High Option Supplement to Medicare

Benefit Booklet

University of California

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blue of california
Claims Administered by Blue Shield of California

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Benefit Booklet

Notice

This Benefit Booklet describes the terms and conditions of coverage for your High Option Supplement to Medicare. It is your right to view the booklet prior to enrollment in the Plan. Please read this Benefit Booklet carefully and completely so that you understand which services are covered health care Services, and the limitations and exclusions that apply to your Plan. If you or your Dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

PLEASE NOTE THAT THIS PLAN DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY.

If you have questions about the Benefits of your Plan, or if you would like additional information, please contact the Claims Administrator at the address or telephone number indicated on the last page of this booklet.

High Option Supplement to Medicare

Participant Bill of Rights

As a Plan Participant, 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 Plan, the Services offered 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. Receive Medicare covered preventive health Services.
10. Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
11. 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.
12. Communicate with and receive information from Customer Service in a language you can understand.
13. Be fully informed about the Claims Administrator dispute procedure and understand how to use it without fear of interruption of health care.
14. Voice complaints or grievances about the Plan or the care provided to you.
15. Make recommendations regarding the Claims Administrator's Member rights and responsibilities policy.

High Option Supplement to Medicare

Participant Responsibilities

As a Plan Participant, you have the responsibility to:

1. Carefully read all 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 Plan as explained in this booklet.
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. 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 Plan.
10. Help the Claims Administrator to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other Plan coverage.
11. Notify the Claims Administrator as soon as possible if you are billed inappropriately or if you have any complaints.
12. Treat all Plan personnel respectfully and courteously as partners in good health care.
13. Pay your share of charges for services received on time.

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This booklet constitutes only a summary of the High Option Supplement to Medicare. The Plan document must be consulted to determine the exact terms and conditions of coverage.

The Plan document is on file with your Employer and a copy will be furnished upon request.

Be sure you understand the Benefits of this Plan before Services are received.

NOTICE

Please read this Benefit Booklet carefully to be sure you understand the Benefits, exclusions and general provisions. It is your responsibility to keep informed about any changes in your health coverage. Only Retired Employees and their spouse or Domestic Partner enrolled in Medicare Parts A & B are eligible for this Plan. Medicare will always pay primary for Medicare covered services. The Plan will coordinate with Medicare, paying secondary.

Should you have any questions regarding your Plan, see your former Employer or call the Claims Administrator offices at the phone number listed on the last page on this booklet.

IMPORTANT

No Member has the right to receive the Benefits of this Plan for Services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits provision in this booklet.

Benefits of this Plan are available only for Services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Plan.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the Plan document or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for Services or supplies furnished on or after the effective date of modification. There is no vested right to receive the Benefits of this Plan.

University of California is the Employer. Blue Shield of California has been appointed the Claims Administrator. Blue Shield of California processes and reviews the claims submitted under this Plan.

Blue Shield of California provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Note: The following Summaries of Benefits contains the Benefits and applicable Copayments of your Plan. The Summaries of Benefits represent only a brief description of the Benefits. For more information on what Benefits are covered by Original Medicare (Parts A and B) consult the latest version of the ***Medicare and You*** handbook developed by the U.S. Centers for Medicare and Medicaid Services (CMS).

You can visit CMS website at www.medicare.gov or call the toll-free number 1-800-633-4227. TTY users should call 1-877 486-2048.

Summary of Benefits

Member Calendar Year Deductible for Medicare and Non-Medicare Covered Services	Deductible Responsibility	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Calendar Year Medical Deductible Applies to Non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by Blue Shield.	$50 per Member	

Member Maximum Calendar Year Out-of-Pocket Responsibility for Medicare and Non-Medicare Covered Services	Member Maximum Calendar Year Out-of-Pocket Responsibility
	Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers
Calendar Year Out-of-Pocket Maximum Applies to all medical plan Member liability within Medicare allowable amount for Medicare covered services and Blue Shield allowed amounts for non-Medicare covered services and Medicare covered services not paid by Medicare but paid by Blue Shield. Includes Plan Deductible.	$1,050 per Member

Member Maximum Lifetime Benefits	Maximum Claims Administrator Payment	
	Services by Preferred, Participating, and Other Providers	**Services by Non-Preferred and Non-Participating Providers**
Lifetime Benefit Maximum	No maximum	

Summary of Supplemental Medicare Benefits

MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

A Benefit period begins on the first day you receive services 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.

Benefit[1]	**Medicare Pays**	**Plan Pays**	**Member Pays**
Medicare Part A[2,3,4,5]			
Hospitalization – Semi-private room and board, general nursing and miscellaneous services and supplies			
▪ First 60 days	All but $1,260	$1,260 (Part A Deductible[2)]	$0
▪ 61st through 90th day	All but $315 a day	$315 a day	$0
▪ 91st day and after while using 60 life-time reserve days	All but $630 a day	$630 a day	$0
▪ Once lifetime reserve days are used – additional days	$0	80% of Medicare Eligible Expenses	20% of Medicare Eligible Expenses
▪ Beyond the additional 365 days (See the section, "**Additional Benefits and Coverages (Covered Services) Not Covered By Medicare**," in this booklet for hospital coverage provided after you have exhausted both the Medicare life-time reserved days and the additional 365 day hospitalization benefit.)	$0	80% of Medicare Eligible Expenses	20% of Medicare Eligible Expenses
Skilled Nursing Facility Care – Must meet Medicare's requirements including having been in a Hospital at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the Hospital.			
▪ First 20 days	All approved amounts	$0	$0
▪ 21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0
▪ 101st day and after	$0	$0	You pay all costs
Blood[6]			
▪ First 3 pints	$0	All costs	$0
▪ Additional amounts	100%	$0	$0
Hospice Care			
▪ Must meet Medicare's requirements, including a physician's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

MEDICARE (PART B)

MEDICARE SERVICES PER CALENDAR YEAR

Benefit[1]	Medicare Pays	Plan Pays	Member Pays
Medicare Part B[3,5,7]			
Ambulance Services – Emergency ground transportation to a Hospital or Skilled Nursing Facility for medically necessary services and transportation in any other vehicle could endanger your health. Medicare will pay for transportation in an airplane or helicopter if you require immediate and rapid ambulance transportation that ground transportation can't provide.	80%	Up to $147 plus 20% of the Medicare Eligible Expenses	$0
Medical Expenses-In or Out of the Hospital and Outpatient Hospital Treatment[7] – Physician's services, Inpatient and Outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
▪ First $147 of Medicare Approved Amounts (Deductible)[7]	$0	Up to $147 (Part B Deductible[7])	$0
▪ Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Plan Approved Amounts)	$0	$0	You pay all costs
Blood[6]			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts[7]	$0	Up to $147 (Part B Deductible[7])	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

Benefit[1]	Medicare Pays	Plan Pays	Member Pays
Medicare Part B[3,5,7]			
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0
Home Health Care (Medicare Approved Services)			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment[8] Covered equipment or supplies and replacement or repair services must be obtained from a Medicare-approved supplier for Medicare to pay.			
First $147 each calendar year (Deductible)[7]	$0	Up to $147 (Part B Deductible[7])	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Part B Excess Charges – Above Plan Approved Amounts	$0	$0	You pay all costs

Medicare Covered Benefits Footnotes

1. Only Retired Employees and their spouse or Domestic Partner enrolled in Medicare Parts A & B are eligible for this High Option Supplement to Medicare. Medicare will always pay primary for Medicare covered services. The Plan will coordinate with Medicare, paying secondary.
2. The Part A Deductible of $1,260 applies to Covered Services and items for Hospital Inpatient care, skilled nursing facility care, home health care, hospice care and blood. The Deductible must be paid before Medicare begins providing payment for these Part A Covered Services. The High Option Supplement to Medicare pays the Part A Deductible for you.
3. A Member may select any licensed Physician, Provider, or Hospital, that accepts Medicare, for treating a covered illness or injury within the United States. This Plan will always pay secondary to Medicare for Medicare Covered Services. The Plan will pay secondary using Medicare allowed amounts subtracting the Medicare Part A or Part B Deductible where applicable and the amount paid by Medicare.
4. 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.
5. Inpatient and Outpatient treatment for Substance Abuse Conditions is covered at the same Deductible and Copayment as any other Covered condition based on where the treatment is provided. Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered, but are not considered to be treatment of the Substance Abuse Condition itself.
6. For blood covered by Medicare Part A, in most cases, the Hospital gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the Hospital has to buy blood for you, the Claims Administrator will pay the Hospital costs for the first 3 units of blood you get in a calendar year or you can have the blood donated by you or someone else. For blood covered under Medicare Part B, in most cases, the Provider gets blood from a blood bank at no charge, and you won't have to pay for it or replace it. If the Provider has to buy blood for you, the Claims Administrator will pay the provider costs for the first 3 units of blood you get in a calendar year and the Part B deductible or you can have the blood donated by you or someone else. After the first 3 units of blood, Medicare will pay 80% of approved amounts and the Claims Administrator will pay 20%. You pay nothing.
7. The Part B Deductible of $147 applies to Covered Services and items for doctor's services, Hospital Outpatient care, home health, preventive services and durable equipment. The Deductible must be paid before Medicare begins providing payment for these Part B Covered Services. The High Option Medicare PPO Plan pays the Part B Deductible for you.
8. Durable medical equipment must be obtained from a Medicare-approved supplier for Medicare to pay. They are listed at www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227 and for TTY users 1-877-486-2048.

ADDITIONAL BENEFITS - NON-MEDICARE COVERED SERVICES			
Benefit		**Member Pays[2]**	
	Medicare Pays	**Services by Preferred, Participating, and Other Providers[3]**	**Services by Non-Preferred and Non-Participating Providers[4]**
Acupuncture Benefits			
Acupuncture by certificated acupuncturists up to 24 visits per Member per Calendar Year.	$0	20%	20%
Hearing Aid Benefits			
Hearing aids (2 hearing aids per 36 months, analog or digital)	$0	20%	20%
Hospital Benefits (Facility Services)[1]			
Inpatient Emergency Facility Services	$0	20%	20%[5]
Inpatient non-Emergency Facility Services	$0	20%	20%
Inpatient Medically Necessary skilled nursing Services including Subacute Care	$0	20%	20%
Inpatient Services to treat acute medical complications of detoxification	$0	20%	20%

Benefit		Member Pays[2]	
	Medicare Pays	**Services by Preferred, Participating, and Other Providers[3]**	**Services by Non-Preferred and Non-Participating Providers[4]**
Mental Health and Substance Abuse Benefits [6]			
Inpatient Hospital Services[6,7]	$0	20%	20%
Outpatient Partial Hospitalization[6]	$0	20%	20%
Inpatient Residential Treatment	$0	20%	20%
Outpatient Mental Health Services[6] Includes office visits with Marriage, Family and Child Counselors (MFT, MFCC)	$0	20%	20%
Transgender Benefits All Transgender surgical Services must be prior authorized, in writing, from the Claims Administrator's Medical Director. Services received from a non-network provider are not covered unless prior authorized by the Claims Administrator. When authorized by the Claims Administrator, the non-network provider will be reimbursed at a rate determined by the Claims Administrator and the non-network provider. Benefits follow the World Professional Association for Transgender Health (WPATH) Standards of Care and are subject to the Claims Administrator's conditions of coverage, exclusions, and limitations.			
Ambulatory surgery center Outpatient surgery facility Services	$0	20%	20%
Hospital Inpatient Services	$0	20%	20%
Hospital Outpatient Services	$0	20%	20%
Physician surgery Services	$0	20%	20%

Benefit		Member Pays[2]	
	Medicare Pays	**Services by Preferred, Participating, and Other Providers[3]**	**Services by Non-Preferred and Non-Participating Providers[4]**
Out-of Area BlueCard® Program Plan Participants can receive Covered Services outside of California and outside the United States through the Claim Administrator's BlueCard Program. See the "Additional Benefits and Coverages (Covered Services) Not Covered By Medicare, section of this booklet for additional information.	$0	20%	20%

Note:
For Benefits in the United States but outside of California:

All Covered Services provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/BlueShield provider. Covered Services received from a local Blue Cross Blue Shield contracted provider are paid at the preferred level when billed through the local Blue Plan. A 24 hour toll-free number is available when you are outside California or in the United States and need urgent services. By calling (800) 810-2583 (BLUE), you will be informed about the nearest BlueCard participating provider.

For Benefits outside of the United States:

All Covered Services for emergency and non-emergency care will be eligible for reimbursement when received outside of the United States. Please refer to the Blue Shield Preferred tier for Covered Services and corresponding Member liability. Prescription Drugs are a benefit when obtained outside of the United States. You are responsible for obtaining an English language translation of the claim and all medical records. When you are out of the country, you can call either the toll-free BlueCard Access number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, seven days a week, to locate the nearest BlueCard Worldwide Network provider.

Additional Benefits and Services Not Covered by Medicare Footnotes

1. When you have used all of your Medicare Part A benefit days during a Benefit Period and all of your Medicare lifetime reserve days are exhausted, the plan will provide additional Hospital benefits for the remainder of that Benefit Period.
2. Unless otherwise specified, Copayments are calculated based on the Allowable Amount.
3. Other Providers are not Preferred Providers and so for Services by Other Providers you are responsible for all charges above the Allowable Amount. Other Providers include acupuncturists, nursing homes and certain labs (for a complete list of Other Providers see the Definitions section).
4. For Services by Non-Preferred and Non-Participating Providers you are responsible for all charges above the Allowable Amount.
5. For Emergency Services by Non-Preferred Providers, your Copayment will be the Preferred Provider Copayment.
6. Inpatient and Outpatient treatment for Substance Abuse Conditions is covered at the same Deductible and Copayment as any other covered medical condition based on the treatment location. Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered, but are not considered to be treatment of the Substance Abuse Condition itself.
7. All Mental Health Services and Substance Abuse Condition Services (except for Emergency and urgent Services) must be prior authorized by the Claims Administrator. After all Medicare Part A benefit days during a Benefit Period are exhausted and Medicare lifetime reserved days are exhausted, the plan will provide additional Hospital benefits for the remainder of that Benefit Period.
8. For Emergency Services by Non-Participating Hospitals your Copayment will be the Participating Hospital Copayment based on Allowable Amount.

INTRODUCTION

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

CHOICE OF PROVIDERS AND PAYMENT OF CLAIMS FOR COVERED MEDICARE SERVICES

A Member may select any licensed Physician, Provider, or Hospital, that accepts Medicare, for treating a covered illness or injury within the United States. This Plan will always pay secondary to Medicare for Medicare Covered Services. The Plan will pay secondary using Medicare allowed amounts subtracting the Medicare Part A or Part B Deductible where applicable and the amount paid by Medicare. Providers are paid by Claims Administrator only for the Covered Services they render to Plan Participants. Providers receive no financial incentives or bonuses from the Claims Administrator.

If the Physician, Provider, or Hospital accepts the Medicare assignment method of payment, the Claims Administrator's payment as secondary payor will not be more than the difference between Medicare's allowable charge and the amount paid by Medicare.

Claims are submitted for payment after Services are received. Requests for payments must be submitted to the Claims Administrator by the Medical Provider or Participant within one year after the month in which Services are rendered or the date of processing of Medicare Benefits. The claim must include itemized evidence of 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.

The Claims Administrator will send you an Explanation of Benefits notice showing what was paid, and what, if anything, the Member owes.

The Member may have to pay for Benefits for Services not covered by Medicare, except for those Benefits and Services as stated under the section of this booklet, "Additional Benefits and Coverages (Covered Services) Not Covered by Medicare." The Claims Administrator will provide payment to the Member upon receipt of a properly completed claim form within one (1) year after the month in which Services are rendered.

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

No sums payable hereunder may be assigned without the written consent of the Claim Administrator. 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 the Claims Administrator shall provide payment directly to the provider.

MEDICARE PRIVATE CONTRACTING PROVISION AND PROVIDERS WHO DO NOT ACCEPT MEDICARE

Federal Legislation allows Physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services (**that would otherwise be covered by Medicare**) from these Physicians or practitioners will need to enter into written "private contracts" with these Physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some Physicians or practitioners have never participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more Physicians or practitioners, or if you

choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these Physicians or other practitioners. In either case, no Benefits will be paid by this Plan for services rendered by these Physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see other providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

PREFERRED PROVIDERS FOR ADDITIONAL BENEFITS AND SERVICES NOT COVERED BY MEDICARE

This Plan is specifically designed for you to use the Claims Administrator's Preferred Providers. Preferred Providers include certain Physicians, Hospitals, Alternate Care Services Providers, and other Providers. Preferred Providers are listed in the Preferred Provider directories. All Claims Administrator Physician Members are Preferred Providers. So are selected Hospitals in your community. Many other healthcare professionals, including dentists, podiatrists, optometrists, audiologists, licensed clinical psychologists and licensed marriage and family therapists are also Preferred Providers. They are all listed in your Preferred Provider Directories.

To determine whether a provider is a Preferred Provider, consult the Preferred Provider Directory. You may also verify this information by accessing the Claims Administrator's Internet site located at http://www.blueshieldca.com/uc, or by calling the Claims Administrator's Customer Service at the telephone number shown on the last page of this booklet. Note: A Preferred Provider's status may change. It is your obligation to verify whether the Physician, Hospital or Alternate Care Services provider you choose is a Preferred Provider, in case there have been any changes since your Preferred Provider Directory was published.

Note: In some instances services are covered only if rendered by a Preferred Provider. Using a Non-Preferred Provider could result in lower or no payment by the Claims Administrator for services.

Preferred Providers agree to accept the Claims Administrator's payment, plus your payment of any applicable Deductibles, Copayments, or amounts in excess of specified Benefit maximums, as payment in full for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage provision and the Reductions section regarding Third Party Liability. This is not true of non-Preferred Providers.

You are not responsible to Participating and Preferred Providers for payment for covered Services, except for the Deductibles, Copayments, and amounts in excess of specified Benefit maximums, and except as provided under the Exception for Other Coverage provision.

The Claims Administrator contracts with Hospitals and Physicians to provide Services to Members for specified rates. This contractual arrangement may include incentives to manage all services provided to Members in an appropriate manner consistent with the contract. If you want to know more about this payment system, contact the Claims Administrator's Customer Service at the number provided on the last page of this booklet.

If you go to a Non-Preferred Provider, the Claims Administrator's payment for a Service by that Non-Preferred Provider may be substantially less than the amount billed. You are responsible for the difference between the amount the Claims Administrator pays and the amount billed by Non-Preferred Providers. It is therefore to your advantage to obtain medical and Hospital Services from Preferred Providers.

Payment for Emergency Services rendered by a Physician or Hospital who is not a Preferred Provider will be based on the Allowable

Amount but will be paid at the Preferred level of benefits. You are responsible for notifying the Claims Administrator within 24 hours, or by the end of the first business day following emergency admission at a Non-Preferred Hospital, or as soon as it is reasonably possible to do so.

Directories of Preferred Providers located in your area have been provided to you. Extra copies are available from the Claims Administrator. If you do not have the directories, please contact the Claims Administrator immediately and request them at the telephone number listed on the last page of this booklet.

SUBMITTING A CLAIM FORM

Preferred Providers submit claims for payment after their Services have been received. You or your Non-Preferred Providers also submit claims for payment after Services have been received.

You are paid directly by the Claims Administrator if Services are rendered by a Non-Preferred Provider. Payments to you for covered Services are in amounts identical to those made directly to providers. Requests for payment must be submitted to the Claims Administrator within one (1) year after the month Services were provided. Special claim forms are not necessary, but each claim submission must contain your name, home address, Plan number, Participant's number, a copy of the provider's billing showing the Services rendered, dates of treatment and the patient's name. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Claims Administrator Participant's Statement of Claim form to the Claims Administrator service center listed on the last page of this booklet.

Claim forms are available on the Claims Administrator's Internet site located at http://www.blueshieldca.com/uc or you may call the Claims Administrator's Customer Service at the number listed on the last page of this booklet to ask for forms. If necessary, you may use a photocopy of the Claims Administrator claim form.

CALENDAR YEAR DEDUCTIBLE FOR MEDICARE AND NON-MEDICARE COVERED SERVICES

Applies to Non-Medicare covered services and to Medicare covered services not paid by Medicare but paid by Blue Shield.

This Plan will pay for Non-Medicare covered Services once the per Member Calendar Year Deductible amount as shown on the Summary of Benefits is satisfied. This Deductible must be made up of charges covered by the Plan. Charges in excess of the Allowable Amount do not apply toward the Deductible. The Deductible must be satisfied once during each Calendar Year by or on behalf of each Member separately. Note: The Deductible also applies to a newborn child or a child placed for adoption, who is covered for the first 31 days even if application is not made to add the child as a Dependent on the Plan.

PARTICIPANT'S MAXIMUM CALENDAR YEAR OUT-OF-POCKET RESPONSIBILITY FOR MEDICARE AND NON MEDICARE COVERED SERVICES

Applies to all medical Plan Member liability within Medicare allowable amount for Medicare covered services and Blue Shield Allowed Amounts for non-Medicare Covered Services and Medicare covered services not paid by Medicare but paid by Blue Shield. Includes Plan Deductible.

The per Member maximum out-of-pocket responsibility each Calendar Year for covered Services rendered by any combination of Preferred Providers, Non-Preferred Providers and Other Providers is shown on the Summary of Benefits.

Once a Member's maximum responsibility has been met, the Plan will pay 100% of the Allowable Amount for that Member's covered Services for the remainder of that Calendar Year, except as described below.

Charges for Services which are not covered, charges above the Allowable Amount, and charges in excess of the amount covered by the Plan are the Participant's responsibility and are not included in the maximum Calendar Year out-of-pocket responsibility.

Copayments and charges for Services not accruing to the Participant's maximum Calendar Year out-of-pocket responsibility continue to be the Participant's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

PRINCIPAL MEDICARE BENEFITS AND COVERAGES (COVERED SERVICES)

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

MEDICARE PART A

This Plan will pay the following:

Hospitalization

Medicare Part A Deductible: Coverage for all of the Medicare Part A Inpatient Hospital Deductible Amount per Benefit Period.

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.

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;

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;

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 Participant's lifetime);

Note: Participants 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.

Skilled Nursing Facility Care

Skilled Nursing Facility Care Covered Services 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.

Blood

Coverage 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.

Hospice

This Plan will provide coverage for hospice care which includes cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

MEDICARE PART B

This Plan will pay the following:

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, provided the Participant is receiving concurrent benefits from Medicare for the same Services.

Benefits for the coverage listed above shall be paid when the Participant 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.

Blood

Coverage 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 additional blood after the first three (3) pints, the Plan will pay the $147 Part B Deductible plus 20% of Medicare Approved Amounts.

Durable Medical Equipment

Plan will pay the $147 Part B Deductible plus 20% of the remainder charges of Medicare approved charges. Participant is responsible for all costs for Part B excess charges (above plan approved amounts.

ADDITIONAL BENEFITS AND COVERAGES (COVERED SERVICES) NOT COVERED BY MEDICARE

ACUPUNCTURE BENEFITS

Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine (M.D.) or a certificated acupuncturist up to a per Member per Calendar Year visit maximum as shown on the Summary of Benefits**.**

HEARING AID BENEFITS

Benefits are provided for two hearing aids each 36 months, analog or digital, including ear mold(s), the initial battery, cords and other ancillary equipment. The Benefit also includes visits for fitting, counseling and adjustments.

The following services and supplies are not covered:

1. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase;
2. Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss;
3. Replacement parts for hearing aids, repair of hearing aids after the covered warranty period and replacement of hearing aids more than once in any period of 24-month period;
4. Surgically implanted hearing devices.

HOSPITAL BENEFITS (FACILITY SERVICES) (Other than Mental Health Benefits)

After all Medicare Part A benefit days for Medical and Mental Health conditions during a Benefit Period are exhausted and Medicare lifetime reserved days are exhausted, this Plan the plan will provide additional Hospital benefits for the remainder of that Benefit Period. Residential care is not covered.

The following Benefits and Services are provided at the Copayment listed in the Summary of Benefits.

Inpatient Services for Treatment of Illness or Injury

1. Any accommodation up to the Hospital's established semi-private room rate, or, if Medically Necessary as certified by a Doctor of Medicine, the intensive care unit.
2. Use of operating room and specialized treatment rooms.
3 Reconstructive Surgery is covered when there is no other more appropriate covered surgical procedure, and with regards to appearance, when Reconstructive Surgery offers more than a minimal improvement in appearance. In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery is covered on either breast to restore and achieve symmetry incident to a mastectomy including treatment of physical complications of a mastectomy and lymphedemas. Benefits will be provided in accordance with guidelines established by the Claims Administrator and developed in conjunction with plastic and reconstructive surgeons.

No benefits will be provided for the following surgeries or procedures unless for Reconstructive Surgery:

- Surgery to excise, enlarge, reduce, or change the appearance of any part of the body;

- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body;
- Hair transplantation; and
- Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology.

This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

4. Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
5. Rehabilitation when furnished by the Hospital and approved in advance by the Claims Administrator.
6. Drugs and oxygen.
7. Administration of blood and blood plasma, including the cost of blood, blood plasma and blood processing.
8. X-ray examination and laboratory tests.
9. Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
10. Use of medical appliances and equipment.
11. Subacute Care.
12. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
13. Medically Necessary Inpatient detoxification Services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room, or when Medically Necessary Inpatient detoxification is prior authorized by the Plan.

MENTAL HEALTH BENEFITS

After all Medicare Part A benefit days for Medical and Mental Health Conditions during a Benefit Period are exhausted and Medicare lifetime reserved days are exhausted, the plan will provide additional Hospital benefits for the remainder of that Benefit Period. Residential care is covered.

Benefits are provided for Inpatient Hospitalization, Partial Hospitalization and Outpatient Services for the diagnosis and treatment of Covered Mental Health Conditions, including Substance Abuse, by Hospitals, Doctors of Medicine, or licensed marriage and family therapists.

All non-Emergency Inpatient Mental Health Services must be prior authorized by the Claims Administrator including those obtained outside of California. See the "Care for Covered Services Outside of California" section of this booklet for an explanation of how payment is made for out of state Services. For prior authorization, Participants should call the Claims Administrator's Customer Service telephone number indicated on the last page of this booklet.

The Copayments for covered Mental Health Services, if applicable, are shown in the Summary of Benefits section of this booklet.

Note: Inpatient Services which are Medically Necessary to treat the acute medical complications of detoxification are covered as part of the medical Hospital Benefits and are not considered to be treatment of the Substance Abuse Condition itself.

RESIDENTIAL CARE PROGRAM FOR MENTAL HEALTH CONDITION

Benefits are provided for 24-hour care in a residential treatment facility pursuant to written,

specific and detailed treatment programs for full-time participating clients under the direction of an administrator and Physician for chronic mental health conditions. Residential Care Program Services must be prior authorized by the Benefits Administrator. The residential facility cannot accept or retain clients who require Inpatient Hospital level or acute psychiatric care.

RESIDENTIAL CARE PROGRAM FOR SUBSTANCE ABUSE CONDITION

A Residential Care Substance Abuse Program is a program provided in a licensed facility that provides structured 24-hour residential services designed to promote treatment and maintain recovery from the recurrent use of alcohol, drugs, and/or related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes. Residential Care Program Services must be prior authorized by the Benefits Administrator.

TRANSGENDER BENEFITS

Benefits

Benefits are provided for the following Services and no others, for a physician diagnosis of gender identity disorder (gender dysphoria) to Members who meet recognized clinical criteria guidelines:

Transgender Surgical Services

Subject to the Plan hospital and professional physician service copayments as shown on the Summary of Benefits, Hospital and Professional Services are provided for transgender surgical services.

Benefits will be provided in accordance with guidelines established by the Claims Administrator. These services must be prior authorized by the Plan.

The Claims Administrator has a Plan transgender network of contracted hospital and transgender surgery providers. Services received from a non-network provider are not covered unless prior authorized by the Claims Administrator. When authorized by the Claims Administrator, the non-network provider will be reimbursed at a rate determined by the Claims Administrator and the non-network provider.

Benefits are also provided for necessary travel and lodging expenses to receive these services when pre-authorized by the Plan.

Reimbursement for all associated travel expenses is limited to:

1. travel to and from the transplant center on an approved flight, train, or current IRS mileage for auto travel; and
2. hotel accommodations not to exceed $200 per day for one room double occupancy; and
3. meals not to exceed $75/day per person; and
4. up to 6 round trips per Benefit, and
5. $5,000 one time maximum amount for recipient and companion expenses in total.

Covered transgender travel expenses are not subject to the Calendar Year Deductible and do not accrue to the Participant's maximum Calendar Year Out-of-Pocket responsibility.

Plan Principal Limitations, Exceptions, Exclusions and Reductions

This Benefit is subject to the principal limitations, exceptions, exclusions and reductions listed in your booklet with the exception of the exclusions for transgender or gender dysphoria conditions, reconstructive surgery and penal implant devices and surgery and related services.

CARE FOR COVERED SERVICES OUTSIDE CALIFORNIA

Out-of-Area Programs

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Claims Administrator calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement

with its providers. See the BlueCard Program section in this booklet.

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Claims Administrator's payment practices in both instances are described in this booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Claims Administrator for payment. The Claims Administrator will notify you of its determination within 30 days after receipt of the claim. The Claims Administrator will pay you at the Non-Preferred Provider Benefit level. Remember, your Copayment is higher when you see a Non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Claims Administrator and the amount billed.

Charges for Services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in Copayment calculations.

To receive the maximum Benefits of your Plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

1. call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at http://www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2. visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after Services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Claims Administrator, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.

CARE FOR COVERED SERVICES OUTSIDE THE UNITED STATES

Benefits will also be provided for Covered Services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center either at the toll-free BlueCard Access number (1-800-

810-2583) or collect (1-804-673-1177), 24 hours a day, 7 days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call the Claims Administrator at the customer service number noted on the back of your identification card. For Inpatient Hospital care, contact the BlueCard Worldwide Service Center to arrange 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 to the BlueCard Worldwide Service Center.

When you receive services from a Physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at http://www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in this booklet). However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment and Deductible amounts, if any, as stated in this booklet.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this booklet.

ELIGIBILITY AND ENROLLMENT

The University establishes its own Medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements.

ELIGIBILITY

Retirees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the "Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members". A copy of this factsheet is available in the HR Forms and Publications section of UCnet (ucnet.universityofcalifornia.edu). Additional resources are also available in the HR Forms and Publications section of UCnet to help you with your health and welfare plan decisions.

ENROLLMENT

Retirees

Information pertaining to enrollment can be found in the "Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members". A copy of this factsheet is available in the HR and Forms and Publications section of UCnet (ucnet.universityofcalifornia.edu).

END OF COVERAGE UNDER THIS PLAN

Coverage under this Plan can be cancelled immediately upon written notice if an enrolled Member no longer has Part A, Part B and Part D of Medicare. Members are responsible for notifying us if they do not have, or lose, coverage under either Part A, Part B and Part D of Medicare.

Additionally, coverage in this Plan ends:

1. If the Plan terminates, your coverage ends at the same time. This Plan may be canceled or changed without notice to you.
2. If the Plan no longer provides coverage for the class of beneficiaries to which you belong. Coverage ends on the effective date of that change.
3. If the Plan is amended to delete coverage for a spouse or Domestic Partner, Coverage ends on the effective date of that change, or for a Medicare member, the first of the month following submission of the change.
4. Coverage for the spouse or Domestic Partner ends when the Retired Employee's coverage ends.
5. Coverage ends at the end of the period for which required charges have been paid to the Claims Administrator on your behalf.
6. If you voluntarily cancel coverage at any time, coverage ends on the date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
7. If the Member no longer meets the eligibility requirements of this Plan. Coverage ends as of the date coinciding with or following the date the Member ceases to meet such requirements.

Note: If a marriage or Domestic Partnership terminates, the Retired Employee survivor or disabled person must give or send to us written notice of the termination. Coverage for a former spouse or Domestic Partner ends according to the "Eligible Status" provisions.

You may be entitled to continued benefits under terms which are specified elsewhere under Extension of Benefits.

SUSPENSION OF COVERAGE

Entitlement to Medi-Cal

If a Member becomes entitled to Medi-Cal, the Benefits of this Plan will be suspended for up to 24 months. A request for suspension of coverage must be made within 90 days of Medi-Cal entitlement.

If the Member loses entitlement to Medi-Cal, the Benefits of this Plan will be automatically reinstated as of the date of the loss of entitlement, provided notice is given to the Claims Administrator within 31 days of that date.

UTILIZATION REVIEW

State law requires that health plans disclose to Participants and health plan providers the process used to authorize or deny health care services under the Plan.

The Claims Administrator 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 Claims Administrator's Customer Service Department at the number listed on the last page of this booklet.

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 Benefit limitations and exclusions.

THE CLAIMS ADMINISTRATOR ONLINE

The Claims Administrator's Internet site is located at http://www.blueshieldca.com/uc. Members with Internet access and a Web browser may view and download healthcare information.

PRINCIPAL LIMITATIONS, EXCEPTIONS, AND EXCLUSIONS

The following Services are limited or excluded from all benefits unless otherwise stated in the Plan or any endorsements. Additional coverage information is available in the federal "Medicare and You" handbook available on line at www.medicare.gov or by calling the toll-free number 1-800-633-4227. TTY users should call 1-877-486-2048.

1. Physical examinations, except for a one-time "Welcome to Medicare" physical examination if received within the first 12 months of the Participant's initial coverage under Medicare Part B and a yearly "Wellness" exam thereafter.
2. Immunizations are limited to those covered under Medicare Part B Preventive Services.
3. Foot exams and treatment except for diabetic-related nerve damage and/or when certain Medicare coverage conditions are met.
4. Examinations for and the cost of eye glasses except for tests for glaucoma every 12 months if you are high risk for the condition. One pair of eyeglasses with standard frames (or one set of contact lenses) is covered after cataract surgery that implants an intraocular lens.
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 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.
7. Dental care and treatment, dental surgery and dental appliances.
8. Services for cosmetic purposes.
9. Blood and plasma, except that this exclusion shall not apply to the first three (3) pints of blood the Participant receives in a Calendar Year.
10. Services not specifically listed as benefits.
11. Services for which the Member is not legally obligated to pay, or Services for which no charge is made to the Member.
12. Services for which the Member is not receiving benefits from Medicare.

Medical Necessity

Unless otherwise noted in this booklet as a Covered service, the benefits of this Plan 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 conditions, and which, as determined by the Claims Administer, are:

a) consistent with the Claim Administrator's 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. Claims Administrator reserves the right, at its option, to waive this provision.

LIMITATIONS FOR DUPLICATE COVERAGE

In the event that a Member is both enrolled as a Member under this Plan and entitled to benefits under any of the conditions described in paragraphs 1. through 4. of this section, the Claim Administrator's liability for Services provided to the Member 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 Member'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 Member 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 Member is entitled under any workers' compensation or employers' liability law, provided however that Claims Administrator's rights under this paragraph will be limited to the establishment of a lien upon such other Benefits up to the amount paid by the Claims Administrator's for the treatment of the Sickness or Accidental Injury which was the basis of the Participant's claim for benefits under such workers' compensation or employers' liability law.

4. Benefits provided to the Member 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 contract.

EXCEPTION FOR OTHER COVERAGE

Participating Providers and Preferred Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for Services rendered under this Plan.

CLAIMS REVIEW

The Claims Administrator reserves the right to review all claims to determine if any exclusions or other limitations apply. The Claims Administrator may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

REDUCTIONS – THIRD PARTY LIABILITY

If a Member's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable or paid under the Plan unless the Member agrees in writing, in a form satisfactory to the Plan, to do all of the following:

1. Provide the Plan with a written notice of any claim made against the third party for damages as a result of the injury or illness;
2. Agree in writing to reimburse the Plan for Benefits paid by the Plan from any Recovery (defined below) when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from the Member's own uninsured or underinsured motorist coverage;
3. Execute a lien in favor of the Plan for the full amount of Benefits paid by the Plan;
4. Ensure that any Recovery is kept separate from and not comingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the Plan;
5. Periodically respond to information requests regarding the claim against the third party, and notify the Plan, in writing, within 10 days after any Recovery has been obtained;
6. Direct any legal counsel retained by the Member or any other person acting on behalf of the Member to hold that portion of the Recovery to which the Plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

If a Member fails to comply with the above requirements, no benefits will be paid with respect to the injury or illness. If Benefits have been paid, they may be recouped by the Plan, through deductions from future benefit payments to the Member or others enrolled through the Member in the Plan.

"Recovery" includes any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist coverage, related to the illness or injury, without reduction for any attorneys' fees paid or owed by the Member or on the Member's behalf, and without regard to whether the Member has been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in the name of the Member, except for uninsured or underinsured motorist coverage. The Recovery includes all monies received, regardless of how held, and includes monies directly received as well as any monies held in any account or trust on behalf of the Member, such as an attorney-client trust account.

The Member shall pay to the Plan from the Recovery an amount equal to the Benefits actually paid by the Plan in connection with the illness or injury. If the Benefits paid by the Plan in connection with the illness or injury exceed the amount of the Recovery, the Member shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

The Member's acceptance of Benefits from the Plan for illness or injury caused by a third party shall act as a waiver of any defense to full reimbursement of the Plan from the Recovery, including any defense that the injured individual has not been "made whole" by the Recovery or that the individual's attorneys fees and costs, in whole or in part, are required to be paid or are payable from the Recovery, or that the Plan should pay a portion of the attorneys fees and

costs incurred in connection with the claims against the third party.

If the Member receives Services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from the Member the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such Services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

COORDINATION OF BENEFITS

When a Member who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for Hospital or medical expenses, such Member will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual cost during any Calendar Year. Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are Incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit amount payable by each plan separately.

If the covered Member is also entitled to benefits under any of the conditions as outlined under the "Limitations for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the Member as an Employee will provide its benefits before the plan covering the Member as a Dependent.

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the Dependent child of a Member whose date of birth (excluding year of birth), occurs earlier in a Calendar Year, will determine its benefits before a plan which covers the Dependent child of a Member whose date of birth (excluding year of birth), occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph will not apply, and the rule set forth in the plan which does not have the provisions of this paragraph will determine the order of benefits.

1. In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent will determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.
2. Regardless of (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of that parent will determine its benefits before any other plan which covers the child as a Dependent child.
3. If the above rules do not apply, the plan which has covered the Member for the longer period of time will determine its benefits first, provided that:
    a. a plan covering a Member as a laid-off or retired Employee, or as a Dependent of that Member will determine its benefits after any other plan covering that Member as an Employee, other than a laid-off or retired Employee, or such Dependent; and
    b. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining

its benefits after the other, then paragraph (a.) above will not apply.

If this Plan is the primary carrier in the case of a covered Member, then this Plan will provide its Benefits without making any reduction because of benefits available from any other plan, except that Physician Members and other Participating Providers may collect any difference between their billed charges and this Plan's payment, from the secondary carrier(s).

If this Plan is the secondary carrier in the order of payments, and the Claims Administrator is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will pay the benefits that would be due as if it were the primary plan, provided that the covered Member (1) assigns to the Claims Administrator the right to receive benefits from the other plan to the extent of the difference between the benefits which the Claims Administrator actually pays and the amount that the Claims Administrator would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with the Claims Administrator in obtaining payment of benefits from the other plan, and (3) allows the Claims Administrator to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another plan, the Claims Administrator may pay to the other plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as Benefits paid under this Plan. The Claims Administrator shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by the Claims Administrator in excess of the maximum amount of payment necessary to satisfy these provisions, the Claims Administrator shall have the right to recover the excess from any person or other entity to or with respect to whom such payments were made.

The Claims Administrator may release to or obtain from any organization or person any information which the Claims Administrator considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other plan. Any person claiming Benefits under this Plan shall furnish the Claims Administrator with such information as may be necessary to implement these provisions.

COB Savings. A COB Savings, if any, for a calendar year is created for a Member under this Plan when a Member is covered by more than one plan and this Plan is not the primary carrier based on this Coordination of Benefits (COB) provisions. The COB Savings is the amount saved by the Plan that is not the primary carrier for the benefit of the Member.

The following criteria are used to create a COB Savings:

1. If this Plan is not the primary carrier, then its benefits may be reduced so that the benefits and services of all the plans do not exceed allowable expense.
2. The benefits of this Plan will never be greater than the sum of the benefits that would have been paid if you were covered only under this Plan.
3. If this Plan is the primary carrier, the benefits under this Plan will be determined without taking into account the benefits or services of any other plan. When this Plan is the primary carrier, nothing will be applied to this Plan’s COB Savings.

COB Savings for a Member are not carried forward from one year to the next. At the end of each calendar year, the COB Savings for a Member returns to zero and a new COB Savings is created for the next calendar year.

Effects of the COB Savings on the Plan Benefits

The COB Savings provisions will apply if this Plan is not the primary carrier and the benefits under this Plan and any other plan exceed the allowable expense for the calendar year.

The COB Savings is determined by subtracting the amount the primary carrier paid from the amount this Plan would have paid had it been the primary carrier.

When this Plan is not the primary carrier, the amounts saved, determined on a claim-by-claim basis, are recorded as a COB Savings and are used to pay allowable expenses, not otherwise paid, that are incurred by the Member during the Calendar Year.

EXTENSION OF BENEFITS

If a Member becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the Plan terminates, the Claims Administrator will extend the Benefits of this Plan, subject to all limitations and restrictions, for covered Services and supplies directly related to the condition, illness, or injury causing such Total Disability until the first to occur of the following: (1) 12:01 a.m. on the day following a period of twelve months from the date coverage terminated; (2) the date the covered Member is no longer Totally Disabled; (3) the date on which the covered Member's maximum Benefits are reached; (4) the date on which a replacement carrier provides coverage to the Member that is not subject to a Pre-existing Condition exclusion. The time the Member was covered under this Plan will apply toward the replacement plan's pre-existing condition exclusion.

No extension will be granted unless the Claims Administrator receives written certification of such Total Disability from a licensed Doctor of Medicine (M.D.) within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by the Claims Administrator.

GROUP CONTINUATION COVERAGE

CONTINUATION OF GROUP COVERAGE

Please examine your options carefully before declining this coverage.

COBRA

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies:

The COBRA group continuation coverage is provided through federal legislation and allows employees or retirees and their enrolled family member who lose group coverage because of certain "qualifying events" to elect continuation coverage for 18, 29, or 36 months. Qualifying events are situations that would ordinarily cause an individual to lose group health coverage.

An eligible employee or retiree and his/her enrolled family member(s) is entitled to elect continuation coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. Any change in benefits under the plan will also apply to COBRA enrollees.

Two "qualifying events" allow enrollees to request the continuation coverage for 18 months.

1. The covered employee's separation from employment for reasons other than gross misconduct.
2. Reduction in the covered employee's hours to less than the number of hours required for eligibility.

The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined by the Social Security Administration (SSA) to be disabled within the first 60 days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

Three "qualifying events" allow eligible employees or retirees and their enrolled family member(s) to elect the continuation coverage for up to 36 months.

1. The employee's or retiree's death.

2. Divorce, legal separation or annulment of the covered employee or retiree from the employee's or retiree's spouse or termination of the domestic partnership.
3. A dependent child's loss of eligibility.

Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

If elected, COBRA continuation coverage is effective the first day of the month following the date coverage under the group plan terminates.

The COBRA continuation coverage will remain in effect for the maximum coverage period or until any of the following events occur:

1. The termination of all employer provided group health plans;
2. The required premium for the Member's coverage is not paid on a timely basis;
3. The Member becomes covered by another group health plan after electing COBRA without limitations as to pre-existing conditions;
4. The Member becomes eligible for Medicare benefits after electing COBRA;
5. The continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled.
6. The Member notifies the plan or COBRA administrator that he/she wishes to cancel overage.

You will receive notice from your Employer's COBRA Administrator of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced.

Contact your Employer or your Employer's COBRA Administrator directly if you need more information about your eligibility for COBRA group continuation coverage.

GENERAL PROVISIONS

NON-ASSIGNABILITY

Coverage or any Benefits of this Plan may not be assigned without the written consent of the Claims Administrator. Possession of an ID card confers no right to Services or other Benefits of this Plan. To be entitled to Services, the Member must be a Participant who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment under the terms of this Plan.

Participating Providers and Preferred Providers are paid directly by the Claims Administrator. The Member or the provider of Service may not request that payment be made directly to any other party.

If the Member receives Services from a Non-Preferred Provider, payment will be made directly to the Participant, and the Participant is responsible for payment to the Non-Preferred Provider. The Member or the provider of Service may not request that the payment be made directly to the provider of Service.

PLAN CHANGES

The Benefits of this Plan, including but not limited to Covered Services, Deductible, Copayment, are subject to change at any time. The Claims Administrator will provide at least 60 days' written notice of any such change.

Benefits for Services or supplies furnished on or after the effective date of any change in Benefits will be provided based on the change.

PLAN INTERPRETATION

The Claims Administrator shall have the power and discretionary authority to construe and interpret the provisions of this Plan, to determine the Benefits of this Plan and determine eligibility to receive Benefits under this Plan. The Claims Administrator shall exercise this authority for the benefit of all Members entitled to receive Benefits under this Plan.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

The Claims Administrator 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. The Claims Administrator will not disclose this information without your authorization, except as permitted by law.

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

The Claims Administrator'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 Claims Administrator's Customer Service Department at the number indicated on the last page of this booklet, or by accessing the Claims Administrator's internet site located at http://www.blueshieldca.com/uc and printing a copy.

If you are concerned that the Claims Administrator 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/uc

ACCESS TO INFORMATION

The Claims Administrator 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 Plan. You agree that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. You agree to assist the Claims Administrator in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing the Claims Administrator with information in your possession. Failure to assist the Claims Administrator 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 the Claims Administrator will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

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.

RIGHT OF RECOVERY

Whenever payment on a claim has been made in error, the Claims Administrator will have the right to recover such payment from the Participant or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. The Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Participant or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another

payor, payments made after termination of the Participant's or Member's eligibility, or payments on fraudulent claims.

CUSTOMER SERVICE

If you have a question about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that you have experienced, you may contact the Claims Administrator's Customer Service Department as indicated on last page of this booklet. The hearing impaired may contact the Customer Service Department through the Claims Administrator's toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

Note: The Claims Administrator has established a procedure for our Participants and Dependents to request an expedited decision. A Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The Claims Administrator shall make a decision and notify the Member and Physician as soon as possible to accommodate the Member's condition not to exceed 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 Claims Administrator's Customer Service Department as indicated on the last page of this booklet.

SETTLEMENT OF DISPUTES

INTERNAL APPEALS

Initial Internal Appeal

If a claim has been denied in whole or in part by the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may request that the Claims Administrator give further consideration to the claim by contacting the Customer Service Department via telephone or in writing including any additional information that would affect the processing of the claim. The Claims Administrator will acknowledge receipt of an appeal within 5 calendar days. Written requests for initial internal appeal may be submitted to the following address:

Blue Shield of California
Attn: Initial Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Appeals must be filed within 180 days after you receive notice of an adverse benefit decision. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator.

Final Internal Appeal

If you are dissatisfied with the initial internal appeal determination by the Claims Administrator, the determination may be appealed in writing to the Claims Administrator within 60 days after the date of the notice of the initial appeal determination. Such written request shall contain any additional information that you wish the Claims Administrator to consider. The Claims Administrator shall notify you in writing of the results of its review and the specific basis therefore. In the event the Claims Administrator finds all or part of the appeal to be valid, the Claims Administrator, on behalf of the Employer, shall reimburse you for those expenses which the Claims Administrator allowed as a result of its review of the appeal. Final appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator. Written requests for final internal appeals may be submitted to:

Blue Shield of California
Attn: Final Appeals
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Expedited Appeal (Initial and Final)

You have the right to an expedited decision when the routine decision-making process might

pose an imminent or serious threat to your health, including but not limited to severe pain or potential loss of life, limb or major bodily function. The Claims Administrator will evaluate your request and medical condition to determine if it qualifies for an expedited decision. If it qualifies, your request will be processed as soon as possible to accommodate your condition, not to exceed 72 hours. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may call or write as instructed under the Initial and Final Appeals sections outlined above. Specifically state that you want an expedited decision and that waiting for the standard processing might seriously jeopardize your health.

EXTERNAL REVIEW

Standard External Review

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment or a rescission of coverage, you, a designated representative, a provider or an attorney on your behalf may request an external review within four months after notice of the final internal appeal determination. Instructions for filing a request for external review will be outlined in the final internal appeal response letter.

Expedited External Review

If your situation is eligible for an expedited decision, you, a designated representative, a provider or an attorney on your behalf may request external review within four months from the adverse benefit decision without participating in the initial or final internal appeal process. To request an expedited decision, you, a designated representative, a provider or an attorney on your behalf may fax a request to (916) 350-7585, or write to the following address. Specifically state that you want an expedited external review decision and that waiting for the standard processing might seriously jeopardize your health.

Blue Shield of California
Attn: Expedited External Review
P.O. Box 5588
El Dorado Hills, CA 95762-0011

Other Resources to Help You

For questions about your appeal rights, or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

DEFINITIONS

PLAN PROVIDER DEFINITIONS

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

Hospital —

1. a licensed institution primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for care and treatment of sick and injured persons on an Inpatient basis, under the supervision of an organized medical staff, and which provides 24 hour a day nursing service by registered nurses. A facility which is principally a rest home or nursing home or home for the aged is not included.
2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3. a psychiatric healthcare facility as defined in Section 1250.2 of the Health and Safety Code.

Non-Participating/Non-Preferred Providers — any provider who has not contracted with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider.

Other Providers —

1. Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; licensed psychiatric nurses; registered dieticians; certified nurse midwives; licensed occupational therapists; certificated acupuncturists; certified respiratory

therapists; enterostomal therapists; licensed speech therapists or pathologists; dental technicians; and lab technicians.

2. Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and Outpatient clinics not MD owned; portable X-ray companies; lay-owned independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

Outpatient Facility — a licensed facility, not a Physician's office or Hospital, that provides medical and/or surgical services on an Outpatient basis.

Participating Physician — a selected Physician or a Physician Member that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment-in-full for covered Services, except as provided under the Payment and Participant Copayment provision in this booklet.

Participating Provider — a Physician or a Hospital, that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable Deductibles and Copayments, as payment in full for covered Services.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Physician Member — a Doctor of Medicine who has enrolled with the Claims Administrator as a Physician Member.

Preferred Hospital — a Hospital under contract to the Claims Administrator which has agreed to furnish Services and accept reimbursement at negotiated rates, and which has been designated as a Preferred Hospital by the Claims Administrator.

Preferred Provider — a Physician Member, Preferred Hospital, Preferred Dialysis Center, or Participating Provider.

Skilled Nursing Facility — 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.

ALL OTHER DEFINITIONS

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

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

Allowed Charges (Allowable Amount) — the Claims Administrator Allowance (as defined below) for the Service (or Services) rendered, or the provider’s billed charge, whichever is less. The Claims Administrator Allowance, unless otherwise specified for a particular service elsewhere in this booklet, is:

1. For a Participating Provider, the amount that the provider and the Claims Administrator have agreed by contract will be accepted as payment in full for the Services rendered; or
2. For a Non-Participating/Non-Preferred Provider (excluding a Hospital/ Outpatient Facility) in California who provides non-Emergency Services, the amount the Claims Administrator would have allowed for a Participating Provider performing the same service in the same geographical area.
3. For a Non-Participating/Non-Preferred Provider (excluding a Hospital/ Outpatient Facility) who provides Emergency Services, the Reasonable and Customary Charge.
4. For a Hospital/ Outpatient Facility that is a Non-Participating/Non-Preferred Provider in California who provides Emergency or non-Emergency Services, the amount negotiated by the Claims Administrator.
5. For a provider anywhere, other than in California, within or outside of the United

States, which has a contract with the local Blue Cross and/or Blue Shield plan, the amount that the provider and the local Blue Cross and/or Blue Shield plan have agreed by contract will be accepted as payment in full for service rendered; or

6. For a non-participating provider (i.e., that does not contract with the Claims Administrator or a local Blue Cross and/or Blue Shield plan) anywhere, other than in California, within or outside of the United States, who provides non-Emergency Services, the amount that the local Blue Cross and/or Blue Shield plan would have allowed for a non-participating provider performing the same services. If the local plan has no non-participating provider allowance, the Claims Administrator will assign the Allowable Amount used for a Non-Participating/Non-Preferred Provider in California.

Benefits (Services) — those Services which a Member is entitled to receive pursuant to the Plan Document.

Benefit Period — 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 — a period beginning on January 1 of any year and terminating on January 1 of the following year.

Claims Administrator — the claims payor designated by the Employer to adjudicate claims and provide other services as mutually agreed. Blue Shield of California has been designated the Claims Administrator.

Clinical Laboratory Services — Includes certain blood tests, urinalysis, some screening tests, and more.

Coinsurance — the percentage of the Allowable Amount that a Member is required to pay for specific Covered Services after meeting any applicable Deductible.

Copayment — the amount that a Member is required to pay for specific Covered Services after meeting any applicable Deductible.

Covered Services (Benefits) — those Services which a Member is entitled to receive pursuant to the terms of the Plan Document.

Custodial or Maintenance Care — 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 Member 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 care; or
2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – The amount paid by the Participant for specific covered Services before Original Medicare or a retiree Medicare plan begins to pay.

Dependent and Domestic Partner—

Please refer to the "Eligible Family Members" section of the "Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members". A copy of this factsheet is available in the Health and Welfare section of the At Your Service website (atyourservice.ucop.edu). Additional resources are also available in the Health and Welfare section of At Your Service to help you with your health and welfare plan decisions.

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

Durable Medical Equipment (DME) — Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a doctor or other health care provider enrolled in Medicare for use in the home. Some items must

be rented. In all areas of the country, you must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

Employer — is University of California and is the Plan Sponsor and Plan Administrator. The Employer is responsible for funding the payment of claims for benefits under the Plan.

Home Health Care — Limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor or other health care provider enrolled in Medicare must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.

Hospice Care — For people with a terminal illness. Your doctor must certify that you're expected to live six months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment and other covered services as well as services Medicare usually doesn't cover, such as spiritual and grief counseling. A Medicare-approved hospice usually gives hospice care in your home or other facility where you live like a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility which contracts with the hospice. Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to five days each time you get respite care. Medicare will pay for covered services for health problems that aren't related to your terminal illness. You can continue to get hospice care as long as the Hospice medical director or Hospice doctor recertifies that you're terminally ill.

Inpatient – A Member 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 — the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Medicare Benefits — 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 — expenses of the kinds covered by Medicare Part A and B to the extent recognized as reasonable and medically necessary by Medicare.

Member — either a Participant or Dependent.

Mental Health Condition — for the purposes of this Plan, means those conditions listed in the "Diagnostic & Statistical Manual of Mental Disorders Version IV" (DSM4), except as stated herein, and no other conditions. Mental Health Conditions include Severe Mental Illnesses and Serious Emotional Disturbances of a Child, but do not include any services relating to the following:

1. Diagnosis or treatment of Substance Abuse Conditions;
2. Diagnosis or treatment of conditions represented by V Codes in DSM4;
3. Diagnosis or treatment of any conditions listed in DSM4 with the following codes:

   294.8, 294.9, 302.80 through 302.90, 307.0, 307.3, 307.9, 312.30 through 312.34, 313.9, 315.2, 315.39 through 316.0.

Mental Health Services — Services provided to treat a Mental Health Condition.

Out-of-Pocket Maximum - the highest Deductible, Copayment and Coinsurance amount an individual is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum.

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

Partial Hospitalization/Day Treatment Program — a treatment program that may be free-standing or Hospital-based and provides Services at least five (5) hours per day and at least four (4) days per week. Patients may be admitted directly to this level of care, or transferred from acute Inpatient care following acute stabilization.

Participant — a Retired Employee who has been accepted by the Employer and enrolled by the Claims Administrator as a Participant and who has maintained enrollment in accordance with this Plan.

Plan — University of California High Option Supplement to Medicare for eligible Retired Employees and Dependents of the Employer.

Plan Administrator — is The Regents of University of California.

Plan Sponsor — is The Regents of University of California.

Residential Care — services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not qualify for Acute Care or Skilled Nursing Services.

Residential Care Program for Mental Health Condition - is provided in a licensed facility which operates pursuant to written, specific and detailed treatment programs for full-time participating clients under the direction of an administrator and Physician for chronic mental health conditions. It includes diagnosis and treatment including ongoing evaluation and observation of the client for changes in physical, mental, emotional and social functioning and the consultation services of a dietitian, Physician, social worker, psychologist and other consultants when needed. The residential facility cannot accept or retain clients who require Inpatient Hospital level or acute psychiatric care.

Residential Care Program for Substance Abuse Condition - is provided in a licensed facility that provides structured 24-hour residential services designed to promote treatment and maintain recovery from the recurrent use of alcohol, drugs, and/or related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

Retired Employee — an individual who meets the eligibility requirements established by the Employer and accepted by the Claims Administrator.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (other than a primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;

b. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.

Services — include medically necessary healthcare services and medically necessary supplies furnished incident to those services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Sickness — an illness or disease of a covered person which first manifests itself after the effective date of the Plan and while coverage is in effect.

Substance Abuse Condition — for the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

Subacute Care — skilled nursing or skilled rehabilitation 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.

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

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

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For claims submission and information contact the Claims Administrator.

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

Participants may call Customer Service Department toll free:

1-855-201-8375

The hearing impaired may call Customer Service through the toll-free TTY number: 1-800-241-1823