing the Agreement for non-payment of dues, Blue Shield will mail you a Notice Confirming Termination of Coverage, which will inform you of the following:

- (1) That the Agreement has been cancelled, and the reasons for cancellation;
- (2) The specific date and time when coverage for you ended;
- (3) Information regarding the availability of reinstatement of coverage under the Agreement.

## **3. REINSTATEMENT OF THE AGREEMENT AFTER TERMINATION/CANCELLATION**

If the Agreement is terminated for non-payment 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 Confirming Termination 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 non-payment of dues more than twice during the preceding 12-month period, then Blue Shield is not required to reinstate you, and you will need to re-apply for coverage. In this case, Blue Shield may impose different dues and consider your medical condition.

## **4. SUSPENSION**

- a) If a Subscriber becomes entitled to Medical assistance, 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, if any, minus any monies paid by Blue Shield for claims after such date of suspension. 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 within 90 days of that date and pays the dues amount attributable to the retroactive period.

- b) Blue Shield shall suspend the benefits and dues of this Agreement for a Subscriber when that Subscriber:
- is Totally Disabled as defined herein and entitled to Medicare Benefits by reason of that disability;
  - is covered under a group health plan as defined in section 42 U.S.C. 1395y(b)(1)(A)(v); and
  - 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 Totally Disabled 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:

- the Subscriber has notified Blue Shield of such loss of group coverage within 90 days after the date of such loss; and
- the Subscriber pays the dues attributable to the period, effective as of the date of loss of group coverage.

If the above criteria have been satisfied, the effective date of the reinstatement will be the date of the loss of group coverage. Blue Shield shall:

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

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### C. PAYMENT OF DUES

Monthly dues are as stated in Appendix A. Blue Shield of California offers a variety of options and methods by which you may pay your Dues. Please call Customer Service at 1-**800-248-2341** to discuss these options. Dues payments by mail are to 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 at the time of enrollment under this plan, subject to the right reserved by Blue Shield to modify these dues with at least thirty (30) days' notice.

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## II: SERVICE BENEFITS

### PRESUMPTION THAT MEDICARE BENEFITS ARE AVAILABLE TO THE SUBSCRIBER

The benefits of this Agreement are based on the presumption that the Subscriber is enrolled in Medicare. Payments of benefits for Subscribers who are not so enrolled shall be in amounts and for Services identical to those for which payments are made for Subscribers who are so enrolled.

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:

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#### **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 also 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;

- 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.
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.

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#### **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 when the Subscriber receives concurrent benefits from Medicare.
3. Medicare Part B Deductible: Coverage for all of the Medicare Part B Deductible Amount per Calendar Year regardless of hospital confinement.
4. One Hundred Percent (100%) of the Medicare Part B Excess Charges.

Blue Shield will pay 100% of the difference between the amount paid by Medicare and the amount billed, subject to Medicare's regulation, with respect to Services that are benefits under this section.

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 from Medicare 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. NurseHelp 24/7 As part of Lifepath Advisers, Subscribers may call a registered nurse via 1-866-543-3728, a 24-hour, toll-free telephone number to receive confidential advise and information about minor illnesses and injuries, chronic conditions, fitness, nutrition and other health related topics. There is no charge for these services.

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### **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.

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### **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 Plan contract benefit limitations and exclusions.

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## **III: BENEFIT PAYMENTS**

Blue Shield may pay the benefits of this Agreement directly to the Physician, Hospital, or Sub-

scriber. 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 and 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 any 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.

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## **IV: EXCLUSIONS AND LIMITATIONS**

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### **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. Examinations for and the cost of eye glasses and hearing aids.
4. Services for cosmetic purposes.
5. 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.
6. Services for transgender or gender dysphoria conditions, including but not limited to, intersex surgery (transsexual operations), or any related services, or any resulting medical complications, except for treatment of medical complications that is medically necessary.
7. 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.
8. Services performed in a Hospital by house officers, residents, interns, or others in training.
9. Acupuncture.
10. Physical examinations, except for a one-time physical examination within 6 months of the Subscriber's first coverage under Medicare Part B; routine immunizations, or routine foot care.
11. Services not specifically listed as benefits.
12. Services for which the Subscriber is not legally obligated to pay, or Services for which no charge is made to the Subscriber.

13. Services for which the Subscriber is not receiving benefits from Medicare.

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.

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## **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 exclusion, Blue Shield's liability for Services (including room and board) 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.

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## **C. MEDICAL NECESSITY**

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.

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#### D. CLAIMS REVIEW

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

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#### 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 1-800-248-2341.

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#### V: DEFINITIONS

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

**Agreement** means this document and endorsements issued by Blue Shield and the Subscriber's application.

**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 fixed Calendar Year amount which the Subscriber must pay out-of-pocket for specific covered Services that are a benefit of the Plan before he becomes entitled to receive any benefit payments from the Plan.

**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.

**Effective Date** means the date on which an Applicant, who has met the enrollment and prepayment requirements of this Agreement, is accepted by Blue Shield as a Subscriber. The Effective Date for any Endorsement shall be the same unless otherwise stated.

**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 two programs (called Part A and Part B) established by Title 1 of Public Law 89-97 as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as The Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**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 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.

**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 who has been enrolled and accepted by Blue Shield as a Subscriber under this Health Service Agreement and has maintained his 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.

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## **VI: GENERAL PROVISIONS**

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### **A. IDENTIFICATION CARDS**

An Identification 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.

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### **B. GRIEVANCE PROCESS**

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

### **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:

**1-800-248-2341**

The hearing impaired may contact Blue Shield's Customer Service Department through Blue Shield's toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: Blue Shield of California 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 the Plan at the telephone number noted in this Evidence of Coverage. 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 of California 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. See the previous Customer Service section for information on the expedited decision process.

### **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.

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### **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 **1-800-248-2341** 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.

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.

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### **D. ACTS OF THIRD PARTIES**

If the Subscriber is injured through 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 or other available remedy to recover the reasonable costs of the Services provided to the Subscriber paid by Blue Shield.

The Subscriber is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Subscriber anticipates bringing 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 assist them in exercising their equitable right to restitution or other available remedies; and
3. Provide Blue Shield with a lien, in the amount of reasonable costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

A Subscriber's failure to comply with 1 through 3, above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

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### **E. INDEPENDENT CONTRACTORS**

Providers are neither agents nor employees of the plan but are independent contractors. In no instance shall the plan 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.

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## **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 (see front page). Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

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## **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 and notice to Blue Shield may be mailed to Blue Shield of California, P.O. Box 272540, Chico, California, 95927-2540.

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## **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 that date.

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## **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 Administrative Code. Any provision required to be in this Agreement by reason of such Codes 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.

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## **J. LEGAL PROCESS**

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

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## **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.

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## **L. GENDER, ETC.**

The masculine gender includes the feminine; the singular includes the plural.

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## **M. 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.

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## **N. 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 "the Plan"), 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 the Plan to use the Blue Shield Service Mark in the State of California and that the Plan 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 the Plan and that neither the Association nor any per-

son, entity, or organization affiliated with the Association, shall be held accountable or liable to the Subscriber for any of the Plan's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Agreement.

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## **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 1-800-248-2341, 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](mailto:BlueShieldca_Privacy@BlueShieldca.com)

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## **P. ACCESS TO INFORMATION**

Blue Shield of California 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 of California that information that is reasonably needed by Blue Shield of California. You agree to assist Blue Shield of California in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield of California with information in your possession. Failure to assist Blue Shield of California 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 of California will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

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## **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:

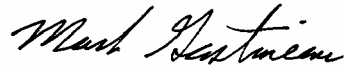
Sr. Manager, Regulatory Filings  
Blue Shield of California  
50 Beale Street  
San Francisco, CA 94105

Phone: (415) 229-5065

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.

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



Mark Gastineau, Vice President  
Individual , Small Group & Government Business Unit  
Blue Shield of California