USC University of Southern California

USC Senior Care Plan

An Employer-Sponsored Supplemental Plan to Medicare

Summary Plan Description
and Plan Document
2024

USC Senior Care Plan

An Employer-Sponsored Supplemental Plan to Medicare
for Former Employees of the University of Southern California

Summary Plan Description and Plan Document
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INTRODUCTION

USC Senior Care Plan – *A University (as Employer) sponsored separate supplemental plan to Medicare coverage exclusively for the former employees of the University of Southern California* (*and their spouses, mutual financial dependents or registered domestic partners). This Plan Document/Summary Plan Description is separate from any USC sponsored plan covering current employees. This Plan Document/Summary Plan Description is not part of any summary plan description for current employees.*

This Plan offers coverage with no out-of-pocket expenses for Medicare covered physician services provided by Keck Medicine of USC Physicians, and no cost to you for Medicare covered hospital services rendered at the Keck Hospital of USC, USC Arcadia Hospital, USC Norris Cancer Hospital and USC Verdugo Hills Hospital. Please note that not all providers at USC Arcadia Hospital and Verdugo Hills Hospital are Keck Medicine of USC Physicians. Therefore, you may incur out-of-pocket expenses for Medicare covered physician services at these facilities.

Because it is a separate plan exclusively available to former employees of the University (and their spouses, mutual financial dependents or registered domestic partners) USC is able to offer a supplemental plan that is comprehensive, as well as cost effective. Here are a few benefits of the **USC Senior Care Plan** (the "Plan"):

1. You keep your Medicare benefits (unlike some plans which make you sign over those benefits).

2. You do not need to take a physical exam to apply.

3. Premiums are not based on your age or health condition.

4. You can see a doctor as often as you need.

5. You can see <u>any</u> doctor, provided that doctor accepts Medicare.

6. You will have easy access to the outstanding primary and specialty physicians at USC with <u>no co-payment or deductible for Medicare-approved services</u> and without the need for referral from a primary care physician.

7. You will have vision benefits that will help cover the cost of care provided by an optometrist.

8. You will have dental benefits that will help cover preventive and other services.

How to use this Summary Plan Description (SPD) and Plan Document

It is important to familiarize yourself with the USC Senior Care Plan so that you can take full advantage of your benefits. This document is a Summary Plan Document and Plan Document for the Plan. This Summary Plan Description/Plan Document is divided into the following sections:

- "***Introduction***" explains the USC Senior Care Plan, including why you should purchase a plan supplemental to Medicare, who is eligible, how to apply, how to enroll and maintain effective coverage, payment of premiums and the process for Plan replacement.

- "***Benefits***" lists the hospital (Part A) and medical (Part B) services, supplies, vision, dental and other benefits covered under the Plan.

- "***Exclusions & Limitations***" lists those services and supplies that are typically excluded or not covered under the USC Senior Care Plan.

- "***Getting Assistance***" explains where you can get answers to questions, how to file claims and appeals.

- "***Termination of Membership***" describes the process of termination under the USC Senior Care Plan.

- "***Miscellaneous Information***" contains other pertinent information, which may prove to be beneficial while participating in the USC Senior Care Plan.

Why Purchase a Plan Supplemental to Medicare?

Medicare is divided into several parts. Part A, available to most Americans without a monthly premium, helps pay for hospital bills. Medicare Part B is available for a monthly premium and covers most costs of physician services. When you turn 65 you become eligible for Medicare. After you retire (and are at least sixty-five (65) years of age) and enroll in Medicare Parts A and B, Medicare will become your primary medical coverage. You may decide that you need more coverage than Medicare Parts A and B provide. Here are some examples of the gaps in Medicare:

- With Medicare Part A, you must pay a deductible when you are hospitalized. After 60 days in the hospital you pay an additional daily per diem which increases after 90 days. A new benefit period, with another deductible, starts after you have been out of the hospital for 60 consecutive days. (Please refer to the booklet "Medicare and You" sent to you by Medicare for exact deductible and per diem amounts.)

- With Medicare Part B, you must pay 20 percent of the physician's Medicare-approved fees for participating providers and up to 35 percent for non-participating providers not accepting Medicare assignments after meeting an annual deductible.

Who is Eligible under the USC Senior Care Plan?

To enroll in the USC Senior Care Plan, you must meet both of the following requirements:

1. You were formerly employed at some time as either full-time or part-time (benefits-eligible) Faculty or Staff (yourself, spouse, mutual financial dependent or registered domestic partner) by the University of Southern California (USC). Your former employment must have ended due to a bona fide termination rather than a temporary termination for the purpose of seeking enrollment in the USC Senior Care Plan.
2. You must be legally enrolled under Medicare Parts A & B when the USC Senior Care Plan coverage becomes effective.

To qualify, you may not be enrolled in a Medicare Advantage or any other health insurance plan other than Medicare Part A, Part B and Part D (the prescription drug program). For those retirees who receive a stipend from the University, the retiree Stipend Program will remain unchanged.

Once you are enrolled under the USC Senior Care Plan, you are responsible for maintaining both Medicare Part A and Part B coverage in effect. If you fail to maintain enrollment in Medicare Part A and Part B, any remaining benefits under this Plan are forfeited and eligibility will cease.

Please note: USC Senior Care Plan does not include any type of prescription drug benefit. USC Senior Care Plan is Non-Creditable coverage for purposes of Part D of Medicare.

Enrollment

You may enroll in the Plan at any time during the year by completing the Application for Enrollment and returning the application along with a copy of your Medicare ID card showing enrollment in both Medicare Part A and Part B to USC Health Plans. In order for your enrollment to take place on the first of the month, your application for enrollment must be received with all necessary documentation **no later than the 10th of the month prior** to your desired effective date.

Please read the information carefully before you complete and sign the form. Be certain that all information has been properly recorded. Once you are enrolled, both this Summary Plan Description/Plan Document and the Application for Enrollment are the governing documents between you and USC Senior Care Plan regarding membership.

It is each member's responsibility to notify USC Health Plans of any changes in residence, automatic deduction information (from credit card or checking account) or health insurance coverage, including any change in eligibility for Medicare coverage. Failure to do so may result in termination of benefits under the Plan.

Effective Date of Coverage

After we receive your completed Application for Enrollment, we are required to verify your (or your spouse's) past employment with the University of Southern California as well as your enrollment under Medicare Part A and Part B.

The Plan will notify you in writing of the effective date of your coverage. The effective date of plan coverage will be the first day of the month following approval of your completed application, provided that all eligibility conditions have been met.

You will receive a USC Senior Care Plan membership card that includes your Identification Number and Claim Submission Address. In order to ensure that all medical claims are processed and paid accordingly, please make sure to present **both** your Medicare and USC Senior Care Plan identification cards to a Provider/Facility at the time services are being rendered. Providers may verify eligibility for members by calling HealthComp at **(855) SCPLANS or (855) 727-5267** during customer service hours, Monday through Friday from 6:00 am to 5:00 pm (Pacific Time).

Payment of Premium

You pay for the full cost of the USC Senior Care Plan. There are two (2) options for automatically paying your monthly premium:

1. Automatic Deduction from Bank Account
2. Automatic Payment from Credit Card

You must select one of those options. The monthly premium, per member, will be **automatically deducted from your credit card or checking account on the first day of each month.** If you fail to maintain one of those automatic payment options, your coverage will immediately cease.

If the Plan is not able to deduct the premium payment on the first day of the month (because a credit card has expired or bank account has been closed), a final billing showing the amount owed will be sent to your last address of record. If outstanding payment is not received within 15 days of mailing, coverage shall automatically be terminated without further notice as of 12:01 am (Pacific Time) on the last day of the previous billing period for which premium payment had been received by the Plan. The Plan is not liable to pay any claims in the event you were not considered eligible at the time services were rendered, or if you elected to receive medical services which are not covered by Medicare.

Plan Replacement

If by enrolling in the Plan you are replacing another health insurance plan, you should make sure that such replacement does not result in a period where you are uninsured. The Plan will not be responsible for any such gap in coverage.

BENEFITS

Here's a summary of Out-of-Pocket Costs and Benefit Highlights:

USC Senior Care Plan Comparison

Out of Pocket Costs			
	Medicare	**USC Senior Care Plan**	
	Providers accepting assignment	**USC Providers**	**Non-USC Providers**
Medicare Monthly Part B Premium (Increases Based on Income)	$174.70	$174.70	
Plan Premium (In addition to monthly Medicare Part B Premium)	N/A	$275/month, $3,300/year	
Annual Deductible	Part B - $240	**Total Combined A & B Services**	
		$0	$200
Benefit Period* Deductible	Part A - $1,632	N/A	
Annual Out of Pocket	N/A	$0	2% of Medicare allowed charges, for each covered service
Pharmacy Benefit	Not Covered	Not Covered	
Dental Benefit	Not Covered	Covered	
Vision Benefit	Not Covered	Covered	
Benefit Highlights – Member Costs			
	Medicare	**USC Senior Care Plan**	
	Providers accepting assignment	**USC Providers**	**Non-USC Providers**
Physician Office Visit	20% of Medicare allowed charges (after annual deductible)	$0	2% of Medicare allowed charges (after annual deductible)**
Diagnostic Tests, X-rays and Lab Services	20% of Medicare allowed charges (after annual deductible). If done at a hospital as an outpatient you may be charged more, not to exceed the Part A deductible	$0	2% of Medicare allowed charges (after annual deductible)

Benefit Highlights – Member Costs, continued			
	Medicare	**USC Senior Care Plan**	
	Providers accepting assignment	**USC Providers**	**Non-USC Providers**
Durable Medical Equipment	20% of Medicare allowed charges (after annual deductible)	$0 – when equipment available	2% of Medicare allowed charges (after annual deductible)
Outpatient Surgery	20% of Medicare allowed charges (after annual deductible)	$0	2% of Medicare allowed charges (after annual deductible)
Inpatient Hospital Stay **1 through 60 Days**	$1,632 Benefit period* deductible	$0	2% of Medicare allowed charges (after annual deductible)
Inpatient Hospital Stay **61 through 90 Days**	$408 per day	$0	2% of Medicare allowed charges (after annual deductible)
Inpatient Hospital Stay Beyond 90 Days (Up to 60 additional lifetime reserve days)	$816 per day	$0	2% of Medicare allowed charges (after annual deductible)
After Lifetime Reserve	Not Covered	Not Covered	
Skilled Nursing Facility **1 through 20 Days**	$0	Not available	$0
Skilled Nursing Facility **21 through 100 Days** (Benefit limited to 100 days per calendar year)	$204 per day	Not available	2% of Medicare allowed charges (after annual deductible)
Skilled Nursing Facility **More than 100 Days**	Not Covered	Not Covered	
Home Health Care Services (Approved by Medicare)	$0	Not available	$0

* Benefit period begins on first day of hospitalization and ends 60 days after discharge; therefore, unless beneficiary is readmitted within 60 days after discharge, another deductible applies.

** See example on page 15.

Benefit Highlights – Member Costs, continued			
	Medicare	**USC Senior Care Plan**	
	Providers accepting assignment	**USC Providers**	**Non-USC Providers**
Emergency Room	20% of Medicare allowed charges (after annual deductible)	Not available	2% of Medicare allowed charges (after annual deductible)
Urgent Care Visit	20% of Medicare allowed charges (after annual deductible)	Not available	2% of Medicare allowed charges (after annual deductible)
Hearing Exam	20% of Medicare allowed charges (after annual deductible)	$0 (deductible does not apply)	2% of Medicare allowed charges (after annual deductible)
Hearing Aids	Not Covered	Not Covered	
Pharmacy Benefit	Not Covered Member required to enroll in a Part D Prescription Drug Plan	Not Covered Member required to enroll in a Part D Prescription Drug Plan	Not Covered Member required to enroll in a Part D Prescription Drug Plan
Dental Benefits	Not Covered	Covered	
Vision Benefits	Not Covered	Covered	

OTHER BENFITS			
	Medicare	**USC Senior Care Plan**	
Foreign Travel	**Providers accepting assignment**	**USC Providers**	**Non-USC Providers**
Additional Deductible per Calendar Year	Not Covered	N/A	You pay an additional deductible of $250
Remainder of Charges	Not Covered	N/A	You pay 20% of billed charges after additional $250 deductible. ($50,000 lifetime benefit max.)

DENTAL BENEFITS – Group # 3378-3002 – Delta Dental		
In-Network		**Out-of-Network**
Delta Dental PPO Dentist	**Delta Dental Premier Dentist**	**Non-Delta Dentist**
Your out-of-pocket expense will probably be less because Delta PPO dentists have agreed to charge PPO patients reduced fees.	You will be charged no more than the fees allowed by Delta Dental (Premier dentist fees are generally higher than PPO dentist fees.)	You will be responsible for the difference if your dentist charges more than Delta Dental's allowed fees.
You may be charged only the patient share at the time of treatment, not Delta's portion.	You may be charged only the patient share at the time of treatment, not Delta's portion.	You may have to pay the entire amount in advance and wait for reimbursement.
Benefits	**In-Network**	**Out-of-Network**
Deductible (Per Person) (applies to all services and supplies, except where noted below)	You pay $25 per calendar year	You pay $50 per calendar year
Maximum Benefits (Per Person)	$1,500 per calendar year	
Diagnostic and Preventive Includes: Oral examinations, cleanings, x-rays, examinations of tissue biopsy, fluoride treatment, space maintainers, and specialist consultations.	Plan pays 100% of allowed fee (deductible waived)	Plan pays 100% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists
Basic Includes: Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, and tissue removal (biopsy).	Plan pays 80% of allowed fee after annual deductible	Plan pays 80% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists after annual deductible
Major Includes: Bridges, partial dentures, full dentures, crowns, jackets, cast restorations.	Plan pays 60% of allowed fee after annual deductible	Plan pays 60% of Premier dentist's allowed fee or the fee that satisfies a majority of Delta dentists after annual deductible

VISION BENEFITS

Covered Persons in the USC Senior Care Plan are automatically enrolled in Vision Service Plan (VSP). As a VSP member, you have access to one of the nation's largest provider networks - VSP's Choice Network. To find a participating VSP Choice Network provider, go to VSP's website at **www.vsp.com** or call VSP at (800) 877-7195. Once you have chosen the VSP Choice

Network provider you would like to see, call the provider's office and schedule an appointment. **Make sure you identify yourself as a VSP member** and give them your USC Senior Care Plan ID number, located on your Plan ID card, and the provider's office will take care of the rest.

You can choose to see any eyecare provider—a VSP doctor; retail chain affiliate providers, including Costco and Eyecare Center of America retail stores; or any other provider. You'll receive the most out of your benefit when you see a VSP doctor, including WellVision exams and services to ensure the health of your eyes. As a VSP member, you'll receive additional discounts on overages and non-covered services and selections, like lens options. There are no claim forms required with VSP doctors.

VSP covers one eye exam every calendar year after a $15 copay, frames once every other calendar year, and lenses once every calendar year. There is a $25 copay for frames and/or lenses. Each provider's office has a limited selection of frames to choose from. Contact lenses are covered up to $150 (in lieu of glasses).

	VSP CHOICE NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Eye Exam (one exam per 12-month period)	$15 copay per visit	Plan pays up to $45 per visit after a $15 copay per visit
Standard Lenses (one set of lenses/ 12-month period)	$25 copay*	$25 copay*
Single vision	Plan pays 100%	Plan pays up to $45
Lined bifocal	Plan pays 100%	Plan pays up to $65
Lined trifocal	Plan pays 100%	Plan pays up to $85
Lenticular	Plan pays 100%	Plan pays up to $125
Options:** Progressive	You pay $55	Plan pays up to $85
Scratch Coating	You pay $17 - $33	Not Covered
Anti-reflective coating	You pay $41 - $85	Not Covered
Photochromatic	You pay $41 - $75	Not Covered
Polycarbonate	You pay $35	Not Covered
Frames (one set of frames/ 24-month period)	Plan pays up to $170 retail allowance, after a $25 copay* (20% discount off any amount over the allowance)	Plan pays up to $55 retail allowance, after a $25 copay*
Contact Lens Benefit	Plan pays up to $150, in lieu of lenses and frames	Plan pays up to $150, in lieu of lenses and frames

* Only **one** copay applies when lenses and frames are purchased at the same time.

** Note: Prices shown reflect the standard option price for each respective category. Premium options may vary. Prices are valid only through VSP Choice Providers.

VSP's Laser VisionCare Program provides discounts through VSP-contracted laser centers. Discounts for PRK and LASIK (including Custom LASIK) average 15%. The maximum you will pay for laser eye surgery with a VSP-contracted provider is $1,500 per eye for PRK; $1,800 per eye for LASIK; and $2,300 per eye for Custom LASIK.

Additional Coverage Plan Details

Ambulance

USC Senior Care Plan pays for ambulance services if determined as medically necessary by Medicare.

Dental

Delta Dental PPO is a preferred provider plan. The Plan provides the maximum benefit when you visit a PPO dentist. PPO dentists are Delta dentists who have agreed to charge PPO patients reduced fees. Delta endodontists, oral surgeons and periodontists are not PPO dentists, but you also receive in-network benefits when visiting one of these Delta specialists.

To use your Delta Dental PPO plan, just call the dental office of your choice and make an appointment. During your first appointment, give your dentist the Delta Dental Group Number – 3378-3002, and the primary enrollee's (former USC employee's) social security number. When you call a dentist for an appointment, please confirm that the dentist participates in the Delta Dental PPO network.

Under the dental PPO plan, you may visit any licensed dentist you wish. However, you receive the maximum benefits available under the program when you choose Delta Dental PPO providers.

Although your Plan covers many of the most commonly needed services, some services are not covered. If you are unsure whether a particular procedure is covered, or how much of it is paid for by your Plan, check with Delta Dental before proceeding.

The following are among the services not covered by Delta Dental PPO Plan:

1. Cosmetic surgery or dentistry services to correct congenital malformation
2. Experimental procedures
3. Therapeutic drugs, premedication or pain relievers
4. Hospital costs or extra charges for hospital treatment
5. Anesthesia (except general anesthesia for oral surgery)
6. Treatment related to temporomandibular joint (TMJ)

Foreign Travel Emergencies

The USC Senior Care Plan pays 80% of the reasonable cost of **emergency services** provided outside of the United States during the first two months of travel. An additional $250.00 calendar year deductible must be met and benefits are covered up to a lifetime maximum of $50,000. Emergency services are those services with such diagnosis and/or treatment that is required, in the judgment of a physician, in response to an accident or sudden and unexpected onset of a symptom, illness or injury which has, or threatens to, cause severe pain, permanent disability, serious medical complications or loss of life.

Medicare Part A Benefit Period

Medicare Part A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 consecutive days. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Vision

Dollar for dollar you get the best value from Vision Service Plan (VSP) when you visit a VSP Choice Network contracted optometrist.

If you decide not to see a VSP Choice provider, copays still apply and you will also receive a lesser benefit and typically pay more out-of-pocket costs. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP Choice network, call VSP first at (800) 877-7195 for details.

When you choose contacts instead of glasses, your $150.00 allowance is applied toward the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fitting of contacts. Current soft contact lens wearers may qualify for VSP's Contact Lens Care Program that includes a contact lens exam and initial supply of replacement lenses. Learn more from your provider or go to www.vsp.com.

LIMITATIONS AND EXCLUSIONS

Limitations

Non-Participating Providers - Doctors and other health care providers who do not accept Medicare assignment may charge up to 15% over Medicare's approved payment amount (limiting charge). If you choose to receive services from a provider that does not accept Medicare assignment, USC Senior Care Plan is not responsible for paying the limiting charge. If the provider does not accept Medicare assignment and also refuses to bill Medicare on your behalf (i.e., the provider has opted-out of the Medicare Program), there is no coverage under the USC Senior Care Plan.

Exclusions

Please be aware that the USC Senior Care Plan does not cover benefits for the following types of services or supplies:

1. **Prescription Drugs (or any deductibles, copayments or coinsurance relating thereto).**

2. Inpatient hospitalization beyond 365 days, after Medicare lifetime reserve days have been exhausted.

3. Skilled Nursing Facility (SNF) care beyond 100 days.

4. Services and Supplies that are not payable by Medicare except as described in this Summary Plan Description/Plan Document (e.g., Foreign Travel Emergency, Delta Dental and VSP). Some components of a comprehensive physical exam may not be covered by Medicare, routine immunizations, cosmetic surgery, routine foot care, and the cost of hearing aids.

5. Services for or incident to vocational, educational, recreational, art, dance, or music therapies, weight control or exercise programs, 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 approved for payment by Medicare.

6. Services for or incident to inter-sex surgery (transsexual operations) or any resulting medical complications, except as medically necessary under Medicare guidelines or as required by law.

7. Services performed in a hospital by house officers, residents, interns or others in training.

8. Blood or Plasma, except for the first three pints each calendar year for inpatient services and first three pints for outpatient services.

9. Acupuncture.

10. Services for which you are not legally obligated to pay or services for which no charge is made to you.

11. Long-Term Nursing care.

12. Any services rendered by a provider who has opted-out of Medicare or who is not eligible to provide services to Medicare beneficiaries.

13. Ambulance services for any patient transfers from one facility to another, unless the transferring facility cannot accommodate your healthcare needs.

14. Services in which a doctor enters into an agreement with you who has decided not to provide services through the Medicare program.

15. Custodial care.

16. Services provided by a family member or by an entity directly or indirectly controlled by a family member.

GETTING ASSISTANCE

Member Services

If you have questions, please visit the website at uscseniorcare.usc.edu or contact USC Health Plans at (213) 740-0035. You may send inquiries by U.S. mail to the following address or send an email to healthplans@usc.edu:

USC Health Plans
851 Downey Way, Suite 101B
Los Angeles, CA 90089-1057

A written response will be returned to you within 30 working days. **If you have a member complaint, please contact USC Health Plans at (213)740-0035**.

IMPORTANT CONTACTS		
USC Senior Care	USC Health Plans	(213) 740-0035 uscseniorcare.usc.edu
Plan Coverage Questions	HealthComp	(855) SCPLANS / (855) 727-5267 healthcomp.com
Claim Questions	HealthComp	(855) SCPLANS / (855) 727-5267 healthcomp.com
Dental Coverage	Delta Dental	(800) 765-6003 deltadentalins.com
Vision Coverage	VSP	(800) 877-7195 vsp.com
Medicare	Medicare	(800) 633-4227 medicare.gov
Social Security	Social Security Administration	(800) 772-1213 ssa.gov

Claim Procedures for the USC Senior Care Plan

1. To ensure all medical/facility claims are processed and paid properly, please make sure that you present both your Medicare and USC Senior Care Plan identification cards at the time services are being rendered.
2. Providers/Facilities should submit claims to Medicare Part A and Part B first.
3. After Medicare has approved and paid the claim, the Explanation of Medicare Benefits should be attached to the corresponding claim when submitted to the USC Senior Care Plan claims administrator, HealthComp.
4. The claim must be coded with the most current CPT, HCPCS, ICD10 & UB92 revenue codes.
5. Each claim should be submitted to HealthComp by patient or provider within 12 months from the date of the Explanation of Medicare Benefits*.

* Please note that the USC Senior Care Plan will not be liable for any claims incurred before the effective date of your Senior Care coverage or after that coverage terminates.

Medical Claims Address

HealthComp · c/o USC Senior Care Plan · P.O. Box 45018 · Fresno, CA 93718-5018

Examples of How Medicare and the USC Senior Care Plan Works

I. Services provided by USC Providers:

	Cost
Physician charges	$ 2,000
Medicare approved amount	$ 1,800
Medicare pays 80% of the approved amount	$ 1,440
The Plan pays the remaining 20% of Medicare approved amount	$ 360
Member's Responsibility	$ 0

II. Services provided by Non-USC Providers (provided you have already met annual deductible):

	Cost
Physician charges	$ 2,000
Medicare approved amount	$ 1,800
Medicare pays 80% of the approved amount	$ 1,440
Remaining 20% of Medicare approved amount	$ 360
The Plan pays 90% of the remaining 20% of Medicare approved amount	$ 324
Member's Responsibility	$ 36

Plan Interpretation

The Plan Sponsor (USC) reserves the absolute right to amend or terminate the Plan, to increase premiums in its sole discretion, or to terminate any benefit under the USC Senior Care Plan for any reason. The Plan Sponsor and any entity designated by the Plan Sponsor to process claims under the Plan (e.g., the Claims Administrators designated below) has the discretionary authority to determine eligibility for benefits, to interpret the Plan, and to decide claims under the terms of the Plan. The Plan Sponsor has delegated such discretionary authority to interpret the Plan and decide claims under the Plan to the Claims Administrators below.

Any interpretation of the Plan and any decisions on any matter within the discretion of the Plan Sponsor (or designated Claims Administrator) and made by the Plan Sponsor (or designated Claims Administrator) shall be binding on all persons. A misstatement or other mistake in fact shall be corrected when it becomes known, and the Plan Sponsor shall not be liable in any manner for any determination of fact made in good faith. Should benefits or premiums of this Plan change in any way, the Plan Sponsor will utilize its best efforts to notify you within thirty (30) days written notice to your last record of address.

TERMINATION OF COVERAGE

How You May Terminate Coverage

If you wish to terminate your coverage with the USC Senior Care Plan, you are required to provide a thirty (30) day written notice to the following address or send an email to healthplans@usc.edu:

USC Health Plans
851 Downey Way, Suite 101B
Los Angeles, CA 90089-1057

Coverage terminates at midnight (Pacific Time) on the last day of the month following your notice, provided the premium for that month has been timely paid. The Plan is not responsible for any services received after termination of coverage.

In the event of a Member's death, the Plan must be notified in writing immediately. Any premium(s) paid after the Member's death is/are subject to a one (1) month maximum refund because of continuing expenses incurred by the Plan relating to the Member (e.g., continued administrative fees paid to Plan vendors) after such death.

How the USC Senior Care Plan May Terminate

The USC Senior Care Plan (the "Plan") coverage will be terminated if one of the following occurs:

1. You withdraw from the Plan.

2. False representation or concealment of material when applying for coverage or after enrollment.

3. You are not enrolled in Medicare Parts A and B.

4. Fraud or deception in use of Plan services or knowingly permitting such fraud of deception by another.

5. Non-Payment of Member Premiums or failure to maintain one of the automatic payment options required by the Plan. In the event of such a termination, USC, in its sole discretion, reserves the right to deny re-enrollment to such terminated Member.

6. The Plan is terminated.

MISCELLANEOUS INFORMATION

This section presents basic information provided by the Plan Administrator of your Plan concerning the medical coverage maintained by the University of Southern California (USC) under USC Senior Care Plan and your rights as a Plan Participant, to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan Sponsor and Plan Administrator is USC.

Plan Name and Number	Plan Sponsor, Administrator and Identification Number	Agent for Service of Legal Service	Plan Type, Administrator and Plan Year End	Claims Administrators
USC Senior Care Plan (a separate Plan within No. 520)	University of Southern California 3551 Trousdale Parkway, Room 352 Los Angeles, CA 90089-5013 (213) 740-7922	University of Southern California 3551 Trousdale Parkway, Room 352 Los Angeles, CA 90089-5013 (213) 740-7922	Supplemental Plan to Medicare, Self-Insured - December 31	HealthComp P.O. Box 45018 Fresno, CA 93718-5018
			Dental, Self-Insured - December 31	Delta Dental 560 Mission St., Suite 1300 San Francisco, CA 94105
			Vision, Self-Insured - December 31	VSP 3333 Quality Dr. Rancho Cordova, CA 95670

The vendors listed above for coverage with self-insured status provide certain administrative services for the self-insured coverages and have been delegated the same discretionary authority as the Plan Administrator with respect to those services. These vendors provide claims payment and other administrative services under an administrative services contract with the University but they do not assume any financial risk or obligation with respect to claims or benefits under the coverage.

Plan Administration

The administration of the Plan shall be under the supervision of the Plan Administrator listed above. To the fullest extent permitted by law, the Plan Administrator shall have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan and the Plan Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan. Any determination by the Plan Administrator shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously.

Any claims administrator has discretionary authority to construe any and all terms of the Plan, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the Plan. Any and all of the claims administrator's decisions with respect to the Plan shall be conclusive and binding on all persons.

Sources of Plan Contributions

Participants pay the full cost of the benefits under the Plan through their contributions. USC does not contribute toward the cost of the benefits under the Plan. Medical, dental and vision benefits under the Plan are self-insured by the Plan Sponsor and such benefits are paid from the Plan Sponsor's general assets.

Amendment and Termination of the Plan

The Plan Sponsor has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Plan Sponsor shall not have any obligation whatsoever to maintain the Plan for any given length of time, and the Plan Sponsor may at any time amend or terminate the Plan, in whole or in part. Any such amendment or termination shall be effected by a written instrument signed by or approved by an officer of the Plan Sponsor. No vested rights of any nature are provided under the Plan.

Claims for Benefits

A claim for benefits is a request for a Plan benefit or benefits, made by a participant or his or her authorized representative that complies with the Plan's reasonable procedure for making benefit claims.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 series) and updated Summary Plan Description/Plan Document, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive summaries of the Plan annual financial reports. The Plan Administrator is required by law to furnish each participant with copies of these summary annual reports.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants. No one may discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse a Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIMS FOR BENEFITS – ERISA Time Frames

NOTIFICATION OF CLAIMS DECISION: URGENT CARE CLAIMS

The Plan Administrator (or the applicable claims administrator, i.e., HealthComp for USC Senior Care Plan medical claims, Delta Dental for dental claims and VSP for vision claims, hereafter the "delegate") will notify the claimant of the Plan's claims decision as soon as possible, but not later than 72 hours after receipt of the claim by the Plan.

NOTIFICATION OF CLAIMS DECISION: NON-URGENT CARE CLAIMS

Pre-Service Claims

The Plan Administrator (or the delegate) will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 15 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Plan and the Plan Administrator (or the delegate) notifies the claimant in writing or electronically prior to the expiration of the initial 15-day period.

Post-Service Claims

The Plan Administrator (or the delegate) will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 30 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Plan and the Plan Administrator (or the delegate) notifies the claimant in writing or electronically prior to the expiration of the initial 30-day period. The notice to the claimant will state the reason for the extension and the date by which the Plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

APPEAL OF ADVERSE CLAIMS DECISIONS

Upon receipt of an adverse claims decision, the claimant has up to 180 days to file an appeal with the Plan Administrator (or the delegate). The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the Plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

NOTIFICATION OF CLAIMS DECISION ON REVIEW

The Plan Administrator (or the delegate) will notify the claimant of the Plan's claims decision on review within a reasonable time period appropriate to the circumstances.

Urgent Care Claims

For urgent care claims, the Plan Administrator (or the delegate) will notify the claimant of the Plan's claims decision on review as soon as possible, but not later than 72 hours after receipt of the claimant's request for review of an adverse claims decision.

Pre-Service Non-Urgent Care Claims

For pre-service claims, the Plan Administrator (or the delegate) will notify the claimant of the Plan's claims decision on review not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse claims decision.

Post-Service Non-Urgent Care Claims

For post-service Plan claims, the Plan Administrator (or the delegate) will notify the claimant of the Plan's claims decision on review not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse claims decision.

Summary of HIPAA Privacy Rights

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of private health information.

The University and its group health plans will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the plans will require all of its business associates to also observe HIPAA's privacy rules. In particular, the plans will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. If you have questions about the privacy of your health information, please contact USC Senior Care Plan member services at 213-740-0035 or the University's designated privacy official.