Benefit Booklet

California's Valued Trust
PPO Retiree Plan1 (Medicare Supplement Plan 1)
Group Number: WP0000009-M0037756
Effective Date: October 1, 2024

blue california

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Summary of Supplemental Medicare Benefits

Plan 1

California's Valued Trust (CVT)
Effective October 1, 2024

Benefits[1]

	Medicare Pays	Claims Administrator Pays	Member Pays
Medicare Part A[2, 3, 4, 5]			
Hospitalization – Hospital inpatient benefits for conditions other than Mental Health or Substance Use Disorder Condition. Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but Part A Deductible	Part A Deductible[2]	$0
61st through 90th day	All but Medicare Copayment	Medicare Copayment	$0
91st day and after while using 60 lifetime reserve days	All but Medicare Copayment	Medicare Copayment	$0
Once lifetime reserve days are used – lifetime maximum benefit of an additional 365 days	$0	100% of Medicare Eligible Expenses	$0

Benefits[1]

	Medicare Pays	Claims Administrator Pays	Member Pays
Hospitalization – Hospital inpatient Benefits for Mental Health Conditions[9]			
First 60 days	All but Part A Deductible	Part A Deductible[2]	$0
61st through 90th day	All but Medicare Copayment	Medicare Copayment	$0
91st day and after while using 60 lifetime reserve days	All but Medicare Copayment	Medicare Copayment	$0
Hospitalization – Hospital inpatient Benefits for Substance Use Disorder Conditions.[9]			
First 60 days	All but Part A Deductible	Part A Deductible[2]	$0
61st through 90th day	All but Medicare Copayment	Medicare Copayment	$0
91st day and after while using 60 lifetime reserve days	All but Medicare Copayment	Medicare Copayment	$0
Once 190 day liftetime maximum is reached – lifetime maximum benefit of an additional 515 days[10]	$0	100% of Medicare Eligible Expenses	$0
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 Medicare Copayment	Medicare Copayment	$0
101st day and after	$0	$0	All costs

Benefits[1]

	Medicare Pays	Claims Administrator Pays	Member Pays
Blood[6]			
First 3 pints	$0	3 pints	$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 Copayments/ cost share for inpatient respite care	Medicare Copayments and Coinsurance	$0
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%	20%	Part B Deductible[7]
Medical Expenses (In or Out of the Hospital and Outpatient Hospital Treatment) – Physician's services, Inpatient and Outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	80%	20%	Part B Deductible[7]
Blood[6]			
First 3 pints	$0	All costs	$0
Additional amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	80%	20%	Part B Deductible[7]
Home Health Care (Medicare Approved Services)			
Medically necessary skilled care services and medical supplies	100%	$0	$0

Benefits[1]

	Medicare Pays	Claims Administrator Pays	Member Pays
Medically necessary skilled care services and medical supplies, once you have exhausted your Medicare benefits *Up to $1,600 per Member, per Calendar Year for 8 additional weeks of Home Health Care visits.*	$0	$40	100% of additional charges above $40
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.	80%	20%	Part B Deductible[7]

Notes

1 Only Retired Employees and their spouse or Domestic Partner enrolled in Medicare Parts A & B are eligible for this Retiree Preferred Plan. Medicare will always pay primary for Medicare covered services. The Plan will coordinate with Medicare, paying secondary.

2 The Part A Deductible 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 Retiree Preferred Plan 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 Use Disorder 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 Use Disorder 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 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. You are responsible for paying the Part B Deductible. Once you have paid the Part B Deductible of Medicare approved amounts for Covered Services, your Medicare Part B Deductible will have been met for the calendar year.

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.

9 You will pay for any additional inpatient Mental Health or Substance Use Disorder services you receive after Medicare has paid the 190 day lifetime maximum for these services.

10 For inpatient Hospital services for the treatment of Substance Use Disorders, the plan will pay for up to 515 addiitonal days during your lifetime, once you have exhausted your Medicare Benefits.

Benefits

	Medicare Pays	Claims Administrator Pays	Member Pays
Foreign Travel – Not covered by Medicare[1]			
Medically Necessary Emergency Services, beginning during the first 60 days of each trip outside the United States.			
First $250 each Calendar Year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

1 Please see the *Out-of-area services* section of the Benefits Booklet for more information. Call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

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Introduction

Welcome! We are happy to have you as a Member of the California's Valued Trust (CVT) health Plan (Plan).

This health Plan will help you pay for medical care and provide you with access to a network of doctors, Hospitals, and other Health Care Providers. The types of services that are covered, the providers you can see, and your share of cost when you receive care may vary depending on the terms of the Plan, as described in further detail in this Benefit Booklet.

About this Evidence of Coverage

The Benefit Booklet describes the health care coverage that is provided under the Plan. The Benefit Booklet tells you:

- Your eligibility for coverage;
- When coverage begins and ends;
- How you can access care;
- Which services are covered under your Plan (Covered Services);
- Which services are not covered under your Plan; and
- Important financial concepts, such as Copayment, Coinsurance, and Deductible.

This Benefit Booklet includes a *Summary of Benefits* section that lists your Cost Share for Covered Services. Use this summary to figure out what your cost will be when you receive care. 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 medicare.gov or call the toll-free number (800) 633-4227. TTY users should call (877) 486-2048.

Please read this Benefit Booklet carefully. Some topics in this document are complex. 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. For additional explanation on these topics, you may be directed to a section at the back of the Benefit Booklet called *Other important information about your Plan*. Pay particular attention to sections that apply to any special health care needs you may have. Be sure to keep this Benefit Booklet in your files for future reference.

Tables and images

In this Benefit Booklet, you will see the following tables and images to highlight key information:

This table provides easy access to information

Phone numbers and addresses

This table provides easy access to information
Answers to commonly-asked questions
Examples to help you better understand important concepts

This box tells you where to find additional information about a specific topic.

This box alerts you to information that may require you to take action.

"You" means the Member

In this Benefit Booklet, "you" or "your" means any Member enrolled in the Plan, including the Participant and all Dependents. "Your Employer" means the Participant's Employer.

Capitalized words have a special meaning

Some words and phrases in this Benefit Booklet may be new to you. Key terms with a special meaning within this Benefit Booklet are capitalized and defined in the *Definitions* section.

How to contact Customer Service

If you have questions at any time, we're here to help. The Claims Administrator's website and app are useful resources. Visit blueshieldca.com or use the Claims Administrator's mobile app to:

- Download forms;
- View or print a temporary ID card;
- Access recent claims;
- Find a doctor or other Health Care Provider; and
- Explore health topics and wellness tools.

The Claims Administrator's contact information appears at the bottom of every page.

Contacting Customer Service

If you need information about	*You should contact*
Medical Benefits, including prior authorization and claims submission	Connect Member Services: 1-888-499-5532 Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540
Prior authorization of radiological services	National Imaging Associates: (888) 642-2583

If you are hearing impaired, you may contact Customer Service through the Claims Administrator's toll-free TTY number: 711.

Your bill of rights

	As a Member, 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, and the Physicians and other Health Care Providers available to care for you.
5	Have reasonable access to appropriate medical and mental health services in accordance with the terms of your Plan.
6	Participate actively with your Physician in decisions about your medical and mental health care. To the extent the law permits, 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	An explanation of your medical or mental health condition, and any proposed, appropriate, or Medically Necessary treatment alternatives from your Physician, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost or Benefit coverage.
9	Receive Medicare covered preventive health services.
10	Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
11	Have confidential health records, except when the law requires or permits disclosure. 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 complaint and grievance process and understand how to use it without the fear of an interruption in your health care.
14	Voice complaints or grievances about your Plan or the care provided to you.

	As a Member, you have the right to:
15	Make recommendations on the Claims Administrator's Member rights and responsibilities policies.

Your responsibilities

	As a Member, you have the responsibility to:
1	Carefully read all plan materials, including this Benefit Booklet, immediately after you are enrolled so you understand how to: • Use your Benefits; • Minimize your out-of-pocket costs; and • Follow the provisions of your Plan as explained in the Benefit Booklet.
2	Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when you need it.
3	Provide, to the extent possible, information needed for you to receive appropriate care.
4	Understand your health problems and take an active role in developing treatment goals with your Physician, whenever possible.
5	Follow the treatment plans and instructions you and your Physician agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6	Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7	Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8	Communicate openly with your Physician so you can develop a strong partnership based on trust and cooperation.
9	Offer suggestions to improve the Plan.
10	Help the Claims Administrator maintain accurate and current records by providing timely information regarding changes in your 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 or grievances.
12	Treat all Plan personnel respectfully and courteously.
13	Pay your share of charges services in full and on time.

How to access care

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

Health care professionals and facilities

This Plan covers care from Participating Providers and Non-Participating Providers. You do not need a referral.

Choice of providers – 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.

Participating Providers for additional Benefits – Non-Medicare Covered Services

Participating Providers have a contract with the Claims Administrator and agree to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services. As a result, when you receive Covered Services from a Participating Provider, you will not be responsible for any costs in excess of the applicable Cost Share. When you receive Covered Services from a Non-Participating Provider, you will be responsible for the applicable Cost Share and may also be responsible for additional costs, such as charges from the Non-Participating Provider that are over the Allowable Amount and charges for services above any maximum Benefit allowance.

Some services will not be covered unless you receive them from a Participating Provider. See the *Summary of Benefits* section to find out which Covered Services must be received from a Participating Provider.

If a provider leaves this Plan's network, the status of the provider will change from Participating to Non-Participating.

Visit ***blueshieldca.com*** or use the Claims Administrator's mobile app and click on ***Find a Doctor*** for a list of your plan's ***Participating Providers***.

Non-Participating Providers

Non-Participating Providers do not have a contract with the Claims Administrator to accept the Claims Administrator's Allowable Amount as payment in full for Covered Services.

Except for Emergency Services and services received at a Participating Provider facility (Hospital, Ambulatory Surgical Center, laboratory, radiology center,

imaging center, or certain other outpatient settings) under certain conditions, you will pay more for Covered Services from a Non-Participating Provider.

Common types of providers
Primary Care Physicians (PCPs)
Other primary care providers, such as nurse practitioners and physician assistants
Physician Specialists, such as dermatologists and cardiologists
Physical, occupational, and speech therapists
Mental health providers, such as psychiatrists, psychologists, and licensed clinical social workers
Hospitals
Freestanding labs and radiology centers
Ambulatory Surgery Centers

ID cards

The Claims Administrator will provide the Participant and any enrolled Dependents with identification cards (ID cards). Only you can use your ID card to receive Benefits. Your ID card is important for accessing health care, so please keep it with you at all times. Temporary ID cards are available at blueshieldca.com or on the Claims Administrator's mobile app.

Canceling appointments

If you are unable to keep an appointment, you should notify the provider at least 24 hours before your scheduled appointment. Some offices charge a fee for missed appointments unless it is due to an emergency or you give 24-hour advance notice.

Second medical opinion

You can consult a Participating or Non-Participating Provider for a second medical opinion in situations including but not limited to:

- You have questions about the reasonableness or necessity of the treatment plan;
- There are different treatment options for your medical condition;
- Your diagnosis is unclear;
- Your condition has not improved after completing the prescribed course of treatment;
- You need additional information before deciding on a treatment plan; or

- You have questions about your diagnosis or treatment plan.

You do not need prior authorization from the Claims Administrator or your Physician for a second medical opinion.

Care outside of California

The Blue Cross Blue Shield Association can help you access care from participating and non-participating providers in those geographic areas.

See the ***Out-of-area services*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Emergency Services

If you have a medical emergency, ***call 911 or seek immediate medical attention*** at the nearest hospital.

The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition. Emergency Services are covered at the Participating Provider Cost Share, even if you receive treatment from a Non-Participating Provider.

After you receive care, the Claims Administrator will review your claim for Emergency Services to determine if your condition was in fact an Emergency Medical Condition. If you did not require Emergency Services and did not reasonably believe an emergency existed, you will be responsible for the Participating or Non-Participating Provider Cost Share for that non-emergency Covered Service.

For the lowest out-of-pocket expenses, you can go to a Participating Physician's office for emergency room follow-up services, such as suture removal and wound checks.

If you cannot find a Participating Provider

Call Customer Service if you need help finding a Participating Provider who can provide the care you need close to home. If a Participating Provider is not available, you can ask to see a Non-Participating Provider at the Participating Provider Cost Share. If the services cannot reasonably be obtained from a Participating Provider, we will approve your request and you will only be responsible for the Participating Provider Cost Share.

Medical Management

Prior authorization

Coverage for some Benefits requires pre-approval from the Claims Administrator. This process is called prior authorization. Prior authorization requests are reviewed for Medical Necessity, available plan Benefits, and clinically appropriate setting. The prior authorization process also identifies Benefits that are only covered from Participating Providers or in a specific clinical setting.

If you see a Participating Provider, your provider must obtain prior authorization when required. When prior authorization is required but not obtained, the Claims Administrator may deny payment to your provider. You are not responsible for the Claims Administrator's portion of the Allowable Amount if this occurs, only your Cost Share.

If you see a Non-Participating Provider, you or your provider must obtain prior authorization when required. When prior authorization is required but not obtained, and the services provided are determined not to be a Benefit of the Plan or Medically Necessary, the Claims Administrator may deny payment and you will be responsible for all billed charges.

You do not need prior authorization for Emergency Services or emergency Hospital admissions at Participating or Non-Participating facilities. For non-emergency inpatient services, your provider should request prior authorization at least five business days before admission.

Visit blueshieldca.com and click on Prior Authorization List for more details about medical and surgical services and select prescription Drugs that require prior authorization.

Prescription Drugs administered by a Health Care Provider

Drugs administered by a Health Care Provider in a Physician's office, an infusion center, the Outpatient Department of a Hospital, or provided at home through a home infusion agency, are covered under the medical benefit and require prior authorization.

Frequently-utilized services that require prior authorization

Benefit	*Services that require prior authorization*
Medical	• Surgery • Prescription Drugs administered by a Health Care Provider • Non-emergency inpatient facility services, such as Hospitals and Skilled Nursing Facilities • Non-emergency ambulance services • Routine patient care received while enrolled in a clinical trial • Hospice program enrollment
Advanced imaging	• CT (Computerized Tomography) scan • MRI (Magnetic Resonance Imaging) • MRA (Magnetic Resonance Angiography) • PET (Positron Emission Tomography) scan • Diagnostic cardiac procedure utilizing nuclear medicine
Mental health and substance use disorder	• Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Behavioral Health Treatment • Electroconvulsive therapy • Psychological testing • Partial Hospitalization Program • Intensive Outpatient Program • Transcranial magnetic stimulation

When a decision will be made about your prior authorization request

Prior authorization or exception request	*Time for decision*
Routine medical and mental health and substance use disorder requests	Within five business days
Expedited medical and mental health and substance use disorder requests	Within 72 hours

Expedited requests include urgent medical requests. Once the decision is made, your provider will be notified within 24 hours. Written notice will be sent to you and your provider within two business days.

Your payment information

Paying for coverage

The Employer is responsible for funding the payment of claims for Benefits under this Plan.

Paying for Covered Services

Your Cost Share is the amount you pay for Covered Services. It is your portion of the Claims Administrator's Allowable Amount.

Your Cost Share includes any:

- Deductible;
- Copayment amount; and
- Coinsurance amount.

See the ***Summary of Benefits*** section for your ***Cost Share*** for Covered Services.

Deductible

The Deductible is the amount you pay for specific Covered Services before Original Medicare or a retiree Medicare plan begins to pay.

See the *Summary of Benefits* section for details on which Covered Services are subject to the Deductible and how the Deductible works for your plan.

Copayment and Coinsurance

A Covered Service may have a Copayment or a Coinsurance. A Copayment is a specific dollar amount you pay for a Covered Service. A Coinsurance is a percentage of the Allowable Amount you pay for a Covered Service.

Your provider will ask you to pay your Copayment or Coinsurance at the time of service. For Covered Services that are subject to your plan's Deductible, you are also responsible for all costs up to the Allowable Amount until you reach your Deductible.

Claims

When you see a Participating Provider, your provider submits the claim to the Claims Administrator. When you see a Non-Participating Provider, you must submit the claim to the Claims Administrator.

Claim forms are available at blueshieldca.com. Please submit your claim form and medical records within one year of the service date.

See the *Out-of-Area services* section in the *Other important information about your plan* section for more information on claims outside of California.

How to submit a claim			
Type of claim	***What to submit***	***Where to submit it***	***Due date***
Medical services	• The Claims Administrator claim form; and • The itemized bill from your provider	Blue Shield of California P.O. Box 272540 Chico, CA 95927	Within one year of the service date

Payment of claims for covered Medicare services

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 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.

Claim processing and payments

The Claims Administrator will process your claim within 30 business days of receipt if it is not missing any required information. If your claim is missing any required information, you or your provider will be notified and asked to submit the missing information. The Claims Administrator cannot process your claim until we receive the missing information.

Once your claim is processed, you will receive an explanation of your Benefits. For each service, the explanation will list your Cost Share and the payment made by the Claims Administrator to the provider.

When you receive Covered Services from a Non-Participating Provider, the Claims Administrator may send the payment to the Participant, or directly to the Non-Participating Provider.

The Participant must make sure ***the Non-Participating Provider*** receives the ***full billed amount***, whether or not the Claims Administrator makes payment to the Non-Participating Provider.

Your coverage

This section explains eligibility and enrollment for this Plan. It also describes the terms of your coverage, including information about effective dates and the different ways your coverage can end.

Eligibility for this Plan

Retired Employees

You are in an eligible status if you are a Retired Employee and you are actively enrolled under both Part A and Part B of Medicare.

Retired Employee's Spouse or Domestic Partner

The Retired Employee's spouse or Domestic Partner is eligible to be enrolled as a Dependent, provided that the spouse or Domestic Partner is actively enrolled under Part A and Part B of Medicare.

Enrollment and effective dates of coverage

To enroll as a Retired Employee, or to enroll a spouse or Domestic Partner, the Retired Employee must properly file an application. An application is considered properly filed only if it is personally signed, dated, and given to the Plan Administrator within 31 days from your eligibility date. The Claims Administrator must receive this information within 90 days. If any of these steps are not followed, your coverage may be denied.

Timely Enrollment

If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows:

Retired Employees

Your coverage beings on the date specified in the participation agreement.

Retired Employee's Spouse or Domestic Partner

You become eligible on the later of:

- If the application of a person enrolling as a Subscriber includes application for an eligible Spouse or Domestic Partner, the Subscriber's effective date; or
- For a new Spouse of a Subscriber who is already enrolled under the Plan, the first day of the month following the date of marriage, but only if an application to enroll the spouse has been filed within 31 days of the date of marriage; or
- For a new Domestic Partner of a Subscriber who is already enrolled under the Plan, the first day of the month following the date of appication, but only if an application to enroll the domestic partner has been filed within 31 days following six consecutive months orom the date the domestic partnership commenced.

If you become eligible before the Plan takes effect, coverage begins on the effective date of the Plan, provided the enrollment application is on time and in order.

Open enrollment period

There is a yearly Open Enrollment Period. During that time, an individual who meets the eligibility requirements as a Retired Employee under this Plan may enroll in this Plan. The Retired Employee may also enroll an eligible spouse or Domestic Partner at that time.

Late Enrollment and Disenrollment

If you are a Late Enrollee or disenrollee, you may enroll without waiting for the next Open Enrollment Period if you are otherwise eligible under any one of CVT's qualifying events. Please call CVT Member Services at (800) 288-9870 for a listing of qualifying events.

Plan changes

The Plan Sponsor has the right to change the Benefits and terms of this Plan as the law permits. This includes, but is not limited to, changes to:

- Terms and conditions;
- Benefits;
- Cost Shares;
- Participant Contributions; and
- Limitations and exclusions.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain the original Benefits.

When coverage ends

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

Additionally, coverage in this Plan ends:

- If the Plan terminates, your coverage ends at the same time. This Plan may be canceled or changed without notice to you.
- 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.
- If the Plan is amended to delete coverage for a spouse or Domestic Partner, Coverage ends on the effective date of that change.
- Coverage for the spouse or Domestic Partner ends when the Retired Employee's coverage ends.
- Coverage ends at the end of the period for which required charges have been paid to the Claims Administrator on your behalf.
- 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.

- If the Member no longer meet 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 must give or send to us written notice of the termination.

The Claims Administrator may terminate your and your Dependent's coverage for cause immediately upon written notice to you and your Employer for the following:

- Material information that is false, or misrepresented information provided on the enrollment application or given to your Employer or the Claims Administrator;
- Permitting use of your Participant identification card by someone other than yourself or your Dependents to obtain Services;
- Obtaining or attempting to obtain Services under the group by means of false, materially misleading, or fraudulent information, acts or omissions;
- Abusive or disruptive behavior which: (1) threatens the life or well-being of the Claims Administrator personnel and providers of Services, or, (2) substantially impairs the ability of the Claims Administrator to arrange for services to the Member, or, (3) substantially impairs the ability of providers of Service to furnish Services to the Member or to other patients.

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 90 days of that date.

Total Disability While Covered Under Retiree Preferred Plan

The Claims Administrator shall suspend the Benefits of this Plan for a Member when that Member:

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

After all of the above criteria have been satisfied, Benefits of this Plan for the Member will be suspended for any period that may be provided by federal law.

For Members who have suspended their Benefits under this Plan as specified above, and who subsequently lose coverage under their group plan, the Benefits of this Plan will be reinstated only when the Claims Administrator is notified within 90 days of the date of the loss of group coverage.

The effective date of the reinstatement will be the date of the loss of group coverage. The Claims Administrator shall:

- provide the group's Plan retirement coverage in effect at the date of the reinstatement; and
- provide classification terms no less favorable than those which would have been applied had coverage not been suspended.

Medicare Benefits

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.

Inpatient Mental Health and Substance Use Disorder services

You will pay for any additional inpatient Mental Health or Substance Use Disorder services you receive after Medicare has paid:

- the first 90 days of coverage during any one Benefit Period, provided you have no additional lifetime reserve days remaining; or
- the first 150 days of coverage during any one Benefit Period, provided you have all of your lifetime reserve days remaining and choose to use them. If you have fewer than 60 lifetime reserve days available, or choose to use

fewer than the number you have available, your payment responsibility increases accordingly.

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, subject to the Medicare Part B Deductible provided the Participant is receiving concurrent benefits from Medicare for the same Services.

Coverage for these Benefits 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 Copayment, Coinsurance and Deductibles required under Medicare.

Benefits include:

- Ambulance Services
- Blood
- Clinical Laboratory Services
- Home Health Care (Medicare Approved Services)
- Durable Medical Equipment

The Plan will pay the remainder charges of Medicare approved charges after the Part B Deductible. You are responsible for all costs for Part B excess charges above plan approved amounts.

The Claims Administrator provides coverage for Medically Necessary services and supplies only. Experimental or Investigational services and supplies are not covered.

All Benefits are subject to:

- Your Cost Share;
- Any Benefit maximums; and
- The terms, conditions, limitations, and exclusions of this Plan.

Exclusions and limitations

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 online at medicare.gov or by calling the toll-free number 1-800-633-4227. TTY users should call 1-877-486-2048.

	General exclusions and limitations
1	This Plan only covers services that are Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.
2	Hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation.
3	Continuous Nursing Services, private duty nursing, or nursing shift care.
4	For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a Mental Health Condition.
5	Hearing aids, examinations for hearing aids, and the fitting of hearing aids.
6	Acupuncture.
7	Dental care and treatment, dental surgery and dental appliances.
8	Treatment of sexual dysfunctions and sexual inadequacies. This exclusion does not apply to the treatment of organically-based conditions.
9	Any services related to assisted reproductive technology (including associated services such as radiology, laboratory, medications, and procedures) including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, Zygote Intrafallopian Transfer (ZIFT), Intracytoplasmic sperm Injection (ICSI), pre-implantation genetic screening, donor services or procurement and storage of donor embryos, oocytes, ovarian tissue, or sperm, any type of artificial insemination, services or medications to treat low sperm count, services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Claims Administrator's health plan, or services incident to reversal of surgical sterilization, except for Medically Necessary treatment of medical complications of the reversal procedure.

General exclusions and limitations	
10	Services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.
11	Services performed by your spouse, Domestic Partner, child, brother, sister, or parent.
12	Services provided by an individual or entity that: • Is not appropriately licensed or certified by the state to provide health care services; • Is not operating within the scope of such license or certification; or • Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services.
13	Services that are Experimental or Investigational in nature.
14	Member convenience items or services, such as internet, phones, televisions, guest trays, personal hygiene items, food delivery services, and air conditioners.
15	Services incident to any injury or disease arising out of, or in the course of, employment for salary, wage, or profit if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation. However, if the Claims Administrator provides payment for such services, we will be entitled to establish a lien up to the amount paid by the Claims Administrator for the treatment of such injury or disease.
16	Hospital care programs or services provided in a home setting (Hospital-at-home programs).
17	Outpatient prescription Drugs.
18	Rehabilitative services, such as physical therapy and occupational therapy.
19	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.
20	Immunizations are limited to those covered under Medicare Part B Preventive Services.
21	Foot exams and treatment except for diabetic-related nerve damage and/or when certain Medicare coverage conditions are met.
22	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

General exclusions and limitations	
	with standard frames (or one set of contact lenses) is covered after cataract surgery that implants an intraocular lens.
23	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.
24	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.
25	Services for cosmetic purposes.
26	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.
27	Services not specifically listed as Benefits.
28	Services for which the Subscriber is not legally obligated to pay, or Services for which no charge is made to the Subscriber.
29	Services for which the Member is not receiving benefits from Medicare.
30	Speech therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness.

Settlement of Disputes

Internal Appeals

Initial Internal Appeal

If you have received an Adverse Benefit Determination on a claim from the Claims Administrator, you, a designated representative, a provider or an attorney on your behalf may submit a request for an appeal to the Claims Administrator. Contact Customer Service via telephone, mail, or by visiting the Claims Administrator's website at blueshieldca.com and include relevant information, such as:

- Your name;
- Member ID number;
- Date of service;
- Claim number;
- Provider name;
- Your explanation of what happened and why you believe the original determination was incorrect; and
- Any other supporting documents.

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 submitted within 180 days after you receive notice of an Adverse Benefit Determination. The Claims Administrator will acknowledge receipt of an appeal within five calendar days. Appeals are resolved in writing within 30 days from the date of receipt by the Claims Administrator, unless qualified for an expedited decision.

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 receipt 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 therefor. 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 either you or your Health Care Provider 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 to the Claims Administrator. Written requests for final internal standard 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. To initiate a request for 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. 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.

External Review

Standard External Review

If you are dissatisfied with the final internal appeal determination, and the determination involves medical judgment, a rescission of coverage, or consideration of whether the Plan is complying with surprise billing and cost-share protections under the federal No Surprises Act, you, a designated representative, a provider or an attorney on your behalf, may request an external review with an Independent Review Organization.

Requests for external review must be submitted within four months after notice of the final internal appeal determination. The Independent Review Organization will provide a determination within 45 days after the Independent Review Organization receives the request for the external review. Instructions for submitting 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 Determination without participating in the initial or final internal appeal process.

To initiate a request for an expedited external review, you, a designated representative, a provider or an attorney on your behalf may fax a request to (844) 696-6071, 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).

Other important information about your Plan

This section provides legal and regulatory details that impact your health care coverage. This information is a supplement to the information provided in earlier sections of this document.

Out-of-area services

Overview

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Services outside of California, the claims for those services may be processed through one of these Inter-Plan Arrangements described below.

See the ***Care outside of California*** section for more information about receiving care while outside of California. To find participating providers while outside of California, visit ***bcbs.com***.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global® Core when accessing Out-of-Area Covered Health Care Services. Although Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from a provider outside the BlueCard® Service Area, you will typically have to pay the providers and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard® Service Area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider

information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global® Core claim

When you pay directly for services outside the BlueCard® Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global® Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

Limitation 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 Covered 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 Covered 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:

- Benefits provided under Title XVIII of the Social Security Act (commonly known as "Medicare").
- Any Covered 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.
- 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.
- Benefits provided to the Member for Covered 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

A Participating Provider may seek reimbursement from other third-party payors for the balance of their charges for services you receive under this Plan.

Reductions – third-party liability

If your 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 you agree in writing, in a form satisfactory to the plan, to do all of the following:

- 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;
- 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 your own uninsured or underinsured motorist coverage;
- Execute a lien in favor of the Plan for the full amount of Benefits paid by the plan;
- 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;
- 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;
- Direct any legal counsel retained by you or any other person acting on your behalf 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 you fail 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 you or others enrolled through you 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 you or on your behalf, and without regard to whether you have been "made whole" by the Recovery. Recovery does not include monies received from any insurance policy or certificate issued in your name, 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 your behalf, such as an attorney-client trust account.

You 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, you shall not be responsible to reimburse the Plan for the Benefits paid in connection with the illness or injury in excess of the Recovery.

Your 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.

THE FOLLOWING LANGUAGE APPLIES UNLESS THE PLAN IS PART OF AN EMPLOYEE WELFARE BENEFIT PLAN SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"); IF THE PLAN IS SUBJECT TO ERISA, THE FOLLOWING LANGUAGE DOES NOT APPLY.

If you receive services from a Participating Hospital for injuries or illness, the Hospital has the right to collect from you the difference between the amount paid by the Plan and the Hospital's reasonable and necessary charges for such services when you receive payment or reimbursement for medical expenses.

General provisions

Independent contractors

Providers are neither agents nor employees of the Claims Administrator but are independent contractors. In no instance shall the Claims Administrator be liable for the negligence, wrongful acts, or omissions of any person providing services, including any Physician, Hospital, or other Health Care Provider or their employees.

Assignment

The Benefits of this plan, including payment of claims, may not be assigned without the written consent of the Claims Administrator. Participating Providers are paid directly by the Claims Administrator. When you receive Covered Services from a Non-Participating Provider, the Claims Administrator, at its sole discretion, may make payment to the Participant or directly to the Non-Participating Provider. If the Claims Administrator pays the Non-Participating Provider directly, such payment does not create a third-party beneficiary or other legal relationship between the Claims Administrator and the Non-Participating Provider. The Participant must make sure the Non-Participating Provider receives the full billed amount, whether or not the Claims Administrator makes payment to the Non-Participating Provider.

Plan interpretation

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

Access to information

The Claims Administrator may need information from medical providers, from other carriers or other entities, or from the Member, in order to administer the Benefits and

eligibility provisions of this plan and the Contract. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to the Claims Administrator that information that is reasonably needed by the Claims Administrator. Members also 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 the Member's 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 the Member's consent, except as otherwise permitted or required by law.

Right of recovery

Whenever payment on a claim is made in error, the Claims Administrator has the right to recover such payment from the Participant or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. With notice, 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 (Cost Share or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Participant's coverage, or payments made on fraudulent claims.

Definitions

Accidental Injury	Accidental bodily injury sustained by the covered person.
Activities of Daily Living	Activities related to independence in normal everyday living. Recreational, leisure, or sports activities are not considered Activities of Daily Living.
Adverse Benefit Determination	A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for Benefits that is: • based on a determination of a Participant's or Dependent's eligibility to participate in the Plan; • resulting from the application of any utilization review; or • a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
Allowable Amount	The maximum amount the Claims Administrator will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Evidence of Coverage, the Allowable Amount is: • 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 Covered Service rendered. • For a Non-Participating Provider who provides Emergency Services anywhere within or outside of the United States: o Physicians and Hospitals: the amount is the Reasonable and Customary amount; or o All other providers: the amount is the provider's billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield plan have agreed upon some other amount. • For a Non-Participating Provider in California, who provides services other than Emergency Services: o The amount the Claims Administrator would have allowed for a Participating Provider performing the same service in the same geographical area; • Non-Participating dialysis center: for services prior authorized by the Claims Administrator, the

	amount is the Reasonable and Customary amount.
	• For a provider outside of California but inside the BlueCard® Service Area, the lower of:
	  o The provider's billed charge, or
	  o The local Blue Plan's Non-Participating Provider payment or the pricing arrangement required by applicable state law.
	• For a provider outside California and outside the BlueCard® Service Area, the amount allowed by Blue Shield Global® Core.
	• For a Non-Participating Provider outside of California (within the BlueCard® Service Area) that does not contract with a local Blue Cross and/or Blue Shield plan, who provides services other than 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. Or, if the local Blue Cross and/or Blue Shield plan has no Non-Participating Provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California
	.

Benefits (Covered Services)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Benefit Period	The total duration of all successive confinements, including those that occurred before the effective date of the Plan, that are separated from each other by less than 60 days.
BlueCard® Service Area	The United States, Commonwealth of Puerto Rico, and U.S. Virgin Islands.
Calendar Year	The 12-month consecutive period beginning on January 1 and ending on December 31 of the same 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	Laboratory tests include certain blood tests, urinalysis, tests on tissue specimens, and some screening tests.

Coinsurance	The percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Continuous Nursing Services	Nursing care provided on a continuous hourly basis, rather than intermittent home visits for Members enrolled in a Hospice Program. Continuous home care can be provided by a registered or licensed vocational nurse, but is only available for brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
Copayment	The specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.
Cost Share	Any applicable Deductibles, Copayment, and Coinsurance.
Covered Services (Benefits)	Medically Necessary services and supplies you are entitled to receive pursuant to the Contract.
Deductible	The amount paid by the Participant for specific Covered Services before Original Medicare or a retiree Medicare plan begins to pay.
Dependent	The spouse or Domestic Partner of an eligible Employee, who is determined to be eligible and who has been enrolled and accepted by the Claims Administrator as a Dependent and has maintained participation in accordance with the Claims Administrator Plan: • A spouse who is legally married to the Participant and who is not legally separated from the Participant, and actively enrolled under Part A and Part B of Medicare; A Domestic Partner to the Participant who meets the definition of Domestic Partner as defined in this Evidence of Coverage, and actively enrolled under Part A and Part B of Medicare.
Domestic Partner	An individual who is personally related to the Participant by a domestic partnership that meets all the following requirements: • Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code; • The partners have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

	• The partners are:
	  o not currently married to someone else or a member of another domestic partnership, and
	  o not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;
	• Both partners are capable of consenting to the domestic partnership; and
	• If required under your Plan Sponsor's eligibility requirements, provide a declaration of domestic partnership.
	
	The domestic partnership is deemed created on the date when both partners meet the above requirements.

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 Medical Condition	A medical condition, including a psychiatric emergency, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that you reasonably believe the absence of immediate medical attention could result in any of the following: • Placing your health in serious jeopardy (including the health of a pregnant woman or her unborn child); • Serious impairment to bodily functions; • Serious dysfunction of any bodily organ or part; • Danger to yourself or to others; or • Inability to provide for, or utilize, food, shelter, or clothing, due to a mental disorder.
Emergency Services	The following services provided for an Emergency Medical Condition: • Medical screening, examination, and evaluation by a Physician and surgeon, or other appropriately licensed persons under the supervision of a Physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility;

	• Additional screening, examination, and evaluation by a Physician, or other personnel within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition, within the capability of the facility; and • Care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care Hospital or to an acute psychiatric Hospital. •
Employee	An individual who meets the eligibility requirements set forth in the Plan Document between the Claims Administrator and the Employer.
Employer (Contractholder)	Is California's Valued Trust (CVT)and is the Plan Sponsor and Plan Administrator as these terms are defined in the Employees Retirement Income Security Act of 1974 as amended unless otherwise stated herein. The Employer is responsible for funding the payment of claims for Benefits under the Plan.
Experimental or Investigational	Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services that require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies that themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.
Family	The Participant and all enrolled Dependents.

Health Care Provider	An appropriately licensed or certified professional who provides health care services within the scope of that license, including, but not limited to: • Acupuncturist; • Audiologist; • Board certified behavior analyst (BCBA); • Certified nurse midwife; • Chiropractor; • Clinical nurse specialist; • Dentist; • Hearing aid supplier; • Licensed clinical social worker; • Licensed midwife; • Licensed professional clinical counselor (LPCC); • Licensed vocational nurse; • Marriage and family therapist; • Massage therapist; • Naturopath; • Nurse anesthetist (CRNA); • Nurse practitioner; • Occupational therapist; • Optician; • Optometrist; • Pharmacist; • Physical therapist; • Physician; • Physician assistant; • Podiatrist; • Psychiatric/mental health registered nurse; • Psychologist; • Registered dietician; • Registered nurse; • Registered respiratory therapist; • Speech and language pathologist.
Home Health Aide	An individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the home.
Home Health Care	Limited to medically-necessary part-time or inter-mittent 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 medi-cal supplies for use at

	home. You must be home-bound, 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, nurs-ing, 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 Medi-care 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.
Hospital	An entity that meets one of the following criteria: • A licensed and accredited facility primarily engaged in providing medical, diagnostic, surgical, or psychiatric services for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and that provides 24-hour a day nursing service by registered nurses; • A psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code. A facility that is principally a rest home, nursing home, or home for the aged, is not included in this definition.
Host Blue	The local Blue Cross and/or Blue Shield licensee in a geographic area outside of California, within the BlueCard® Service Area.
Independent Review Organization	An entity that conducts independent external reviews of Adverse Benefit Determinations.

Inpatient	A Member who has been admitted to a Hospital or a Skilled Nursing Facility as a registered bed patient and is receiving Covered Services under the direction of a Physician.
Infertility	May be either of the following: • A demonstrated condition recognized by a licensed Physician or surgeon as a cause for Infertility; or • The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.
Intensive Outpatient Program	An outpatient treatment program for Mental Health Conditions or Substance Use Disorder Conditions that provides structure, monitoring, and medical/psychological intervention at least three hours per day, three times per week.
Inter-Plan Arrangements	The Claims Administrator's relationships with other Blue Cross and/or Blue Shield licensees, governed by the Blue Cross Blue Shield Association.
Late Enrollee	An eligible Retired Employee or Dependent who declined enrollment in this coverage at the time of the initial enrollment period, and who subsequently requests enrollment for coverage, provided that the initial enrollment period was a period of at least 30 days. Coverage is effective for a Late Enrollee the earlier of 12 months from the date a written request for coverage is made or at the Employer's next open enrollment period.
Medical Necessity (Medically Necessary)	Benefits are provided only for services that are Medically Necessary. Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by the Claims Administrator, are: • Consistent with the Claims Administrator's medical policy; • Consistent with the symptoms or diagnosis; • Not furnished primarily for the convenience of the patient, the attending Physician or other provider; • Furnished at the most appropriate level that can be provided safely and effectively to the patient; and • Not more costly than an alternative service or sequence of services at least as likely to produce

	equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease. Hospital inpatient services that are Medically Necessary include only those services that 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 in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient admission is not Medically Necessary for certain services, including, but not limited to, the following: • Diagnostic studies that can be provided on an outpatient basis; • Medical observation or evaluation; • Personal comfort; • Pain management that can be provided on an outpatient basis; and • Inpatient rehabilitation that can be provided on an outpatient basis. The Claims Administrator reserves the right to review all services to determine whether they are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.
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	An individual who is enrolled and maintains coverage in the plan pursuant to the Plan Document as either a Participant or a Dependent. Use of "you" in this document refers to the Member.
Mental Health Condition	Mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Services	Services provided to treat a Mental Health Condition.
Non-Participating (Non-Participating Provider)	Any provider who does not participate in this plan's network and does not contract with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services. Also referred to as an out-of-network provider. Certain services of this plan are not covered or benefits are reduced if the service is provided by a Non-Participating Provider.
Out-of-Area Covered Health Care Services	Medically Necessary Emergency Services, Urgent Services or Out-of-Area Follow-up Care provided outside the Plan Service Area.
Out-of-Area Follow-up Care	Non-emergent Medically Necessary services to evaluate your progress after Emergency or Urgent Services are provided outside the Plan Service Area.
Outpatient Department of a Hospital	Any department or facility integrated with the Hospital that provides outpatient services under the Hospital's license, which may or may not be physically separate from the Hospital.
Outpatient Facility	A licensed facility that provides medical and/or surgical services on an outpatient basis but is not a Physician's office or a Hospital.
Partial Hospitalization / Day Treatment Program	An outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. You may be admitted directly to this level of care or transferred from inpatient care following stabilization.
Participant	A Retired Employee who has been accepted by the Employer and enrolled by the Claims Administrator and who has maintained enrollment in accordance with this plan.
Participating (Participating Provider)	A provider who participates in this Plan's network and contracts with the Claims Administrator to accept the Claims Administrator's payment, plus any applicable Member Cost Share, as payment in full for Covered Services. Also referred to as an in-network provider.
Physician	An individual licensed and authorized to engage in the practice of medicine.

Plan	the California's Valued Trust (CVT) Retiree Medical Plan (Medicare Supplement Plan) for eligible Retired Employees and Dependents of the Employer.
Plan Administrator	Is California's Valued Trust (CVT).
Plan Document	The document adopted by the Plan Sponsor that establishes the services that Participants and Dependents are entitled to receive under the Plan.
Plan Service Area	A geographical area designated by the Plan within which a plan shall provide health care services.
Plan Sponsor	Is California's Valued Trust (CVT).
Plan Year	The 12-month consecutive period established by the Employer.
Retired Employee	An individual who meets the eligibility requirements set forth in the Plan Document.

Serious Emotional Disturbances of a Child	A minor under the age of 18 years who has 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.
	
	The child must 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:
	
	• As a result of the mental disorder, the child has substantial impairment in at least two of the following areas:
	  o Self-care;
	  o School functioning;
	  o Family relationships;
	  o Ability to function in the community; and
	  o Either 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 one year without treatment;
	
	• The child displays one of the following:
	  o Psychotic features;
	  o Risk of suicide; or

	○ Risk of violence due to a mental disorder; • The child meets special education eligibility requirements under Chapter 26.5 (starting with Section 7570) of Division 7 of Title 1 of the Government Code.
Severe Mental Illnesses	Conditions with the following diagnoses: • Schizophrenia • Schizoaffective 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.
Skilled Nursing	Services performed by a licensed nurse who is either a registered nurse or a licensed vocational nurse.
Skilled Nursing Facility (SNF)	A health facility or a distinct part of a Hospital which participates in the Medicare program and is licensed by the California Department of Public Health that provides continuous Skilled Nursing care to patients whose primary need is for availability of Skilled Nursing care on a 24-hour basis.
Specialist	Specialists include Physicians with a specialty as follows: • Allergy; • Anesthesiology; • Dermatology; • Cardiology and other internal medicine specialists; • Neonatology; • Neurology; • Oncology; • Ophthalmology; • Orthopedics; • Pathology; • Psychiatry; • Radiology; • Any surgical specialty; • Otolaryngology; • Urology; and

	• Other designated as appropriate.
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 that is primarily a rest-home, convalescent facility, or home for the aged is not included.
Substance Use Disorder Condition	Drug or alcohol abuse or dependence.
Substance Use Disorder Services	Services provided to treat a Substance Use Disorder Condition.
Total Disability (Totally Disabled)	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.
Urgent Services	Those Covered Services rendered outside of the Plan Service Area (other than Emergency Services) which are Medically Necessary to prevent serious deterioration of your health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until you return to the Plan Service Area.

Notices about your plan

Notice about this Administrative Services Only plan: The Plan Document is on file with your former Employer and a copy will be furnished upon request.

California's Valued Trust (CVT) 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.

Notice about plan Benefits: Benefits are only available for services and supplies you receive while covered by this Plan. You do not have the right to receive the Benefits of this Plan after coverage ends, except as specifically provided under the *Extension of Benefits* section and, when applicable, the *Continuation of group coverage* section. The Claims Administrator may change Benefits during the term of coverage as specifically stated in this Benefit Booklet. Benefit changes, including any reduction in Benefits or elimination of Benefits, apply to services or supplies you receive on or after the effective date of the change.

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.

Notice about Medical Necessity: Benefits are only available for services and supplies that are Medically Necessary. The Claims Administrator reserves the right to review all claims to determine if a service or supply is Medically Necessary. A Physician or other Health Care Provider's decision to prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary.

Notice about reproductive health services: Some Hospitals and providers do not provide one or more of the following services that may be covered under your Plan and that you or your family member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or contact Customer Service to ensure that you can obtain the health care services you need.

Notice about Participating Providers: The Claims Administrator contracts with Hospitals and Physicians to provide services to Members for specified rates. This contractual agreement may include incentives to manage all services for Members in an

appropriate manner consistent with the Plan. To learn more about this payment system, contact Customer Service.

Notice about confidentiality of personal and health information: The Claims Administrator protects the confidentiality/privacy of individually-identifiable personal information, including protected health information. Individually-identifiable personal information includes health, financial, and/or demographic information - such as name, address, and Social Security number. The Claims Administrator will not disclose this information without 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 Customer Service or by visiting blueshieldca.com.

Members who are concerned that the Claims Administrator may have violated their privacy rights, or who disagree with a decision the Claims Administrator made about access to their individually-identifiable personal information, may contact the Claims Administrator at:

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

Toll-Free Telephone:
1-888-266-8080

Email Address:
blueshieldca_privacy@blueshieldca.com

Notice informing individuals about nondiscrimination and accessibility requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language access services

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwiji' hodíílnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đểđược hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերեն լեզվով անվճար օգնություն ստանալու համար խնդրում ենք զանգահարել 1-866-346-7198.

Russian (Русский): если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.

Japanese (日本語): 日本語支援が必要な場合1-866-346-7198に電話をかけてください。
無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی،لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.

Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਸਹਾਇਤਾ ਲਈ ਕਿਰਪਾ ਕਰਕੇ 1-866-346-7198 'ਤੇ ਕਾੱਲ ਕਰੋ।

Khmer (ភាសាខ្មែរ)៖ សូមជំនួយភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198។

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا، تفضل بالتصال على هذا الرقم: 1-866-346-7198.

Hmong (Hnoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिन्दी): हिन्दी में बिना खर्च के सहायता के लिए, 1-866-346-7198 पर कॉल करें।

Thai (ไทย): สำหรับความช่วยเหลือเป็นภาษาไทยโดยไม่มีค่าใช้จ่ายโปรดโทร 1-866-346-7198

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

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