

NOTICE TO BUYER OR NEW SUBSCRIBER

Please read this Agreement carefully. If you have any questions, contact the Blue Shield of California office nearest you. If you are not satisfied with the Service Agreement, you may surrender it by delivering or mailing it with the Identification (ID) Cards, within 30 days from the date it is received by you, to BLUE SHIELD OF CALIFORNIA, 601 12TH STREET, OAKLAND, CALIFORNIA 94607, OR TO ANY BLUE SHIELD OF CALIFORNIA BRANCH OFFICE. Immediately upon such delivery or mailing, the Agreement shall be deemed void from the beginning, and any dues paid on it will be refunded. Blue Shield of California is not connected with Medicare. THIS CONTRACT DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY.

PREFERRED SENIOR

MEDICARE SUPPLEMENT PLAN EVIDENCE OF COVERAGE AND HEALTH SERVICE AGREEMENT

BLUE SHIELD PREFERRED SENIOR RESTRICTS YOUR CHOICE OF HOSPITALS TO ONLY THOSE HOSPITALS WHO HAVE CONTRACTED WITH BLUE SHIELD AS PREFERRED SENIOR HOSPITALS, UNLESS OTHERWISE SPECIFICALLY STATED IN THIS AGREEMENT. THIS PLAN DOES NOT PROVIDE BENEFITS FOR SERVICES RENDERED IN A NON PREFERRED SENIOR HOSPITAL OTHER THAN AS SET FORTH IN THIS AGREEMENT.

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

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

Subscriber Bill of Rights

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

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

Subscriber Responsibilities

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

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

TABLE OF CONTENTS

INTRODUCTION TO BLUE SHIELD PREFERRED SENIOR	1
PART I: CONDITIONS OF COVERAGE AND PAYMENT OF DUES	1
A. ENROLLMENT	1
B. DURATION OF THE AGREEMENT	1
C. TERMINATION/CANCELLATION, REINSTATEMENT AND SUSPENSION OF THE AGREEMENT	1
D. PAYMENT OF DUES	4
PART II: PROVIDERS OF MEDICAL SERVICES COVERED BY THIS AGREEMENT	4
PART III: DEDUCTIBLE	4
PART IV: MAXIMUM BENEFITS	4
PART V: SERVICE BENEFITS	5
A. HOSPITAL AND SKILLED NURSING FACILITY SERVICES	5
B. PROFESSIONAL SERVICES	5
C. EMERGENCY SERVICES	6
D. SERVICES NOT COVERED BY MEDICARE BUT INCLUDED IN BLUE SHIELD COVERAGE ..	6
E. HEALTH EDUCATION AND HEALTH PROMOTION	7
F. SECOND MEDICAL OPINION POLICY	7
PART VI: BENEFIT PAYMENTS	7
PART VII: EXCLUSIONS AND LIMITATIONS	8
PART VIII: MEDICAL NECESSITY	9
PART IX: CLAIMS REVIEW	9
PART X: UTILIZATION REVIEW	9
PART XI: DEFINITIONS	10
PART XII: GENERAL PROVISIONS	11
A. IDENTIFICATION CARDS	11
B. GRIEVANCE PROCESS	11
C. CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE	13
D. REDUCTIONS – THIRD PARTY LIABILITY	13
E. INDEPENDENT CONTRACTORS	14
F. ENDORSEMENTS	14
G. NOTIFICATIONS	14
H. COMMENCEMENT OR TERMINATION OF COVERAGE	14
I. STATUTORY REQUIREMENTS	15
J. LEGAL PROCESS	15
K. ENTIRE AGREEMENT: CHANGES	15
L. GRACE PERIOD	15
M. PLAN INTERPRETATION	15
N. NOTICE	15
O. CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION	15
P. ACCESS TO INFORMATION	16
Q. PUBLIC POLICY PARTICIPATION PROCEDURE	16

IMPORTANT!

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

INTRODUCTION TO BLUE SHIELD PREFERRED SENIOR

This Plan is designed to reduce the cost of health care to you, the Subscriber. In order to reduce your costs, much greater responsibility is placed on you for managing the provision of benefits by Blue Shield under this Plan.

To receive maximum benefits under this Plan, Services must be received from a Preferred Senior Provider and such Services must be concurrently payable by Medicare, unless otherwise specifically stated in this Agreement.

Failure to meet these requirements may result in your incurring a substantial financial liability and Services may not be covered.

PART 1: CONDITIONS OF COVERAGE AND PAYMENT OF DUES

A. ENROLLMENT

- 1. ELIGIBLE APPLICANT** -- An eligible applicant shall be (a) an individual residing in the Service Area; (b) 67 years of age or over; (c) not residing or confined in a Hospital, Skilled Nursing Facility, rest home, convalescent home, convalescent hospital, sanatorium, or similar institution (not applicable to applicant transferring directly from any other Blue Shield plan); and (d) enrolled under both Parts A and B of Medicare.
- 2. ENROLLMENT OF A SUBSCRIBER** -- An eligible applicant becomes a Subscriber under this Agreement upon notification by Blue Shield that applicant's properly completed application for enrollment has been approved by Blue Shield.
- 3. EFFECTIVE DATE OF BENEFITS** -- A Subscriber is entitled to the benefits of this Agreement on the first day of the month following the date the Subscriber's properly completed application is received by Blue Shield.

Regardless of the Subscriber's coverage under any prior Blue Shield Plan, an applicant for enrollment under this Agreement shall be enrolled only for the benefits of this Agreement. No Subscriber under this Agreement shall simultaneously hold coverage under any other Blue Shield Plan.

B. DURATION OF THE AGREEMENT

This Agreement shall be renewed every three (3) months so long as dues are prepaid. Renewal is subject to Blue Shield's right to amend this Agreement. Any proposed increase in dues or decrease in benefits to this Agreement will be effective after a period of at least sixty (60) days notice to the Subscriber's address of record with Blue Shield.

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

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

This Agreement may be terminated, cancelled, or rescinded as follows:

1. Termination by the Subscriber

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

2. Rescission by Blue Shield

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

For underwritten plans (not guaranteed acceptance) - To determine whether or not you would be offered enrollment through this Agreement, Blue Shield reviewed your medical history based upon the information you provided in your enrollment application, including the health history portion of your enrollment application and any supplemental information that Blue Shield determined was necessary to evaluate your medical history and status. This process is called underwriting.

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

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

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

to recoup from you all amounts paid by Blue Shield under the Agreement.

If this Agreement is rescinded, Blue Shield will provide a 30 day advance written notice that will: (a) explain the basis of the decision and your appeal rights, including your right to request assistance from the California Department of Managed Health Care; (b) clarify that, in the case of a two-party agreement, the Subscriber or Dependent whose application information was not false or incomplete is entitled to new coverage without medical underwriting and will explain how that individual may obtain this coverage; and (c) explain that the monthly Dues for that individual will be determined based on that individual's age.

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

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

4. Cancellation of the Agreement for Nonpayment of Dues

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

Within five (5) business days of canceling or not renewing the Agreement, Blue Shield will

mail you a Notice of End of Coverage, which will inform you of the following:

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

5. Reinstatement of the Agreement after Cancellation

If the Agreement is cancelled for nonpayment of dues, Blue Shield will permit reinstatement of the Agreement or coverage twice during any twelve-month period, without a change in dues and without consideration of your medical condition, if the amounts owed are paid within 30 days of the date the Notice of End of Coverage is mailed to you. If your request for reinstatement and payment of all outstanding amounts is not received within the required 30 days, or if the Agreement is cancelled for nonpayment of dues more than twice during the preceding twelve-month period, then Blue Shield is not required to reinstate your coverage, and you will need to reapply for coverage.

6. Extension of Coverage for Total Disability

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

- a. the end of the period of Total Disability; or
- b. the date on which the Subscriber's applicable maximum benefits are reached; or
- c. a period equivalent in duration to the contract benefit period of three (3) months subject to the following:

- (i) written proof of Total Disability is received by Blue Shield within ninety (90) days of the date on which coverage was terminated; and
- (ii) only a person licensed to practice medicine and surgery as a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.) may certify Total Disability.

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

7. Suspension of Coverage

- a) Entitlement to Medi-Cal

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

- b) Total Disability While Covered Under Group Health Plan

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

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

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

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

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

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

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

D. PAYMENT OF DUES

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

Blue Shield of California
P.O. Box 4700
Whittier, CA 90607-4700

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

Dues are determined based on age at the time of enrollment under this Plan, subject to the right reserved by Blue Shield to modify these dues with at least sixty (60) days notice.

PART II: PROVIDERS OF MEDICAL SERVICES COVERED BY THIS AGREEMENT

Subscribers are entitled to receive Services and benefits under PART V. of this Agreement when the Subscriber receives such Services from a Physician or Preferred Senior Hospital or Other Provider subject to the deductible and other limitations and exclusions of this Agreement. This Plan shall not provide any benefits for Services rendered in a non-Preferred Senior Hospital except as specifically stated under Part V. C. Emergency Services.

PART III: DEDUCTIBLE

This Plan covers the Medicare Part A deductible for Services received from a Preferred Senior Hospital (see PART V. A.) The Medicare Part B deductible is the Subscriber's responsibility.

PART IV: MAXIMUM BENEFITS

The maximum aggregate benefits provided for each Subscriber per Calendar Year shall not exceed \$1,000,000. The maximum aggregate

benefits provided during each Subscriber's lifetime shall not exceed \$2,000,000. This is the value of the benefits provided by Blue Shield to the Subscriber during his eligibility for Medicare without regard to any interruption in the continuity of Blue Shield membership.

PART V: SERVICE BENEFITS

Benefits provided by this Agreement (but only to the extent they are not hereafter excluded) are for the medically necessary treatment of any illness or injury, as follows:

A. HOSPITAL AND SKILLED NURSING FACILITY SERVICES

Blue Shield shall cover the following Services:

1. HOSPITAL

Hospital Inpatient Services which are furnished by a Preferred Senior Hospital when:

- a. such Services are within the category of benefits provided under Part A of Medicare; and
- b. the Subscriber is not entitled to payment for such Services under Medicare by reason of reductions for Medicare coinsurance or deductibles or exhaustion of Medicare Benefits.

Inpatient Services shall include semi-private accommodation in the Hospital of confinement, unless confinement in a subacute skilled nursing or private room is certified as medically necessary by a Physician.

Blue Shield shall provide this benefit through the 515th day of Hospital confinement in any one Benefit Period. Inpatient Hospital psychiatric care is limited to 190 days during the Subscriber's lifetime.

Blue Shield will also pay 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.

2. SKILLED NURSING FACILITY

Blue Shield shall pay the coinsurance required under Medicare toward the charges for Services furnished and billed by a Skilled Nursing Facility for the treatment of an illness or injury, including subacute care, from the 21st through the 100th day when the Subscriber receives concurrent benefits from Medicare.

B. PROFESSIONAL SERVICES

Subject to any benefit limitations and deductibles imposed by Medicare, Blue Shield shall pay the 20% coinsurance not covered by Medicare for the following Services when the Subscriber is receiving concurrent benefits from Medicare for the same Services.

1. Preferred Senior Providers and Non-Preferred Providers

Preferred Senior Providers shall accept the Medicare payment and this Plan's payment of the 20% coinsurance not covered by Medicare as payment in full for the covered Services. Charges by non-Preferred Senior Providers in excess of the amount covered by this Agreement are the Subscriber's responsibility.

- a. Services of a Physician, occupational therapist, chiropractor, audiologist, dispensing optician, dentist, psychologist, optometrist and podiatrist;
- b. Services of a registered physical therapist, acting under the direction of a Physician;

c. Rental or purchase of wheelchairs, hospital beds, iron lungs and other durable medical equipment; and

d. Outpatient Hospital Services.

2. Other Providers

Blue Shield shall pay the 20% coinsurance not covered by Medicare for Services listed in paragraphs a. through e. below. The Subscriber is responsible for any balance due after this Plan's payment.

a. Artificial limbs, artificial eyes and colostomy supplies;

b. Ambulance Services when considered medically necessary to or from a Hospital, Skilled Nursing Facility or the Subscriber's home;

c. Professional charges for outpatient diagnostic X-ray and laboratory tests rendered to the Subscriber;

d. Speech pathology Services where such Services are provided in clinics participating in the Medicare program; and

e. Any Services of Other Providers.

3. Outpatient Psychiatric Care

Medicare bases its 80% payment for Physician's Services for outpatient psychiatric care upon the percentage of the amount Medicare determines to be a reasonable charge for said service. Blue Shield shall pay the 20% coinsurance not covered by Medicare. The Subscriber is responsible for any balance due after Medicare and this Plan's payments.

4. Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions,

high-risk pregnancies or pregnancies that have reached the second or third trimester can request continuation of covered services in certain situations with a provider who is terminated. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

C. EMERGENCY SERVICES

In the event that Emergency Services are obtained by the Subscriber from other than a Preferred Senior Hospital, this Plan shall cover Inpatient Hospital Emergency Services in accordance with the payment provisions of Part V. A. above.

The Subscriber must submit a request for payment of Emergency Services to Blue Shield in accordance with Part VI: Benefit Payments. The Subscriber is responsible for any balance due after this Plan's payment. When Hospital Services are no longer Emergency Services as determined by Blue Shield, this Plan will not provide benefits for any Hospital Services rendered by other than a Preferred Senior Hospital.

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

D. SERVICES NOT COVERED BY MEDICARE BUT INCLUDED IN BLUE SHIELD COVERAGE

EMERGENCY TRAVEL BENEFITS

When a Subscriber requires Emergency Services outside of the United States to which he would be entitled from Medicare while within the United States and to which he loses his entitlement solely by reason of his temporary absence from the United States on a business or pleasure trip, Blue Shield will

pay in addition to the benefits of this Agreement, the benefits that Blue Shield shall determine he would otherwise have been entitled to from Medicare, but in no event shall such benefits be payable when the Subscriber has been absent from the United States for more than six (6) months. This benefit is only available to a Subscriber for a period of six (6) consecutive months immediately preceding commencement of the trip.

E. HEALTH EDUCATION AND HEALTH PROMOTION

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

F. SECOND MEDICAL OPINION POLICY

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

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

PART VI: BENEFIT PAYMENTS

A. Services by Preferred Senior Providers

Blue Shield will pay the benefits of this Agreement directly to the Preferred Senior Provider. The Subscriber is not responsible for submitting requests for payment to Blue Shield for Services received. Providers do not receive financial incentives or bonuses from Blue Shield of California.

B. Services by Non-Preferred Senior Providers and Other Providers

Claims are submitted for payment after Services are received. Requests for payment for Services obtained from non-participating providers or Other Providers must be submitted to Blue Shield by the Subscriber within one (1) year after the month in which Services are rendered or the date of processing of Medicare benefits. Payment for such Services shall be made to the Subscriber. Providers do not receive financial incentives or bonuses from Blue Shield of California.

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

C. Emergency Services by other than Preferred Senior Providers

1. Requests for payment for Emergency Services received from a Hospital other than a Preferred Senior Hospital must be submitted to Blue Shield by the Subscriber with the Explanation of Medicare Benefits (EOMB) and documentation supporting the need for Emergency Services.
2. Requests for payment for Emergency Services must be submitted to Blue Shield by the Subscriber within one (1) year after the month in which Emergency Services are rendered or the date of processing of Medicare benefits. All requests for payment and claim forms must be sent to Blue Shield at the address provided in PART VI. B.

D. Assignment

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

PART VII: EXCLUSIONS AND LIMITATIONS

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

- 1. Custodial Care** -- Services incident to hospitalization or confinement in a health facility primarily for Custodial, Maintenance or Domiciliary Care. This includes services furnished by a rest home, a home for the aged, a nursing home or any similar place.
- 2. Dental Services** -- Dental care and treatment, dental surgery and dental appliances, except as provided by Medicare.
- 3. Vision Care and Hearing Aids** -- Examinations for and the cost of eye glasses and hearing aids, except as provided by Medicare.
- 4. Cosmetic Services** -- Services for cosmetic purposes.
- 5. Vocational and Related Services** -- 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 and prescribed by the attending Physician, and recognized by Medicare, weight control programs or exercise programs.
- 6. Blood** -- Blood plasma, except that this exclusion shall not apply to the first three (3) pints of blood the Subscriber receives in a Calendar Year.
- 7. Acupuncture.**
- 8. Routine Care** -- Physical examinations, except for a one-time "Welcome to Medicare" physical examination if received within the first 12 months of the Subscriber's initial coverage under Medicare Part B, and a yearly "Wellness" exam thereafter; or routine foot care, except as provided by Medicare.

- 9. Routine immunization** except those covered under Medicare Part B preventive services.

- 10. Workers' Compensation** -- Services incident to any injury or disease arising out of, or in the course of, any 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 Blue Shield provides payment for such Services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of the injury or disease.

- 11. Unlisted Services** -- Services not specifically listed as benefits.

- 12. Non-Medicare Services** -- Services not payable by Medicare except as provided under Part V.D.

- 13. Services From Relatives** -- Professional Services received from one who ordinarily resides in the Subscriber's home or is related to the Subscriber by blood or marriage.

- 14. Not Medically Necessary** -- Services which are not medically necessary as described under Part VIII.

15. Duplicate Coverage

In the event that an individual is both enrolled as a Subscriber under this Agreement and entitled to benefits under any of the conditions described in paragraphs 1. through 3. of this exclusion, the Plan's liability for Services (including room and board) provided to the Subscriber for the treatment of any one illness or injury shall be reduced by the amount of benefits paid, or the reasonable value or amount payable to the provider under the Medicare Program, whichever is less, of the Services provided without any liability for the cost thereof, for the treatment of that same illness or injury as a result of the Subscriber's entitlement to such other benefits.

This exclusion is applicable to:

1. Benefits provided under Title XVIII of the Social Security Act (commonly known as Medicare).
2. Any Services, including room and board, provided to the Subscriber by any federal or state governmental agency or by any municipality county or other political subdivision, except that benefits provided under Chapters 7 and 8 of Part 3, Division 9 of the California Welfare and Institutions Code (commonly known as Medi-Cal) are not subject to this paragraph.
3. Benefits provided to the Subscriber for Services under any group insurance contract or health service plan agreement through any employer, labor union, corporation or association, or under any individual policy or health service plan agreement.
 - c. not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
 - d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

2. Hospital Inpatient Services which are medically necessary include only those Services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the Outpatient department of a Hospital, or another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient Services which are not medically necessary include hospitalization:
 - a. for diagnostic studies that could have been provided on an Outpatient basis;
 - b. for medical observation or evaluation;
 - c. for personal comfort.
3. Blue Shield reserves the right to review all claims to determine whether Services are medically necessary.

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

PART VIII: MEDICAL NECESSITY

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

1. Services which are medically necessary include only those which have been established as safe and effective, are furnished in accordance with generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are:
 - a. consistent with Blue Shield medical policy; and
 - b. consistent with the symptoms or diagnosis; and

PART IX: CLAIMS REVIEW

Blue Shield reserves the right to review all claims to determine whether any exclusions or limitations apply, and may use the Services of Physician consultants, peer review committees of professional societies or hospitals, and other consultants.

PART X: UTILIZATION REVIEW

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

State law requires that health plans disclose to Subscribers and health plan providers the process used to authorize or deny health care Services

under the plan. Blue Shield has completed documentation of this process (“utilization”), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the document describing this Utilization Review process, call the Customer Service Department at the telephone number indicated on your Identification Card.

PART XI: DEFINITIONS

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

Benefit Period -- the total duration of all successive Confinements, including those that occurred before the Effective Date of the Agreement, that are separated from each other by less than sixty (60) days.

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

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

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

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

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

Emergency Services -- Services for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Hospital

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

Incurred -- a charge is deemed "incurred" on the date the particular Service which gives rise to it is provided or obtained.

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

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

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

Other Provider -- a Medicare recognized provider who is not a Physician, Hospital, durable medical equipment supplier, occupational therapist, registered physical therapist, chiropractor, audiologist, dispensing optician, dentist, psychologist, optometrist, podiatrist, or pharmacy.

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

Physician -- a licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.).

Preferred Senior Hospital -- a Hospital which has an agreement with Blue Shield to participate in Preferred Senior.

Preferred Senior Physician -- a Physician who has an agreement with Blue Shield to participate in Preferred Senior.

Preferred Senior Provider -- a Physician, Hospital, durable medical equipment supplier, occupational therapist, registered physical therapist, chiropractor, audiologist, dispensing optician, dentist, psychologist, optometrist, podiatrist or pharmacy who has an agreement with Blue Shield to participate in Preferred Senior.

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

Service Area -- that geographical area in the State of California which is served by Preferred Senior. The Service Area is described in the Directory of Preferred Senior Providers.

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

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

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

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

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

PART XII: GENERAL PROVISIONS

A. IDENTIFICATION CARDS

A Preferred Senior Identification (ID) Card will be issued by Blue Shield to the Subscriber for presentation to providers in order that they may bill Blue Shield directly.

B. GRIEVANCE PROCESS

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

CUSTOMER SERVICE

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

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

Customer Service can answer many questions over the telephone.

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

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

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

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

Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Customer Service Representative will initiate on the Subscriber's behalf.

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

Blue Shield will acknowledge receipt of a grievance within five (5) calendar days. Grievances are resolved within thirty (30) days.

The Grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. Grievances are resolved within 30 days. See the previous Customer Service section for information on the expedited decision process.

EXTERNAL INDEPENDENT MEDICAL REVIEW

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

If your grievance involves a claim or Services for which coverage was denied by Blue Shield in whole or in part on the grounds that the service is not medically necessary or is experimental/investigational (including the external review available under the Friedman-Kowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield and wait for at least 30 days before

you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is medically necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

C. CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the telephone number indicated on your Identification Card and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or

remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical Services. The Department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site (<http://www.dmhc.ca.gov>) has complaint forms, IMR application forms and instructions online.

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

D. REDUCTIONS – THIRD PARTY LIABILITY

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

Blue Shield's right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a

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

The Subscriber is required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which such Subscriber expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with Blue Shield to execute any forms or documents needed enable Blue Shield to enforce its right to restitution, reimbursement or other available remedies ; and,
3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,
4. Provide Blue Shield with a lien, in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

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

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

E. INDEPENDENT CONTRACTORS

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

F. ENDORSEMENTS

Endorsements may be issued from time to time subject to the notice provisions of Part I. B. Duration of the Agreement. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

G. NOTIFICATIONS

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

H. COMMENCEMENT OR TERMINATION OF COVERAGE

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

I. STATUTORY REQUIREMENTS

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

J. LEGAL PROCESS

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

K. ENTIRE AGREEMENT: CHANGES

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

L. GRACE PERIOD

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

M. PLAN INTERPRETATION

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

N. NOTICE

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

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

O. CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield of California protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or

social security number. Blue Shield will not disclose this information without your authorization, except as permitted by law.

A statement describing Blue Shield's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. Blue Shield's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices", which you may obtain either by calling the Customer Service Department at the telephone number indicated on your Identification Card, or by accessing Blue Shield of California's internet site located at <http://www.blueshieldca.com> and printing a copy.

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

Correspondence Address:

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

Toll-Free Telephone:

1-888-266-8080
Fax: 1-800-201-9020

Email Address:

privacy@blueshieldca.com

P. ACCESS TO INFORMATION

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

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

Q. PUBLIC POLICY PARTICIPATION PROCEDURE

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

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

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

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

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

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

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

A handwritten signature in black ink, appearing to read "Tim J. Lieb". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

Timothy J. Lieb, Senior Vice President

For information, please direct correspondence to:

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

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

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

