MEDICAL PLAN DOCUMENT

PHC HDP/HSA

Medical Claims Administrator:

brms
Benefit & Risk Management Services

Prescription Drug Claims Administrator:

EXPRESS SCRIPTS®

Effective Date: January 1, 2019

TABLE OF CONTENTS

INTRODUCTION

The purpose of this document is to provide you and your covered Dependents, if any, with summary information on benefits available under this component plan as well as with information on a Covered Person's rights and obligations under the DIGNITY HEALTH Welfare Benefits Plan (the "Plan"), which is commonly known as *FlexAbility*. This component plan document is not the Plan document or the Summary Plan Description, which can be found on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

You are a valued Employee of DIGNITY HEALTH, and your Employer is pleased to sponsor the Plan to provide benefits that can help meet your health care needs. The Plan is self-funded with Employer and Employee contributions.

DIGNITY HEALTH is named the Plan Administrator for the Plan. The Plan Administrator has retained the services of independent third party administrators to process claims and handle other duties for this component plan, known as Claims Administrators. The Claims Administrator for this component plan is Benefit & Risk Management Services, Inc. (hereinafter "BRMS") for medical claims, and Express Scripts for pharmacy claims. The Claims Administrators do not assume liability for benefits payable under the Plan, since they are solely claims-paying agents for the Plan Administrator.

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, Out-of-Pocket amounts, and coinsurance amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the Employer and there is no separate fund that is used to pay promised benefits. As a self-insured welfare plan and one that is covered by the Employee Retirement Income Security Act of 1974 (“ERISA”), the Plan constitutes an “employee welfare benefit plan” within the meaning of Section 3(1) of ERISA.

Some of the terms used in this document begin with a capital letter, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Defined Terms will help you to better understand the provisions of this Plan.

This document describes the PHC HDP/HSA component plan provisions and benefits. Covered Employees and eligible Dependents are responsible for reading this document and related materials (including the Plan document and the Summary Plan Description) completely and complying with all the rules and provisions of these documents.

Each individual covered under this Plan will receive an identification card that he or she may present to providers whenever he or she receives services. On the back of the card are phone numbers to call in case of questions or problems.

The Dignity Health Welfare Benefits Plan Document and the Dignity Health *FlexAbility* Summary Plan Description will govern if there are discrepancies between their provisions and the information in this document. (If there are discrepancies between the Dignity Health Welfare Benefits Plan Document and the Dignity Health *FlexAbility* Summary Plan Description, then the Dignity Health Welfare Benefits Plan Document will govern.) The formal plan documents, texts and insurance contracts which govern the operations of various plans and copies of official documents and reports are on file for review by eligible participants and beneficiaries at the following location, by appointment.

DIGNITY HEALTH
185 BERRY ST STE 300
SAN FRANCISCO CA 94107

This document becomes effective on January 1, 2019.

Translation Services are Available

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-916-631-3051.
繁體中文（Chinese)	注意：如果您使用繁體中文，可以免費獲得語言援助服務。請致電 1-916-631-3051
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-916-631-3051.
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-916-631-3051.
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-916-631-3051번으로 전화해 주십시오.
Հայերեն (Armenian)	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 916-631-3051:
فارسی (Persian/Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-916-631-3051 تماس بگیرید.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1- 916-631-3051.
日本語（Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1- 916-631-3051まで、お電話にてご連絡ください。
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-916-631-3051
ਪੰਜਾਬੀ (Panjabi/ Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-916-631-3051 'ਤੇ ਕਾਲ ਕਰੋ।
ខ្មែរ (Mon-Khmer/ Cambodian)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-916-631-3051។
Hmoob (Hmong)	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-916-631-3051.
□□□□□ (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-916-631-3051 पर कॉल करें।
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-916-631-3051.

Discrimination is Against the Law

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

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Gabrielle Worrell, Senior Benefits Analyst.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Gabrielle Worrell, 3033 N. 3rd Avenue Phoenix, AZ 85013. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Gabrielle Worrell, Senior Benefits Analyst, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

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

Detailed information regarding the Plan's Non Discrimination Policy and the Dignity Health Discrimination Grievance Procedure may be found in the 2019 Dignity Health *FlexAbility* Summary Plan Description (SPD) which is located on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

ELIGIBILITY AND ENROLLMENT

You are responsible for enrolling in the manner and form prescribed by Your Employer. Specific information, shown below, can be found in Resources located on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

- Who is eligible for the plans?
- Who are your eligible dependents?
- Selecting your family coverage categories.
- Enrolling in *FlexAbility*.
- Qualified life events affecting your coverage.
- If You do not enroll, and
- Special enrollment rules.

If you have questions about your Dignity Health benefits, call the Dignity Health Employee Service Center at 1-855-475-4747 and press 1 for benefits.

PLAN AND PROVIDER NETWORK OVERVIEW

Verification of Plan Benefits 1-866-750-0578

Call this number to verify eligibility for Plan benefits before the charge is Incurred.

All benefits described in this document are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are no more than the Maximum Allowable Charges; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The PHC HDP/HSA plan offers two benefit tiers where Out-of-Pocket costs are based on Providers of services.

There are two provider network choices:

- Tier 1: PHC Network
- Tier 2: Anthem Blue Cross PPO Provider Network, which provides a national Anthem network of physicians.

You may obtain more information about the Providers in the PHC Network or in the Anthem Blue Cross PPO Network by contacting BRMS by phone or by visiting their website, as listed below:

Benefit & Risk Management Services (BRMS)
1-866-750-0578
www.brmsonline.com/dignityhealth

Under certain limited circumstances where a covered person may not have a choice for certain hospital-based services or providers (such as anesthesiologists, radiologists, neonatologists, or pathologists) during an elective or emergent admission to a Tier 1 facility; services may be covered at the Tier 1 network benefit level. Under these certain situations beyond the covered person’s control when services are provided by a Tier 2 or out-of-network hospital-based provider during emergencies and/or hospitalizations in a Tier 1 facility; covering the services at Tier 1 network benefit level protects the covered person from financial responsibility and eliminates potential balance billing.

Balance Billing

In the event that a claim submitted by an In-Network or Out-of-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan’s position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Out-of-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by an In-Network Provider being paid in accordance with a discounted rate, it is the Plan’s position that the Covered Person should not be responsible for the difference between the amount charged by the In-Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any In-Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the In-Network Provider.

The Covered Person is responsible for any applicable cost sharing.

Out of Country Care

This Plan will provide benefits for covered expenses Incurred outside the USA for Emergency Conditions only. Plan benefits will be based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the Provider at the time of service. If expenses outside the USA are Incurred, you must submit a translation of the bill to include diagnosis, description of service, charge for each service (currency of the country if not in US dollars), date(s) of service, and name of country where service are rendered. Otherwise, usual Plan procedures for claim submissions should be followed. The Plan Administrator reserves the right to reimburse the directly to the Plan Member.

Coordination of Benefits

Determination of whether this Plan is primary or secondary, and the impact on payment for services and supplies is in accordance with the Coordination of Benefits provisions and Medicare Secondary Payer rules.

Deductibles/Copayments Payable by Covered Persons

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one Deductible amount per Plan and generally it must be paid before any money is paid by the Plan for any Covered Charges. On the first day of the Calendar Year, a new Deductible amount is required. Deductibles accrue toward the 100% maximum Out-of-Pocket payment.

A Copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments accrue toward the 100% maximum Out-of-Pocket payment.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this document.

Government Mandates

The Plan Administrator, subject to the terms and conditions of the Plan as directed and approved by the Employer, agrees to adopt or otherwise incorporate federal and California State mandates applicable to self-funded ERISA health plans.

COST MANAGEMENT SERVICES

Precertification or preauthorization does not guarantee benefits to you or your Provider and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to the Benefit Management Department at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered.

Cost Management Services Phone Number

Anthem Blue Cross – 1-800-274-7767 (Providers)
BRMS – 1-866-750-0578 (Covered Members)

This Cost Management program does not apply if your primary coverage is Medicare or another group health benefit plan.

The provider, patient or family member must call BRMS to receive information regarding certification of certain Cost Management Services.

In-Network Claims

The Provider is responsible for calling to pre-certify hospitalizations and other services as contracted with Anthem Blue Cross.

Out-of-Network Claims

The provider, patient or family member must call Anthem Blue Cross at 1-800-274-7767 to receive certification of certain Cost Management Services. This call must be made at least seven days (business days) in advance of services being rendered or within two days (business days) after an emergency. Note that Out-of-Network services are only covered under very limited circumstances (for example, certain emergencies, preventive care when In-Network care is not available, and limited circumstances where a Covered Person who does not have a choice or cannot make a choice is treated by an Out-of-Network Provider inside of a Tier 1 In-Network facility). See the Schedule of Benefits for further details.

Any costs Incurred because of reduced reimbursement due to failure to follow Cost Management procedures will not accrue toward the 100% maximum Out-of-Pocket payment.

UTILIZATION REVIEW

The utilization review program is designed to help ensure that all Covered Persons receive Medically Necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- Precertification of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided (this list is not an all-inclusive list and is subject to change):

    - Air Ambulance
    - Diagnostic Testing
    - Durable Medical Equipment
    - Home health care
    - Hospitalizations
    - IV Infusion Therapy
    - Medical/Surgical Supplies
    - Mental Disorder inpatient admissions
    - Occupational and Physical Therapy visits over the limits in the Summary of Benefits
    - Orthotics
    - Physical Rehabilitation Facility stays
    - Prosthetics
    - Skilled Nursing Facility stays
    - Substance Use Disorder inpatient admissions
    - Surgery
    - Transgender/Gender Dysphoria coverage/surgery
    - Transplants, including but not limited to organ and stem cell transplants
    - Weight reduction surgical procedures

- Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works:

Pre-certification

Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician,

certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Member ID number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment.

Concurrent Review, Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

CASE MANAGEMENT

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called Case Management, shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PHC HDP/HSA
SCHEDULE OF BENEFITS – MEDICAL

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan.		
Plan Features **PHC HDP/HSA**	**Tier 1** **(PHC Network)**	**Tier 2** **(Anthem Blue Cross PPO Network)**
Deductible per Calendar Year	$3,500 per individual $7,000 per family	$6,600 per individual $11,000 per family
	Deductible is per person. The combined family maximum is three times the illustrated amount. The Tier 1 and Tier 2 deductible "cross apply".	
Percentage Coinsurance	After the Deductible is met, the Plan pays 80% of the Maximum Allowable Charge for most covered services and supplies. See individual service type for details.	After the Deductible is met, the Plan pays 50% of the Maximum Allowable Charge for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible (medical and prescription drug) and Medical and Prescription Drug Copays, per Calendar Year	$5,000 per person $10,000 per family	$6,600 per person $13,200 per family
	Out-of-Pocket Limits combined by tier. **Out-of-Pocket limit does not apply to:** Penalties for failure to follow pre-certification, specific benefits as noted in the Schedule of Benefits, any expenses for which benefits were initially paid at 100% of Maximum Allowable Charges, and any expenses more than Plan limits. Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Maximum Allowable Charges for the remainder of the Calendar Year.	
Foreign Country Providers *(Emergency Condition treatment only)*	Covered at the same benefit for any other provider.	
Cost Management Services Program/Pre-certification	Providers should call Anthem Blue Cross prior to Hospitalizations and before specific services rendered.	

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Abortion, Voluntary or Elective	Not covered	Not covered
	Only allowed if the mother's life is endangered by the Pregnancy.	
Acupuncture	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Maximum $30 paid per visit. Limit 24 visits per Covered Person per Calendar Year. Acupuncture in lieu of anesthesia will be covered.	
Allergy Injections	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Allergy Serum	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Allergy Testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Ambulance ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Professional and volunteer ambulance, sea, and air ambulance are covered. Medically Necessary Emergency Condition Out-of-Network will be covered the same as Anthem Network benefits.	
Ambulatory Surgical Center, Freestanding	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Anesthesia	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Acupuncture in lieu of anesthesia will be covered. Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.	
Autism Spectrum Disorders, Screening, Diagnosis, Treatment	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Assistive Communication Devices	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Biofeedback	Not covered	Not covered
Blood and Blood Product Services	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Cardiac Rehabilitation		
Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an approved plan of care.	

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Chemotherapy		
Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Chiropractic Care	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limit of 24 visits per Covered Person per Calendar Year combined all tiers and combined chiropractic, occupational therapy and physical therapy. Additional care may be approved if determined Medically Necessary. Maintenance Care is not covered.	
Clinical Trials	See type of service rendered	See type of service rendered
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	
Cancer Clinical Trials	See type of service rendered	See type of service rendered
	Covered Person must be diagnosed with cancer and accepted into a Phase I, II, III or IV clinical trial for cancer. Only covers Routine Patient Costs in connection the trial.	
Consultation		
Inpatient Consultation	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient/Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Second Surgical, Voluntary	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Dental Injury Care, Limited	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Coverage is available for: • Up to three days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition. • General anesthesia and associated charges for specific persons (under age 7, developmentally disabled, health compromised) • Conditions directly affecting the upper or lower jawbone or associated bone joints. • Accidental Injury to Sound Natural Teeth if rendered within one year of Injury.	
Diabetic Education	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Diabetic Supplies/Equipment	Per service type rendered. Medically Necessary glucometers, pen delivery systems, and insulin pumps are covered under the Durable Medical Equipment benefit. Syringes are covered under the Medical Supplies (home use) benefit or Prescription Drug Benefits. Additional diabetic supplies are covered under your Prescription Drug Benefits.	
Diagnostic Testing Genetic Testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Coverage will be available when Preventive Care or when determined to be Medically Necessary either during the course of a Pregnancy which is covered by the Plan or to treat an inheritable disease.	
HIV/AIDS testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Laboratory	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Machine Testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Professional Interpretation	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
X-ray	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	☎ No prior authorization required for services covered under the Preventive Care provision of the Plan.	
Dialysis Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Durable Medical Equipment	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Oxygen	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Food Products (Aminoacidopathies Formula, Modified Solid Food Products)	Not covered	Not covered
Enteral Formulas	See the Prescription Drug Benefit	See the Prescription Drug Benefit
Foot Care and Podiatry Services	Per service type rendered. Routine foot care is not covered. **Exception:** Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Custom-made foot orthotics are covered, including Medically Necessary special footwear prescribed to treat diabetes.	

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Hearing Aid/Exam	Not covered	Not covered
Home Health Care ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limit 100 visits per Covered Person per Calendar Year. One HHC visit equals: • Up to four hours of home health aide care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	
Hospice Care	80% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
	Limit 2-90 day periods, followed by an unlimited number of subsequent 60-day periods. Bereavement counseling visits are allowed for a period of one year after death for covered family members. Respite care is also available for no more than 5 consecutive visits.	
Hospital Facility Inpatient Hospital ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi- private accommodations. A Medically Necessary private room is covered.	
Outpatient Hospital Clinic	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing
Emergency Room for Emergency Condition and Related Charges	$200 Copay then 100% of Maximum Allowable Charges	$200 Copay then 100% of Maximum Allowable Charges
	Benefit Copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room. Benefit is the same for Out-of-Network Providers.	
Emergency Room for non-Emergency Condition and Related Charges	Not covered	Not covered
Outpatient Surgical Center	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Other Outpatient Hospital Services and Supplies	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Impotency Treatment	80% of Maximum Allowable Charges, after Deductible	50% of Maximum Allowable Charges, after Deductible
	Limited to office visit charges and medications are covered under the Prescription Drug Benefits. Treatment is not covered by the Plan.	
Infertility Services	Not covered	Not covered

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
In-Hospital/Facility Physician's Care	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Massage Therapy	Not covered	Not covered
Maternity Care Inpatient Hospital Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi- private accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness.	
Prenatal, Delivery and Postpartum Care, Physician Charge	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Related testing is covered separately per service type rendered (sonograms have no frequency limit). Voluntary termination of Pregnancy is not covered.	
Medical/Surgical Supplies ☎	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Compression stockings limited to two pairs per Calendar Year.	
Mental Disorder Treatment Inpatient Facility ☎ General Hospital or Private Proprietary Psychiatric Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi- private room rate or 80% of its lowest daily rate if it does not have semi- private accommodations.	
Inpatient, Physician Charge	80% of Maximum Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient/Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Services must be rendered and billed by a licensed mental health professional performing services within the scope of their license.	
Partial Hospitalization	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Psychological Testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features **PHC HDP/ HSAPHC HDP/HSA**	**Tier 1** **(PHC Network)**	**Tier 2** **(Anthem Blue Cross PPO Network)**
Newborn Care		
Circumcision	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to Maximum Allowable Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered. For special Plan enrollment rights for newborns, see the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.	
Nursing, Private Duty	Not covered	Not covered
Obesity Treatment, Morbid	See type of service rendered	See type of service rendered
	Limited to Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical treatment of Morbid Obesity.	
Travel Expenses	100% of charges	100% of charges
	Limit $3,000 per surgery for persons travelling more than 50 miles from their residence. Limited to transportation for Covered Person and/or one companion, lodging (limited to one room-double occupancy), and other reasonable expenses. Meals are excluded.	
Occupational Therapy Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limit of 24 visits per Covered Person per Calendar Year combined all tiers and combined chiropractic, occupational therapy and physical therapy. ☎Additional care may be approved if determined Medically Necessary. Maintenance Care is not covered.	
Orthotics ☎	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physical Rehabilitation Facility, Inpatient ☎	See Skilled Nursing Facility	See Skilled Nursing Facility

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Physical Therapy		
Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limit of 24 visits per Covered Person per Calendar Year combined all tiers and combined chiropractic, occupational therapy and physical therapy. ☎ Additional care may be approved if determined Medically Necessary. Maintenance Care is not covered.	
Physician Care		
Emergency Room Emergency Condition and Related Charges	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Non-Emergency Condition and Related Charges	Not covered	Not covered
Home, Office, Clinic or Elsewhere Primary Care Provider (including family practitioner, general practitioner, OB/GYN, pediatrician, internist)	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Other	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Outpatient Mental Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, outpatient emergency room visits, rehabilitation therapy, Urgent Care Facility Physician charges and chiropractic care are not covered under this benefit.	
Urgent Care (Physician Charges)	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Preadmission Testing	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; • Your Physician ordered the tests; and • Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs	See Prescription Drug Benefit	See Prescription Drug Benefit
Preventive Care (Includes all Ancillary Charges)	Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing and frequencies (unless listed below). Covered at 100% of Maximum Allowable Charges.	
Breast Pump	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to one per pregnancy.	
Contraceptive Management	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, contraceptive patches, and contraceptive devices. Maximum Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion or removal of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.	
HIV/AIDS vaccine	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Nutritional Counseling (for adults with risk factors and for adults and children with obesity)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to 26 visits (no more frequently than one visit every two weeks) per Covered Person per Calendar Year.	
Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to one per year from age 50 (from age 40 for men at high risk).	
Routine Adult Physical (over age 18)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Includes routine exam and related screening tests based on current medical standards for preventive care. Immunizations follow the recommendations set by the Department of Health and Human Services Centers for Disease Control (CDC).	

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Routine Child Care (up to age 19)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Coverage for health care visits and related testing follows the guidelines of the American Academy of Pediatrics (AAP). Coverage for immunizations follows the recommendations set by AAP or as set by the Department of Health and Human Services Centers for Disease Control (CDC). Routine newborn care is covered as shown above.	
Tobacco Cessation Counseling	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to two attempts per Calendar Year. Each attempt includes a maximum of four intermediate or intensive sessions.	
Prosthetics ☎	50% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Pulmonary Rehabilitation Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Radiation Therapy Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Refractive Surgery	Not covered	Not covered
Respiratory/Inhalation Therapy Freestanding Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Skilled Nursing Facility (SNF), Inpatient ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to 100 days per Calendar Year from admission date combined for Tier 1 and Tier 2. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
Outpatient Services	Benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown previously in this section.	
Speech Therapy Freestanding Facility	80% of Maximum Allowable Charges after Deductible	80% of Maximum Allowable Charges after Deductible
Outpatient Hospital	80% of Maximum Allowable Charges after Deductible	80% of Maximum Allowable Charges after Deductible
Physician Office	80% of Maximum Allowable Charges after Deductible	80% of Maximum Allowable Charges after Deductible
	Limited to 50 visits per Covered Person per Calendar Year. ☎ Additional care may be approved if determined Medically Necessary. Maintenance Care is not covered.	
Sterilization, Voluntary or Elective (Female)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Includes all related services such as anesthesia and facility charges.	
Sterilization, Voluntary or Elective (Male)	Not covered	Not covered
	Male sterilization is only covered if determined to be Medically Necessary same as any other surgery.	
Substance Use Disorder Treatment Detoxification	See type of service rendered	

☎ = Benefits with this symbol require pre-certification. If this Plan is primary, benefits with this symbol require pre-certification. If you have any questions about the pre-certification process, claim status or medical plan benefits, call BRMS at 1-866-750-0578.		
Plan Features PHC HDP/HSA	**Tier 1 (PHC Network)**	**Tier 2 (Anthem Blue Cross PPO Network)**
Inpatient Facility ☎ General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi- private room rate or 80% of its lowest daily rate if it does not have semi- private accommodations.	
Inpatient Physician	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Outpatient/Office	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Partial Hospitalization	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Surgical Charge Benefit ☎ Assistant Surgeon	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Surgeon	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Telemedicine	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	When utilizing LiveHealth Online.	
Therapeutic Injections	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
TMJ ☎	See type of service rendered	See type of service rendered
(Surgery only)	Benefits are available if conservative medical treatment has failed.	
Transgender Healthcare ☎	See type of service rendered	See type of service rendered
Transplants ☎	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Donor Expense	See type of service rendered	See type of service rendered
	Limited to $30,000 per transplant.	
Transplant Travel Benefit	100% of charges	100% of charges
	Limit $10,000 per transplant. Limited to maximums set forth by the Internal Revenue Code at the time services are rendered and must be approved in advance.	
Urgent Care Facility	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Vision Therapy	Not covered	Not covered
Wigs	Not covered	Not covered

SCHEDULE OF BENEFITS - PRESCRIPTION

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by Express Scripts, the Pharmacy Benefit Manager (PBM). Contact the Express Scripts Customer Service Department at 1-844-547-4402 for details.

Any one retail Pharmacy prescription or refill is limited to a 30-day supply. Any one mail order prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs have a quantity limit under the Plan. For additional information on medications that have quantity limits you may call the Express Scripts Customer Service Department.

Covered Drugs and Supplies PHC HDP/HSA	Network
Prescription Drug Benefit (Express Scripts)	**Note:** *You must pay applicable Copayments. The Plan pays the balance of Maximum Allowable Charge.* Copayments per prescription after Prescription Drug $250 Deductible (waived Tier 1 Generic): **Retail** / **Mail Order** **Generic** $10 / $25 **Brand Name** $30 / $75
Prescription Drug Out-of-Pocket Limit	Combined with Medical Out-of-Pocket Limit **Out-of-Pocket limit does not apply to any Plan penalties.** Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Maximum Allowable Charges for the remainder of the Calendar Year.

Benefit includes coverage for Medically Necessary medications and Preventive Care medications. See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/coverage/preventive-care-benefits/ for more details regarding Preventive Care medications.

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

This document is intended to describe the benefits provided under the Plan, but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Claims Administrator if you have questions about specific supplies, treatments or procedures.

Deductible.

- **Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Generally, before benefits can be paid in a Calendar Year a Covered Person must meet the Deductible shown in the Summary of Benefits.

  This amount will accrue toward the 100% maximum Out-of-Pocket payment.

- **Family Unit Limit.** When the maximum amount shown in the Summary of Benefits has been Incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

Percentage Coinsurance. Payment will be made at the rate shown under reimbursement rate in the Summary of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Out-of-Pocket Limit. Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Summary of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

Covered Charges. Covered Charges are the Maximum Allowable Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished.

COVERED MEDICAL SERVICES AND SUPPLIES

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other qualified Provider, if applicable, and are Medically Necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this document.

Abortion, Medically Necessary Only. Facility and other Provider charges for care and treatment related to Medically Necessary abortions are covered. In order for an abortion to be allowed, the mother's life would need to be endangered by the Pregnancy if the Pregnancy were allowed to continue to term.

Acupuncture/Acupressure. Acupuncture/Acupressure is covered when used as anesthesia or for palliative pain relief and when performed by a certified acupuncturist. Acupuncture/Acupressure performed for any other reason is not covered.

Allergy Care. Benefits are available for allergy treatment including, but not limited to, office visits, serum, scratch testing and laboratory testing.

Ambulance Charges. The Maximum Allowable Charges billed by a local land ambulance service for trips to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. In addition, land ambulance transportation from an inpatient (or other facility) to another facility (or other location) will be considered when found Medically Necessary and ordered by a Physician. Such transfers cannot be for the convenience of the patient or family members.

Charges for pre-Hospital medical Emergency Services are covered regardless of whether or not the Covered Person is actually transported to a Hospital.

Air or sea ambulance may be reimbursed only when the patient's condition was so serious that the patient could not be transported safely by land ambulance. Air or sea ambulance may also be reimbursed if the location from which the patient required emergency transportation was inaccessible by land ambulance.

Professional and volunteer ambulance must charge for its services.

Ambulatory Surgical Center. As defined, for outpatient surgery. Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid at the amount that the Claim Administrator determines to be the Maximum Allowable Charge**.**

Anesthesia. Benefits are available for administration of general anesthesia found Medically Necessary for covered surgical procedures. Coverage is limited to anesthesia administration by anesthesiologists and/or Certified Registered Nurse Anesthetists. The Plan will not pay charges for administration of anesthesia given by the surgeon, the assistant surgeon, or by a Hospital employee. Exception: Administration of anesthesia by a Dentist who performed the surgery is covered when the anesthesia is rendered during a covered oral surgical procedure. The allowance for anesthesia includes the usual patient consultation before anesthesia and the usual care after surgery. Anesthesia administration expenses are not covered if the surgery is not covered by the Plan.

Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions, for example: covered electroshock therapy.

Acupuncture/acupressure is covered when used as anesthesia or for palliative pain relief and when performed by a certified acupuncturist.

Autism Spectrum Disorder - Screening, Diagnosis and Treatment. Coverage includes the assessments, evaluations, or tests needed to diagnose whether a Covered Person has Autism Spectrum Disorder, as defined.

It is recommended, but not required, to contact the Claims Administrator to speak with a claims specialist in advance of receiving services for information regarding Providers and treatments that are covered under the Plan.

Covered treatment includes the following care and assistive communication devices prescribed or ordered for a Covered

Person diagnosed with Autism Spectrum Disorder by a licensed Physician or a licensed psychologist:

- Behavioral health treatment – that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a Covered Person.
    - counseling and treatment programs by a licensed Provider, and
    - applied behavior analysis, when provided or supervised by a board-certified Behavior Analyst.
        - Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- psychiatric care by a licensed psychiatrist;
- psychological care by a licensed psychologist;
- medical care provided by a licensed Provider;
- therapeutic care services provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists, including therapeutic care which is deemed habilitative or non-restorative;
- intensive behavioral intervention (comprehensive analysis designed to address all domains of functioning and is provided in multiple settings) for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one- to-one ratio or small group format, as appropriate; and
- prescription drugs and medications.

Coverage under this section is separate from those services which are provided under an early intervention program or individualized service plan provided under any education or public health law, whether or not such services are separately covered under this Plan. However, services provided on a supplemental basis outside of an educational setting are covered if such services are prescribed by a licensed Physician or licensed psychologist because Autism Spectrum Disorder services are covered using the same criteria as other medical services.

Blood Services. Blood, including blood and blood derivatives that are not donated or replaced, blood transfusions, and blood processing when found Medically Necessary. Administration of these items is included.

Coverage also includes services related to blood donations, autologous (patient donates own blood) or directed (donation of blood by individual chosen by patient), when there is a scheduled surgery that customarily requires blood transfusions.

Cardiac Rehabilitation. For outpatient telemetric monitoring during exercise for cardiac rehabilitation rendered at a Hospital or free standing cardiac rehabilitation center. Services must be rendered by a Physician, or by a professional nurse trained in cardiac rehabilitation. Services must be ordered by the attending doctor and found Medically Necessary due to certain medical conditions, such as post valvular or congenital heart surgery; post heart transplants; dilated cardiomyopathy; post myocardial infarction; post bypass surgery or angioplasty; or stable angina. The plan of care must be approved for benefits by the Claims Administrator. The Claims Administrator may request medical records to evaluate the claim for Plan coverage.

This benefit is limited to expenses for telemetric monitored exercise for cardiac rehabilitation only. No other exercise programs are covered. Coverage is limited to frequency up to three times per week and up to a maximum 18 consecutive weeks for an approved plan of care. Related testing procedures such as stress tests will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits. Separate charges for use of exercise equipment are not covered.

Chemotherapy Benefits. This benefit applies when a chemotherapy charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A chemotherapy charge is the Maximum Allowable Charge of a Physician for chemotherapy.

The type of drug for which benefits are provided is limited to anticancer drugs that are not in an Investigational or Experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs).

Oral chemotherapy, subcutaneous injections or intra-muscular injections are not covered under this chemotherapy benefit.

Chiropractic Care. Spinal manipulation/chiropractic services by a licensed doctor of chiropractic (DC) for the detection or correction of the structural imbalance or subluxation in the human body to remove nerve interference resulting from, or related to distortion, misalignment or subluxation of or in the vertebral column. The therapeutic care must be directed at functional improvement (active treatment). Benefits will not be paid for any Maintenance Care or care to prevent worsening. Please see the Summary of Benefits for limits; additional care would be covered if determined to be Medically Necessary.

Clinical Trials (Approved). Routine patient costs and charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

- The clinical trial is approved by any of the following:
    - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services
    - The National Institute of Health
    - The U.S. Food and Drug Administration
    - The U.S. Department of Defense
    - The U.S. Department of Veterans Affairs
- An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
- The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Maximum Allowable Cost, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.
- Coverage will not be provided for:
    - The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
    - The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
    - The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
    - A cost associated with managing an Approved Clinical Trial.

- The cost of a health care service that is specifically excluded by the Plan.

- Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

Consultations, Specialist. A consultation is an examination requested by an attending Physician to obtain an opinion in the evaluation and management of an Illness or Injury. Benefits are not payable for consultation expenses when the consultant is part of the same medical or surgical group as the requesting Physician. If the consultant takes over the management (treatment) of the condition, subsequent management visits are not considered to be consultations.

- **Inpatient Consultations.** Coverage is limited to one inpatient consultation per specialty for each inpatient stay.

- **Outpatient/Office Consultations.** Coverage for outpatient or office consultations is provided for as many specialty opinions requested by the attending Physician as Medically Necessary. Online visits via webcam, chat or voice are covered.

- **Second Opinion Consultation.** Benefits are available for patient-requested second opinion consultations before proceeding with a covered surgical procedure or treatment. The second opinion consultation must be given by a board-certified Physician specialist whose specialty is appropriate to consider the need for the proposed procedure. If the consulting specialist renders the procedure, consultation benefits are not payable. If you or your Dependent seek a third opinion, benefits will be provided on the same basis as the second opinion. Whether or not the second (or third) opinion agrees that procedure is necessary, the Plan will cover the second opinion consultation. It is the patient's decision whether to undergo the procedure.

Contact Lens/Eyeglasses. Initial contact lenses or glasses required following intraocular surgery or cataract surgery, or required to treat corneal disease. No other eyeglasses, contact lens or visual aids, or related exams are covered under this benefit.

Dental Care, Limited Coverage. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures**:**

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Emergency repair due to Injury to Sound Natural Teeth within one year of the Injury.

- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within one year of the Injury
- Excision of benign bony growths of the jaw and hard palate.

- External incision and drainage of cellulitis.

- Incision of sensory sinuses, salivary glands or ducts.

- Reduction of dislocations and excision of Temporomandibular Joints (TMJs).

- Surgical procedure for those covered conditions directly affecting the upper or lower jawbone or associated bone joints.

- A maximum of three days of inpatient Hospital services when a Hospital stay is determined to be Medically Necessary due to an unrelated medical condition.

- General anesthesia and associated facility charges for dental procedures in a Hospital or surgical center for Covered Person if under the age of seven years of age or developmentally disabled regardless of age or the health of the Covered Person is compromised and general anesthesia is Medically Necessary, regardless of age.

- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft

palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diabetic Supplies, Equipment and Education. The following supplies and equipment are covered for the treatment of a diabetic condition when such supplies are ordered or recommended by a Physician and when they are found to be Medically Necessary according to the Plan provisions:

- Blood glucose monitors (standard) and blood glucose monitors for the visually impaired;
- Test strips for glucose monitors, visual reading and urine testing, lancets and automatic lancing devices;
- Injection aids;
- Cartridges for the legally blind;
- Syringes;
- Data management systems;
- Insulin pumps or insulin infusion pumps when Medically Necessary and when conventional injection therapy is found to be inadequate to treat the patient's condition.
- Items such as alcohol, swabs, adhesive tape and gauze are not covered.
- The following items are covered under both the separate Prescription Drug Expense Benefits/Medical Services and Supplies Benefits: Insulin, oral agents to control blood glucose, syringes, and test strips.
- Diabetic self-management education and education relating to diet may be covered for a covered Person with a diabetic condition. Self-management education or diet instruction will only be covered when the patient is initially diagnosed with diabetes or when a Physician diagnoses a significant change in the patient's symptoms or condition that requires changes in the patient's self- management. These educational services will be covered when provided by:
    - A Physician or his/her staff during an office visit for diabetes diagnosis or treatment. When the self-management service education is provided during an office visit, the one benefit payment for the office visit will include payment for the self-management education;
    - A certified diabetes nurse educator, certified nutritionist or certified and registered dietician when referred by a Physician. This education must be provided in a group setting. If it is decided that group education is not available in the patient’s area, the Plan may cover individual education;
    - A professional Provider as described above may be covered for services rendered in the patient's home. However, it must be found to be Medically Necessary for the patient to receive services at home.

Diagnostic Testing, X-ray and Lab Charge Benefits. Diagnostic Testing, X-ray and Laboratory charges are the Maximum Allowable Charges for X-rays and laboratory tests. Benefits are provided for diagnostic services required in the diagnosis of a condition due to Injury or Sickness consisting of:

- Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.
- Diagnostic medical services (machine testing) such as cardiographic and encephalographic testing, radioisotopic studies and other procedures which may be approved when performed and billed by a Physician or covered facility.

- Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician or covered facility.

Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered facility.

- Charges for the following will not be included in this section:
    - premarital exams;
    - routine physical exams;
    - X-ray therapy or chemotherapy; or
    - exams performed as part of dental work, eye tests or fitting of lenses for the eye.

Dialysis. The Covered Person's renal dialysis visits are allowed at the Maximum Allowable Charges minus any applicable Covered Person cost share (i.e., Deductible, Copayment and/or Coinsurance).

Benefits are available for service or supplies related to outpatient dialysis procedures given and billed by Physicians or Medicare-certified dialysis centers. Home self-dialysis is also covered when ordered by the attending Physician and the home setting is found medically appropriate according to Plan provisions. If you are on home dialysis, coverage includes related laboratory tests and consumable or disposable supplies needed for the dialysis. Equipment found Medically Necessary by the Claims Administrator may also be covered. Benefits are not payable for expenses such as alterations to the home, installation of electrical power, water supply, sanitation waste disposal, or air conditioning, or for convenience or comfort items.

Note: Persons of any age who are diagnosed with end stage renal disease (ESRD) should contact the Social Security Office for Medicare eligibility and enrollment details. If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period).See the definition of Maximum Allowable Charges shown later in this document for benefit payment details under the Plan. Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

Durable Medical Equipment. Rental of Durable Medical or surgical Equipment when ordered by the attending Physician and found Medically Necessary according to Plan provisions. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase.

The necessary repairs and maintenance of purchased equipment may be allowed, unless covered by a warranty or purchase agreement. Charges for delivery and service are not covered.

Oxygen and supplies for its administration when found Medically Necessary and appropriate for self-care home use.

Food Products (PKU only). Benefits for the testing and treatment of phenylketonuria (PKU) are covered on the same basis as any other medical condition. Limited coverage is available for certain food supplements, nutrients or food products when ordered, in writing, by a Physician, or other licensed healthcare Provider legally authorized to prescribe drugs. Benefits will not be paid for normal products used in the dietary management of any disorders.

Certain nutritional supplements (formulas) are covered when found Medically Necessary for the therapeutic treatment of phenylketonuria (PKU). The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet.

Foot Care and Podiatry Services. Benefits are available for treatment related to care of the feet. Coverage includes services or supplies rendered and billed by licensed Physicians (medical doctors, osteopaths or podiatrists) for conditions of the feet. Charges for routine foot care are covered for patients with severe systemic disorders, such as diabetes. Services or supplies for orthopedic shoes or shoe inserts are not covered (please refer to Plan Exclusions). Custom-made Medically Necessary foot Orthotics are covered, including Medically Necessary special footwear prescribed to treat diabetes.

Genetic Testing. Genetic testing and diagnostic procedures will be allowed for Covered Persons when determined Medically Necessary either during the course of a Pregnancy which is covered by the Plan or to treat an inheritable disease, and as provided under Preventive Care.

HIV/AIDS Vaccines. Benefits are available for the AIDS vaccination. Benefits are available for HIV testing, regardless of primary diagnosis. Benefits are available for solid organ and other tissue transplantation services if the Covered Person is infected with HIV.

Home Health Care Services and Supplies. Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Summary of Benefits.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Hospice Care Services and Supplies. Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months, and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Summary of Benefits.

- Bed patient either in a designated Hospice Unit or in a regular Hospital bed or in a Skilled Nursing Facility;
- Day care service provided by the Hospice Agency;
- Home care and Outpatient Services provided by the Hospice including intermittent nursing by a registered nurse or licensed practical nurse or by a home health aide;
- Physical, occupational, speech, and respiratory therapy;
- Medical social services and nutritional services;
- Laboratory, X-ray, chemotherapy, and radiation therapy when needed to control symptoms;
- Medical supplies and drugs and medications considered approved for the patient's condition. Benefits are not payable if the drugs or medications are of an Experimental nature;
- Durable Medical Equipment;
- Medical care provided by the Hospice Physician or other Physician designated to render services by the Hospice Agency;
- Respite care limited to no more than five consecutive visits; and
- Bereavement counseling for the family, within one year following the Covered Person’s death.

During this period of acceptance, all the patient's medical services must be provided by or obtained through the Hospice Agency. All services must be billed by the Hospice Agency.

Hospital Charges. This benefit applies when a Hospital charge is incurred for the care of a Covered Person's Injury or Sickness and during a Hospital confinement that starts while that person is covered for this benefit.

- **Inpatient Hospital Care.** The medical services and supplies furnished by a Hospital or a Birthing Center.
    - The Maximum Allowable Charges for room and board are payable as described in the Summary of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.
    - The Plan pays the average semi-private rate for room and board charges by a Hospital or other covered inpatient health facility. If the inpatient facility does not have a semi-private rate, the rate shall be 80% of the room and board charges made by the facility for its lowest priced private room accommodations. If the facility has several semi-private rates, the prevailing, or the most common rate, shall be used.
    - Charges for an Intensive Care Unit stay are payable as described in the Summary of Benefits.
    - Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.
    - Charges for a private room will be covered if a private room is deemed to be Medically Necessary.
    - The Maximum Allowable Charges for Hospital-billed medical services and supplies (other than room and board) and diagnostic X-rays and lab tests are payable.
    - Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid at the amount that the Claim Administrator determines to be the Maximum Allowable Charge.
- **Clinic Services or Supplies.**
- **Outpatient Emergency Condition Care.**
- **Outpatient Surgical Care**.
- **Other Outpatient Services and Supplies** such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.
    - Claims for implants may be denied unless they are submitted with the invoice. The claim with the invoice will be paid at the amount that the Claim Administrator determines to be the Maximum Allowable Charge.

In-Hospital/Facility Physician's Care Benefits. This benefit applies when a medical charge is Incurred for the care of a Covered Person's Injury or Sickness during a covered Hospital/facility confinement. However, a medical charge will not include:

- a charge for care not rendered in the presence of a Physician; or
- a charge for care received on the day of or during the time of recovery from a surgical procedure. However, this limit does not apply if the care is for a condition that is unrelated to the one that required surgery.

IV Therapy/Infusion Services. Ambulatory or home intravenous services ordered by a Physician to include intravenous medications, blood, hydration and electrolyte replacement, and total parenteral nutrition. This benefit includes medical supplies or equipment and drugs and other substances used in IV/infusion therapy.

Maternity. The Maximum Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If you choose to be discharged from the Hospital before the recommended time frames noted above, you are eligible for one Home Health Care visit by a qualified Home Health Care Agency. This visit is separate and does not apply to any visit limits set under any other Home Health Care benefit. A Home Health Care maternity visit must be requested within 48 hours of the time of delivery (96 hours in the case of cesarean delivery). The visit must be rendered within 24 hours of discharge, or of the time of the request, whichever is later. The visit should include parental education; assistance and training in breast or bottle feeding; and the performance of any necessary maternal and newborn clinical assessments. In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are available for services by a Physician or certified nurse midwife for childbirth, cesarean section, and other maternity care rendered for you or your Spouse/Dependents. The Plan excludes services or supplies related to surrogate maternity care (unless the surrogate is a Covered Person, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions). The payment for childbirth, including cesarean section will include the usual care given by a Provider before and after the obstetrical procedure (prenatal or postnatal care).

Medical Supplies (Home Use). Benefits are available for certain medical and surgical supplies used in the home when ordered by the attending Physician and found Medically Necessary according to Plan provisions. Items such as gauze pads, swabs, alcohol, deodorizers, and adhesive tape are not covered. Coverage is limited to the following items:

- Ostomy bags and supplies required for their use.
- Catheters and supplies required for their use.
- Syringes and needles necessary for conditions (e.g., diabetes).
- Extensive surgical dressings necessary for conditions such as cancer, diabetic ulcers and burns.
- Compression stockings limited to two pairs per Calendar Year, if determined to be Medically Necessary.

Mental Disorder Treatment. Covered Charges will include Medically Necessary care, supplies and treatment of Mental Disorders. The Plan shall comply with federal parity requirements. Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

- **Inpatient Treatment.** Medically Necessary services relating to the diagnosis and treatment of mental health disorders comparable to other similar Hospital benefits will be allowed. Coverage includes residential treatment limited to facilities that meet the definition of Provider, Hospital or Psychiatric Facility and care is determined to be Medically Necessary. Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.
- **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:
    - Psychological testing.
    - Partial Hospitalization is covered.
    - Comprehensive psychiatric emergency programs performed on an outpatient basis.
    - Intensive Outpatient Program treatment is covered.

- Services must be rendered and billed by a California State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of California State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.

- Family counseling will be allowed as long as the person is an immediate family member of a person diagnosed with a Mental Health Disorder and is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

Newborn Care. The benefit is limited to the Maximum Allowable Charges made by a Hospital or Physician for routine pediatric care while the newborn Child is Hospital-confined as a result of the Child's birth.

Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn Child is an eligible Dependent and is neither injured nor ill.

For special Plan enrollment rights for newborns, see the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

Nutritional Supplements, Vitamins and Electrolytes. In which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician, and are the sole source of nutrition or are part of a chemotherapy regimen.

Obesity Treatment of Morbid Obesity. Benefits are available for treatment of Morbid Obesity. See the Summary of Benefits for limitations. Surgical intervention must be approved prior to the services being rendered. Morbid Obesity is defined by the National Heart Lung Blood Institute. A written treatment plan must be submitted to the Claims Administrator before services are rendered. Any services not pre-approved will not be covered.

Travel expenses: Certain travel expenses Incurred in connection with an approved, specified bariatric surgery, performed at a designated facility that is 50 miles or more from a Covered Person's place of residence, are covered, provided the expenses are approved in advance. The maximum payment will not exceed $3,000 per surgery for the following travel expenses Incurred by the Covered Person and/or one companion:

- Transportation for the Covered Person and/or one companion to and from the facility.

- Lodging, limited to one room, double occupancy.

- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Occupational Therapy. Services rendered by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy. Please see the Summary of Benefits for limits; additional care would be covered if determined to be Medically Necessary.

Orthotics/Braces. The initial purchase, fitting and repair of Orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Custom-made Medically Necessary foot Orthotics are covered.

Physical Rehabilitation Facility, Inpatient. See Skilled Nursing Facility benefit

Physical Therapy. Services rendered by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. If the patient reaches maximum potential for significant and measurable improved function, or if care is found by the Claims Administrator to be Maintenance in nature, benefits will no longer be payable. Please see the Summary of Benefits for limits; additional care would be covered if determined to be Medically Necessary.

Physician Care. The professional services of a Physician for evaluation and management or therapeutic medical visits in an office, outpatient Hospital, clinic (including retail health clinic), home, or elsewhere. Services must be given and billed by covered healthcare Providers and found Medically Necessary according to Plan provisions.

Consultations, surgical and obstetrical procedures, Mental Disorder care, Substance Use Disorder care, podiatrist care or foot care, rehabilitation therapies, are covered separately.

Preadmission Testing. The Medical Benefits percentage payable will be for diagnostic lab tests and X-ray exams when:

- performed on an outpatient basis within 14 days before a Hospital confinement;
- related to the condition which causes the confinement; and
- performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

Preventive Care/Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, preventive medications such as oral contraceptives and tobacco cessation medications, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).
See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/coverage/preventive-care-benefits/ for more details.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Prosthetics. The initial purchase, fitting and repair of fitted Prosthetic devices which replace body parts. Replacement may be covered if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional. The Plan will allow Prosthetic devices to restore a method for speaking incidental to laryngectomy.

Pulmonary Rehabilitation. Is covered when found Medically Necessary and the services are performed by a Pulmonary Rehabilitation program approved by the Claims Administrator. Patients must meet the Medical Necessity criteria for Pulmonary Rehabilitation of the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) for patients with chronic pulmonary disease.

Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.

PUVA. Psoralen and Ultraviolet A is a therapy that the patient is exposed first to psoralens (drugs containing chemicals that react with ultraviolet light) and then to UVA light, when proven to be Medically Necessary.

Radiation Therapy Benefits. This benefit applies when a radiation charge is Incurred for therapy that is performed as part of the care of a Covered Person's Sickness and while the person is covered for this benefit.

A radiation charge is the Maximum Allowable Charge of a Physician for X-ray, radium or radiotherapy treatment. Radiation charges will not include charges for diagnostic or cosmetic procedures.

Respiratory/Inhalation Therapy. For short-term outpatient respiratory/inhalation therapy when ordered by the attending Physician for therapy services given by certified licensed respiratory therapists or other qualified Provider. Custodial Care or Maintenance Care is not covered.

Skilled Nursing Facility (SNF) Care.

- **Inpatient SNF Services.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
    - the patient is confined as a bed patient in the facility;
    - the attending Physician certifies that the confinement is needed for further care; and
    - the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.
- **Outpatient SNF Services.**
    - **Rehabilitative Therapy.** Benefits are available for outpatient physical therapy, cardiac rehabilitation, occupational, speech therapy and inhalation/respiration therapy rendered to improve function lost due to an Illness or Injury. Such care must be ordered by the attending Physician and rendered by Professional Healthcare Providers licensed to render such care. Refer to the Summary of Benefits for benefit limits.
    - **Other Outpatient Services and Supplies.** Benefits are available for other outpatient facility service or supplies when found Medically Necessary according to Plan provisions. Coverage includes all necessary supplies used during the covered treatment.

Speech Therapy. Services rendered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. If the patient reaches maximum potential for improved, or age appropriate, function, benefits will no longer be payable.

Sterilization, Voluntary or Elective. Facility and other Provider charges for care and treatment related to voluntary female surgical sterilizations are covered. Male sterilizations are only covered if Medically Necessary.

Substance Use Disorder Treatment. Covered Charges will include Medically Necessary care, supplies and treatment of Substance Use Disorders for services by a certified Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) for inpatient or Outpatient Care. The Plan shall comply with federal parity requirements.

- **Inpatient Treatment.** Inpatient detoxification is considered a medical condition eligible for acute care Hospital benefits. Expenses for inpatient Substance Use Disorders (alcohol or drug abuse) rehabilitation are covered separately from detoxification. Medically Necessary services relating to the diagnosis and treatment of mental health disorders comparable to other similar Hospital benefits will be allowed. Coverage includes residential treatment limited to facilities that meet the definition of Provider, Hospital or Substance Use Disorder Facility and care is determined to be Medically Necessary.
    - Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.
- **Outpatient Treatment.** Covered Charges for care, supplies and treatment of Substance Use Disorders for services at a certified alcohol or Substance Use Disorder Facility (freestanding agency or facility or a Hospital center) relating to the diagnosis and treatment of alcoholism, substance use and dependency will be covered. Intensive Outpatient Program treatment and Partial Hospitalization are covered.

- Family counseling will be allowed as long as the person is an immediate family member of a person diagnosed with a Substance Use Disorder and is covered under this Plan. Family therapy will be allowed regardless of the number of family members attending the family therapy session.

- Benefits are not payable for services that consist primarily of participation in programs of a social, recreational, or companionship nature.

Surgical Charge Benefits.

- **Assistant Surgeon.** Charges for assistant surgeon services are covered when found Medically Necessary for performance of the covered procedure. The maximum payment for all assistant surgeons for each surgical procedure is 20% of the value listed for surgery.

- **Surgeon.** This benefit applies when a surgical charge is Incurred for a surgical procedure that is performed as the result of a Covered Person's Injury or Sickness and while that person is covered for this benefit.

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Maximum Allowable Charge for the primary procedures; 50% of the Maximum Allowable Charge for each additional procedure performed in the same area of the body or through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Maximum Allowable Charge for that procedure.

- **Reconstructive Surgery.** The Plan covers care required to significantly restore tissue damaged by an Illness or Injury or for reconstructive surgery that is incidental to or follows surgery resulting from a trauma, an infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a Dependent Child that has resulted in a functional defect.

    - Reconstructive mammoplasties will also be considered Covered Charges. The federally mandated mammoplasty coverage will include reimbursement for:

        - reconstruction of the breast on which a mastectomy has been performed,

        - surgery and reconstruction of the other breast to produce a symmetrical appearance, and

        - coverage of Prostheses and physical complications during all stages of mastectomy, including lymphedemas,

Telemedicine. Telemedicine services offered through LiveHealth Online will be covered. Registration is required and consultations are available via video visits from a smartphone, tablet or computer. Member information must be provided during registration so that the telemedicine claim will be appropriately submitted to Claims Administrator. The applicable telemedicine copayment will apply and must be paid at time of service.

TMJ Syndrome. Medically Necessary services for care and treatment of Temporomandibular Joint syndrome after conservative medical treatment has failed.

Medically Necessary services for care and treatment of Temporomandibular Joint syndrome are covered for conditions that are consistent with the diagnosis of specific organic pathology of the joint that can be demonstrated by X-ray (such as arthritis, ankylosis, tumors, infections or traumatic injuries).

Surgical correction is covered.

The following non-surgical services are covered when rendered or ordered by the attending Physician:

- Initial exam and diagnostic procedures to determine cause of TMJ.
- Subsequent office visits for treatment of a TMJ syndrome consistent with specific organic pathology including the following procedures:
    - Injections.
    - Occlusal treatment/equilibration therapy.
    - One appliance (replacement appliances not covered) and appliance adjustments.
    - Short term physical therapy.
    - Diagnostic tests.

Transgender Services. Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including Medical Necessity requirements, utilization management, and exclusions for cosmetic services. Coverage is provided for specific services according to Plan benefits that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the Plan's prescription drug benefits (if such benefits are included).

Transgender and gender dysphoria services are subject to prior authorization in order for coverage to be provided. Please refer to utilization review program for information on how to obtain the proper reviews.

Transplants - Organ/Autologous Bone Marrow/Stem Cell Transplants. Benefits are available for expenses related to non-Investigational organ or tissue transplants the same as any other Illness. Unless otherwise specifically included, transplants are considered Investigational unless specifically included for Medicare coverage by the Centers for Medicare & Medicaid Services (CMS).

Transplants must meet the Medicare criteria for coverage to be considered for coverage under this Plan. Benefits are not available for expenses related to transplants that have not been approved by CMS or that fail to meet CMS criteria for coverage. Plan coverage for Hospitals will be based on the same criteria set forth by CMS criteria. If CMS restricts coverage for a transplant to approved Hospitals only, then this Plan will only cover those transplants when rendered in the approved Hospital.

Benefits will be available for the following in connection with a covered transplant.

- **Recipient Expenses.** Coverage includes all Plan benefits available for Medically Necessary care and treatment related to covered organ transplants including, but not limited to; pre-transplant care including evaluation, diagnostic tests and X-rays by the transplant Hospital; procurement/tissue harvest and preparation; recipient's transplant surgery and recovery; and post discharge care.
- **Donor Expenses.** Coverage includes expenses Incurred by the live donor(s) for expenses related to procurement of an organ and for transportation of the organ(s) to the extent such charges are not reimbursed by the donor's plan. If you or your Dependent act as a donor, the donor expenses will not be covered by this Plan unless the recipient is a Covered Person under the Plan. Then, donor expenses will be considered as part of the organ recipient's claim.
    - Donor charges and donor search charges will be deemed to be Incurred on the date of the transplant even if the services were rendered before such date. Such benefits, including complications from the

donor procedure for up to six weeks from the date of procurement are covered.

- The Plan will allow cell donor search performed at a nationally accredited bone marrow/stem cell organization only for an approved bone marrow or stem cell transplant, up to a maximum of $30,000 per transplant. Any Covered Charges Incurred for these donor searches will not be applied to the annual maximum payment limits.

- **Autologous Bone Marrow/Stem Cell.** Courses of treatment involving high dose chemotherapy or radiotherapy and autologous bone marrow, stem cell rescue, or other hematopoietic support procedures are not covered as organ and tissue transplants, except for the following (and only then for candidates who meet established national health and age standards): acute leukemia in remission, resistant non-Hodgkin's lymphoma, Hodgkin's disease, and neuroblastoma as allowed under CMS guidelines. If CMS guidelines change, adding or deleting coverage under Medicare, this Plan will include or exclude those procedures. Recipient and donor expenses for covered procedures will be considered on the same basis as organ transplants shown above.

- **Cord Blood Storage.** A Covered Person who needs to store cord blood and the storage is considered Medically Necessary according to the Plan's criteria for cord blood storage at a designated facility.

- **Travel Expenses.** Certain travel expenses Incurred by the Covered Person, up to a maximum of $10,000 per transplant, will be covered for the recipient or donor in connection with a covered organ or tissue transplant, performed at a designated facility that is qualified to provide services. All travel expenses are limited to the maximum set forth in the Internal Revenue Code at the time services are rendered and must be approved in advance. Travel expenses include the following for the recipient (and one companion) or the donor:

    - Ground transportation to and from the approved facility when the facility is 75 miles or more from the recipient's or donor's home. Air transportation by coach is available when the distance is 300 miles or more.

    - Lodging.

        - Note: When the recipient is under the age of 18, this benefit will apply to the recipient and two companions/ caregivers.

        - Meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the facility is locates, rental cars, buses, taxis or shuttle services, except as specifically approved; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver; or return visits for the donor for treatment of a condition found during the evaluation are not covered.

Urgent Care Facility. The Plan covers covered services and supplies provided by a legally operated emergency clinic or center for minor outpatient emergency medical care or emergency minor surgery. An outpatient Hospital emergency room does not qualify as an Urgent Care Facility.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Adverse Benefit Determination is any of the following:

- A denial in benefits.
- A reduction in benefits.
- A rescission of coverage, even if the rescission does not impact a current claim for benefits.
- A termination of benefits.
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (RNs) and does not provide for overnight stays. It must be operated according to the applicable laws of the jurisdiction in which it is located, or accredited by the Joint Commission for the Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Care or a national accreditation organization recognized by the Claims Administrator, or approved by Medicare to render outpatient surgery services. If the center is part of a Hospital, it will not be considered an Ambulatory Surgical Center.

Approved Clinical Trial is a Phase I-IV trial conducted for the prevention, detection, or treatment of cancer or other life-threatening conditions as follows:

- Federally funded or approved by NIH, CDC, AHCRQ, CMS, cooperative group or center of DOD, VA or DOE, or qualified non-governmental entity identified by NIH grant guidelines;
- Study or trial conducted under FDA approved Investigational new drug application;
- Drug trial exempt from FDA approved Investigational new drug application;
- Or as amended by the federal law.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (RN) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Claimant is a Covered Person of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan and that do not exceed the Maximum Allowable Charge.

Covered Person is any person eligible and enrolled for benefits or coverage under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Direct Payment is the right of the Plan to pay a Provider directly pursuant to a Permission for Direct Payment of Benefits and in accordance with the conditions set forth in the Direct Payment section.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

- Deluxe equipment is not allowable when standard equipment is available and medically adequate for the reported condition.

- Disposable Supplies may be allowed if required to operate the medical equipment.

Emergency Condition is a serious medical condition or behavioral condition after the onset of acute symptoms that were sudden and of such severity and/or pain that a prudent person, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result placing the person in serious jeopardy to the health of an individual (including the health of a pregnant woman or her unborn child) or others, if severe behavioral condition; impairment to bodily function; dysfunction of any organ; or serious disfigurement.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services to evaluate an Emergency Condition and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is any subsidiary or DBA of Dignity Health whose Employees may be eligible for benefits described in this component document, including Pacific Central Coast Health Centers.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- if the drug or device cannot be lawfully marketed without approval of the US. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

- if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

- if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

- if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Final Internal Adverse Benefit Determination is an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Final Post-Service Appeal means a second appeal for post-service claims, which constitutes the last internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term “Final Post-Service Appeal” shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant; otherwise in accordance with applicable terms found within this document, the Summary Plan Description, the Plan document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, not including a voluntary level of appeal, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator (PACE).

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved Generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being Generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement (or convalescent nursing home/extended care facility/Skilled Nursing Facility); and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical social services; medical supplies; and laboratory services by or on behalf of the Home Health Care Agency.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or a national accreditation organization recognized by the Claims Administrator; or other accreditation program approved by the Centers for Medicare and Medicaid Services ; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons which are provided by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Immediate Relative of patient or Covered Person is any of the following:

- Spouse/Domestic Partner of the patient or Covered Person;
- Natural or adoptive parent, Child or sibling;
- Stepparent, stepchild, stepbrother or stepsister;
- Father-in-law, mother-in-law, brother-in-law, or sister-in-law;

- Grandparent or grandchild; or

- Spouse of grandparent or grandchild.

Incurred means those services or supplies given to or received by a Covered Person. Such expenses shall be considered to have accrued at the time or date the service or supply is actually provided.

Infertility means either (1) the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of Infertility, or (2) the inability to conceive a Pregnancy or to carry a Pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Program (IOP) is a licensed free-standing or Hospital-based program that includes half- day (i.e., fewer than four hours/day) partial hospitalization programs. IOPs provide services for at least three hours per day for two or more days per week and can be used to treat Mental Health Disorders or can specialize in the treatment of co-occurring Mental Health Disorders and Substance Use Disorders.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Licensed Clinical Social Worker is a licensed social worker with at least six years of post-degree experience who has been certified by the California State Board of Behavioral Sciences for Psychiatric Social Work or similar qualifications outside California.

Maintenance Care is care rendered and directed at relieving discomfort or preserving function secondary to conditions where further enhancement of function cannot be demonstrated or expected. Care that cannot be reasonably expected to lessen the patient's disability enabling him or her to leave an institution. Maintenance Care does not imply the absence of symptoms nor does it imply such services are not necessary. It implies care rendered to maintain a function and prevent the condition from worsening.

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]).

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS).

- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care).

- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

- Medicare cost data as reflected in the applicable individual provider's cost report(s).
- The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.
- Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network.
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
- The allowable charge otherwise specified within the terms of this Plan.
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.
- With respect to Non-Network Emergency Services, the Plan allowance is the greater of:
    - The negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers) (reduced for cost-sharing).
    - One hundred percent (100%) of the Plan's Maximum Allowable Charge payment formula (reduced for cost-sharing).
    - The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration (FDA). To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medically Necessary (Medical Necessity) care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical and dental services; is not conducted for research purposes; is not Experimental or Investigational or not of an educational nature; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Claims Administrator reserves the right to decide, in its discretion, if a service or supply is Medically Necessary.

Medical Record Review is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Health Disorder in the current edition of International Classification of Diseases, published by the US. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. Alternatively, a BMI (body mass index) value greater than 39 may be used to diagnose Morbid Obesity.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with accidents in an automobile or other vehicle, as mandated under the applicable law.

Orthotics are external appliances or devices intended to correct any defect in form or function of the human body. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, corsets, apparel, orthopedic shoes or shoe inserts, or supportive devices for the feet.

Out-of-Pocket means the patient liability portion of the percentage co-payment, Deductible and Copayments.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

PACE is the Plan Appointed Claim Evaluator who the Claims Administrator may use to review second appeals of post-service claims.

Partial Hospitalization (PHP) program or day/night program is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Health Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Claims Administrator, and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts at least 20 hours per week no charge is made for room and board.

Permission for Direct Payment of Benefits is an arrangement whereby the Covered Person, with the permission of the Plan Administrator, permits a Provider to seek and receive payment of eligible Plan benefits, less Deductibles, Copayments and the Coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this document, to the Provider. If a Provider accepts said arrangement, the Provider's right to receive Plan benefits is equal to those of the Covered Person, and are limited by the terms of this document. A Provider that accepts this arrangement agrees that acceptance of a "Direct Payment" from the Plan plus any applicable Deductibles, Copayments and the Coinsurance percentage that is the responsibility of the Covered Person is consideration in full for services, supplies, and/or treatment rendered. Direct Payment is the right of the Plan to pay a Provider directly and the Plan Administrator may revoke or disregard a Permission for Direct Payment of Benefits previously issued to a Provider at its discretion.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Certified Nurse Anesthetist, certified psychiatric nurse, licensed professional counselor, Licensed Professional Physical Therapist, certified registered or Licensed Clinical Social Worker (for care of Mental Disorders), Master of Social Work (MSW), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Dignity Health Welfare Benefits Plan.

Plan Appointed Claim Evaluator (PACE) shall mean an entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by and make determination in accordance with the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

Plan Document is the Dignity Health Welfare Benefits Plan document.

Plan Year is the twelve calendar months from January 1 through December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Primary Care Physician means a Physician who is licensed in the state they are rendering services as a Family Practitioner, General Practitioner, Internist, Pediatrician, Obstetrician/Gynecologist or Doctor of Osteopathy (DO) and is responsible for coordinating and overseeing a patient's medical care. This Plan does not require the designation of a Primary Care Physician.

Prosthetics means the making and application of any artificial part that replaces all or part of a body part, organ or function lost or impaired as the result of disease or Injury. This does not include, for example, eyeglasses or contact lenses, hearing aids, wigs, orthopedic shoes or supportive devices for the feet.

Provider is any legally licensed Physician or any physical therapist, speech therapist, certified or Licensed Clinical Social Worker (for Mental Disorder care), or other health care Providers giving a covered service ordered by a Physician. Any licensed independent laboratory, Hospital, Skilled Nursing Facility, Substance Use Disorder Facility, Hospice Agency, Home Health Care Agency; or other facility/agency included for Plan coverage. Coverage includes charges billed by Urgent Care Facilities, and other health centers or clinics for Covered Services given by Covered Physicians or other healthcare Providers that would otherwise be covered by the Plan. Also, see definitions for certain Providers. To be covered, a Provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

Psychiatric Facility means a private facility that has been approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator as an inpatient facility for the treatment of Mental Disorder and is licensed by appropriate state agencies. A public (government-owned) mental health facility for the treatment of Mental Disorders.

Pulmonary Rehabilitation is an individualized therapeutic multidisciplinary program of care for patients with chronic respiratory disease who remain symptomatic or continue to have decreased function despite standard medical treatment. Pulmonary Rehabilitations' goals are to reduce symptoms, optimize functional status, increase participation, and to train patients to successfully manage their disease process, and improve the overall quality of life for patients with chronic respiratory disease.

Qualified Individual is a Covered Person who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and either (i) the referring Provider is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Rehabilitation Facility means a facility established, equipped and operated, according to the applicable laws of the jurisdiction in which it is located to provide restorative therapy to disabled persons on an inpatient or outpatient basis. The facility must be approved by the Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a national accreditation organization recognized by the Claims Administrator or be a Medicare approved facility for Medicare Part A Skilled Nursing Facility benefits. See also Skilled Nursing Facility.

Routine Patient Costs include all items and services consistent with the coverage provided in this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include the Investigational item/device/service itself; items/services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

- Its services are provided for compensation and under the full-time supervision of a Physician.

- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, Custodial or educational care or care of Mental Disorders.
- It is approved and licensed by Medicare.
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or a national accreditation organization recognized by the Claims Administrator.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth are natural teeth that are fully restored to function; or do not have any decay; or that are not more susceptible to Injury than virgin teeth; or do not have significant periodontal disease.

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Use Disorder Facility is an agency or freestanding facility or a Hospital center that is certified by the California State Department of Health Care Services (DHCS) for the treatment of Substance Use Disorders (drugs and alcohol). For services given outside California, the facility must be certified by a state agency similar to the California State DHCS. If a state does not have a certification regulation, the facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations or a national accreditation organization recognized by the Claims Administrator for the treatment of Substance Use Disorders.

Summary Plan Description is the Dignity Health Welfare Benefits Plan summary plan description, which is the FlexAbility Summary Plan Description, which is located on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video or data communications. LiveHealth Online is the telemedicine provider for this Plan.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.

Urgent Care Claim is a claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

Urgent Care Facility means a medical facility that is open on an extended basis, is staffed by Physicians to treat medical conditions not requiring inpatient or outpatient Hospital care, and which is not a Physician's office.

Waiting Period means the time between the first day of employment and the first day of coverage under the Plan.

PLAN EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered by payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. Exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits section of this document.

Abortion. Elective abortion unless the mother's life would be endangered by the Pregnancy were allowed to continue to term. Note: Complications arising out of an abortion are covered as any other sickness

Administrative Costs. Services that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

Biofeedback. Biofeedback, recreational or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing

Christian Science Practitioners.

Cosmetic Surgery. That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Criminal Activities. Any Injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such Injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Custodial & Maintenance Care. Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, etc.) which could be rendered at home or by persons without professional skills or training. Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution. Any type of Maintenance Care which is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice Care Plan.

Dental Care. Dental procedures except for the prompt repair to the teeth and supporting tissue due to accidental Injury and Hospital expenses for covered dental procedures, if Medically Necessary. All TMJ procedures are excluded under this Plan except if the prior history shows conservative medical treatment has failed.

Diabetic Supplies. Are provided only as a Prescription Drug benefit, see "Prescription Drug Benefits".

Diagnostic Hospital Admissions. Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an outpatient setting.

Disposable Medical Supplies for Home Use. Normal home medical supplies or first aid items.

Drugs in Testing Phases. Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Ecological or Environmental Medicine. Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training. Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation. Training of a Covered Person for the development of skills needed to cope with an accidental Injury or Sickness, except as may be expressly included.

Eligibility. Charges for treatment received before coverage under this option began or after it is terminated.

Excess Charges. Charges in excess of the negotiated contract rate or Maximum Allowable Charge for services or supplies provided.

Exercise Equipment / Health Clubs. Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment. Expenses for treatments, procedures, devices, or drugs which the Plan Sponsor determines, in the exercise of its discretion, are Experimental, Investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the US Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or

- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses. "Reliable evidence" shall include anything determined to be such by the Plan Sponsor, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual.

Foot Care, Routine. Routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include: cutting or removal of corns or calluses and debriding (removal of dead skin or underlying tissue).

Genetic Counseling or Testing. Counseling or testing concerning inherited (genetic) disorders, except as provided under Preventive Care or when such services are determined by a Physician to be Medically Necessary during the course of a Pregnancy which is covered by the Plan or to treat an inheritable disease.

Government-Operated Facilities. Services furnished to the Covered Person in any veterans Hospital, military Hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. NOTE: This exclusion does not apply to treatment of non-service related disabilities or for inpatient are provided in a military or other Federal government Hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Hair Replacement. Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

Hearing Aids and Related Charges. Hearing aids or any other external appliances used to improve hearing acuity, testing necessary to fit a hearing aid, or the fitting of any such devices except as specifically listed in the Medical Services and Supplies in this document.

Holistic, Homeopathic or Naturopathic Medicine. Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy. Treatment by hypnotism.

Infertility Treatment. Charges for treatment of Infertility including but not limited to drug therapy, reversal of surgical sterilization, invitro fertilization, or complications of such procedures.

Impregnation. Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Late-Filed Claims. Claims which are not filed with the Claims Administrator for handling within 12 months after the treatment or services was received.

Learning & Behavioral Disorders. Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism, unless otherwise described in the document.

Maintenance Care. See “Custodial & Maintenance Care”.

Massage Therapy.

Military Service. Conditions which are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments. Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay. Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts. NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Non-Prescription Drugs. Drugs for use outside of a Hospital or other inpatient facility which can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan. Drugs for which there is a non-prescription equivalent available.

Not Covered Provider. Services that are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Listed Services or Supplies. Any services, care or supplies which are not specifically listed in this document as Medical Services and Supplies will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Plan Administrator.

Not Medically Necessary / Not Physician Prescribed. Any services or supplies which are not both (1) Medically Necessary, and (2) Incurred on the advice of a Physician - unless expressly included herein. Inpatient room and board when hospitalization is for services that could have been performed safely on an outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery. Surgery to correct a receding or protruding jaw, unless Medically Necessary.

Other Coverage. Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules. Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or

similar person(s) or group.

Other than Attending Physician. Servicers that are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or disease, and performed by an appropriate Provider.

Outside United States. Charges incurred outside of the United States except in an Emergency Condition or urgent care situation.

Personal Comfort or Convenience Items. Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-Hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Postage, Shipping, Handling Charges, Etc. Any postage, shipping or handling charges which may occur in the transmittal of information to the Claims Administrator. Interest or financing charges.

Prior Coverage's. Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Prior to Effective Date / After Termination Date. Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Prohibited by Law. Charges incurred for services to the extent that payment under this Plan is prohibited by law.

Psychiatric Care. Psychiatric care/chemical dependency benefits do not include telephone psychiatric consultations or testing for intelligence or learning disabilities.

Relative or Resident Care. Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Procured Services. Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of Hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of Medical Services and Supplies in this document.

Subrogation, Reimbursement, and/or Third Party Responsibility. Services that are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Surrogacy. Services rendered to a person, not a Covered Person, who agrees to carry a child on behalf of the Covered Person; or services rendered to the Covered Person to carry a child not their own, except as required under Federal law.

Sterilization Reversal Procedures. A vasectomy or reconstruction (reversal) of a prior elective sterilization procedure.

Telecommunications. Advice or consultation given by or through any form of telecommunication, unless provided through LiveHealth Online.

Travel. Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of Medical Services and Supplies.

Vision Care. Eye examinations for the purpose of prescribing corrective lenses. Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment. Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery. NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery.

Vitamins or Dietary Supplements. Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training. Vocational testing, evaluation, counseling or training.

War or Active Duty. Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Weight Control. Weight reduction surgery reversals; and weight reduction programs, including prescribed medications, unless specifically included in the Summary of Benefits or Medical Services and Supplies section.

Wigs. Benefits do not cover wigs for any reason.

Work-Related Conditions. Any Injury that results or arises from any employment or occupation. Any Sickness for which the Covered Person has, had or could have had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge. Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts (the PBM) is the administrator of the Pharmacy drug Plan.

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact ESI's Customer Service Department, at 1-844-547-4402, for details.

Contingent Therapy Protocol. Some drugs will be managed through the claims processing system. You should call ESI's Customer Service Department for assistance.

Copayments/Deductibles. The Copayment is applied to each covered Pharmacy drug or mail order drug charge once you meet the annual $250 Prescription Drug Deductible and this is shown in the Summary of Benefits. The $250 Prescription Drug Deductible is waived for Tier 1 generic medications. Any one Pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply**.**

Copayment is waived for Generic Drug Prescription Drugs that are mandated as covered under the "Preventive Care" provisions of the federal Patient Protection and Affordable Care Act. If a Generic Drug version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ESI. Contact ESI's Customer Service Department for details on quantity limits and "Preventive Care" provisions under the Plan.

Mail Order Drug Benefit Option. The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order Pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Out-of-Pocket Limit (In-Network). Covered Charges are payable at the percentages shown each Calendar Year until the Out-of-Pocket limit shown in the Summary of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

Pharmacy Utilization Management Program. Certain Prescription Drugs have quantity limits, require prior authorization or step therapy or are excluded under the Plan. For specific information about the Pharmacy Utilization Management Program, call the Express Scripts Customer Service department at 1-844-547-4402.

Pre-authorization Requirements. Some drugs require pre-authorization before benefits become available. The participating Pharmacy or mail order Pharmacy will not provide coverage unless drugs have been approved for benefit payment. If a Pharmacy advises you that you need pre-authorization, you should call ESI's Customer Service Department for assistance. Failure to obtain prior authorization will result in disagreement of benefits.

Specialty Pharmacy Services. ESI has a special program for specialty drugs developed for chronic and or complex Illnesses including but not limited to Crohn's disease, hepatitis C, osteoarthritis, rheumatoid arthritis, Infertility, and pulmonary disease. These drugs may have special handling storage, shipping requirements, or require disease specific treatment programs. They may be injections, infusions, or oral products.

All drugs deemed specialty drugs by ESI and received by mail order will be sent to ESI's Specialty Pharmacy to be filled. A complete list of drugs available under the Specialty Pharmacy is available by calling ESI's Customer Service Department or you may access the list on their website at www.express-scripts.com or www.brmsonline.com/dignityhealth.

Vacation Supply. A supply of medication may be replenished before a normal refill date when needed for a vacation trip. To obtain authorization for an advance supply of drugs, you must phone ESI at 1-844-547-4402. This means that you may receive up to a 90-day supply, limit one fill per Calendar Year. You must pay the applicable multiple Copayment for a vacation supply.

Mandatory Generic Drug Substitution Program. As part of a continuing effort to control costs and preserve the quality of the Plan, you are encouraged to use Generic Drugs whenever appropriate for your condition. A Generic Drug is chemically equivalent to the original Brand Name Drug. The only difference is that the Brand Name manufacturer's patent has expired, allowing other manufacturers to sell the drug. As a result, the Generic manufacturer does not incur research costs and can charge significantly less for the drug. Since Generic Drugs cost less than Brand Name Drugs, cost savings result for you (a lower percentage payable liability amount) and the Plan when you substitute the lower priced drug. If you have any questions about Generic Drugs, ask for advice from your Physician or your pharmacist.

Noncompliance Benefit Reduction. If you or your eligible Dependent receives a Brand Name Drug when a Generic Drug substitution is available, you are responsible for paying the difference between what the Plan would pay for the Generic Drug and the charges for the Brand Name Drug. This can result in substantial payment by you as there is a significant difference in costs between the Brand Name Drugs and Generic Drugs.

Exception. For preventive care drugs mandated as covered under the preventive care provisions of the federal Patient Protection and Affordable Care Act, if a Generic drug would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by ESI. No penalty will apply.

Covered Prescription Drugs

- All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

- Insulin and other diabetic supplies when prescribed by a Physician.

- Injectable drugs or any prescription directing administration by injection.

- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance.

- Phenylketonuria (PKU) formulas and special food products to treat PKU that are listed as Formulary and obtained from a Pharmacy.

- The Plan will comply within one year of the effective date of all new recommendations or guideline changes as required under the federal Patient Protection and Affordable Care Act; the Plan will not cover any item or service that is no longer a recommended preventive service. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by the PBM. Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing unless listed below.

- **Contraceptives** FDA-approved self-administered when prescribed by a Physician for females with reproductive capacity (up to age 50). Over-the-counter emergency contraceptives and barrier contraceptives are only covered at the retail Pharmacy. Benefits are not provided for abortifacient drugs or over-the-counter contraceptives obtained without a prescription other than emergency contraceptives as shown above.

- **Tobacco use cessation agents** when prescribed by a Physician for Covered Persons over age 18 for over-the-counter and prescription forms to include gum, lozenge, patch, inhaler, nasal spray, and oral agents. Two individual tobacco cessation attempts per Calendar Year (180 days) will be covered.

- **Influenza immunization (flu vaccine)**, including administration by injection or inhalation, and the pneumonia vaccine.

Limits to This Benefit. This benefit applies only when a Covered Person incurs a covered Prescription Drug charge.

The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- Quantity limits that could apply to controlled substances based on state regulations.

Expenses Not Covered. This benefit will not cover a charge for any of the following:

- **Administration.** Any charge for the administration of a covered Prescription Drug.
- **Appetite Suppressants/Dietary/Vitamin Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride. Drugs used for Medically Necessary treatment of Morbid Obesity will be allowed.
- **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- **Devices.** Devices of any type, even though such devices may require a prescription, including contraceptive devices. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person, unless as required by federal law.
- **FDA.** Any drug not approved by the Food and Drug Administration.
- **Immunization.** Immunization agents or biological sera, except as specified as covered. Preventive Care immunizations will be covered under the Plan's medical benefits.
- **Infertility.** A charge for Infertility medication.
- **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
- **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.
- **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or drugs as specifically noted as mandated for coverage under the federal Patient Protection and Affordable Care Act or drugs indicated by the Plan (eg, non- sedating anti-histamines).

- **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM – MEDICAL AND PRESCRIPTION

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Network Provider benefits are always paid directly to the Network Provider. Benefits for Hospital or other facility are generally paid directly to the Hospital or facility, if charges have not been paid by you. All other Maximum Allowable Charges/benefits are generally paid directly to you unless you allow the Plan to make a Direct Payment to the Provider with a Permission for Direct Payment of Benefits. This Plan does not recognize assignments to Providers, Physicians or Hospital for any reason including fiduciary matters. Direct Payments to a Provider, Physician or Hospital does not constitute a waiver of this anti-assignment provision and does not confer on the Provider, Physician or Hospital any rights under the Plan or ERISA.

When the claim is processed, BRMS will prepare an Explanation of Benefits Statement. This information should be carefully reviewed to make sure the charges were submitted to BRMS correctly and that the claim was processed accurately.

When a Covered Person has a Claim to submit for payment that person must:

- Obtain a Claim form from the Claims Administrator or at www.brmsonline.com/dignityhealth. For prescription drug claims, obtain a form from Express Scripts at www.express-scripts.com.

- Complete the Employee portion of the form. All questions must be answered.

- Have the Physician or Dentist complete the Provider's portion of the form.

- For Plan reimbursements, attach bills for services rendered. All bills must show:

    - Name of Plan
    - Employee's name
    - Member ID number
    - Name of patient
    - Name, address, telephone number of the Provider of care
    - Diagnosis
    - Type of services/supplies/medications rendered, with diagnosis and/or procedure codes
    - Date of services or receipt of supplies/medications
    - Charges

- For non-prescription drug claims, send the above to the Claims Administrator at this address:

    BRMS
    P.O. Box 2140
    Folsom, CA 95673
    1-866-750-0576

- For prescription drug claims, send the above to Express Scripts at this address:

    ESI Claims
    Express Scripts
    Attn: Commercial Claims
    P.O. Box 14711
    Lexington KY 40512
    1-844-547-4402

When Claims Should Be Filed

Claims should be filed with the Claims Administrator within 180 days of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be declined or reduced unless both:

- it's not reasonably possible, as determined by the Claims Administrator, to submit the claim in that time; and
- the claim is submitted within one year from the date Incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

Claims Procedure

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Claimant or by a representative of a Claimant that complies with the Plan's reasonable procedure for making benefit Claims. A claim does not include a request for a determination of an individual's eligibility to participate in the Plan. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination". See the Defined Terms section for the complete definition of Adverse Benefit Determination.

A Claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal". If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination". If the Claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A Claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the Claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the Claimant, the Claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the Claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

- **Urgent Care Claim**. An Urgent Care Claim involving is any Claim for medical care or treatment where using the timetable for a non- urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

  A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving urgent care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

  In the case of an Urgent Care Claim, the following timetable applies:

Notification to Claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to Claimant, orally or in writing	24 hours
Response by Claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of determination on Appeal	72 hours
Ongoing courses of treatment (concurrent care), notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

  If there is an adverse benefit determination on an Urgent Care Claim, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

- **Concurrent Care Claims.** A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a Claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the Claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the Claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

  Concurrent Care Claims may also involve requests to extend a course of treatment beyond the time period or number of treatments already authorized. For any Concurrent Care Claim that is an Urgent Care Claim, the claim will be decided as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claims, provided the Claimant made the claim at least 24 hours prior to the expiration of the course of treatment.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to Claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow Claimant to appeal
Notification to Claimant of rescission	30 days
Notification of determination on Urgent Care Claim or Appeal of Urgent Care Claims	24 hours (provided Claimant files Claim or Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of determination on Appeal for non-Urgent Claims	15 days
Notification of determination on Appeal for Rescission Claims	30 days

- **Pre-Service Claim.** A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, precertification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

  In the case of a non-urgent Pre-Service Claim, the following timetable applies:

Notification to Claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of determination on Appeal	15 days per benefit appeal
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

- **Post-Service Claim.** A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre- Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the Claimant.

  In the case of a Post-Service Claim, the following timetable applies:

Notification to Claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by Claimant following notice of insufficient information	45 days
Notification of determination on Appeal	30 days per benefit appeal

Claims Denial Notice

You will receive a written notice of the Plan's claims decision. If your claim is denied, the notification will include:

- Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to you as soon as practicable along with their corresponding meanings;

- A statement of the specific reason(s) for the decision, including (i) the Plan's denial code and its corresponding meaning and (ii) the Plan's standard, if any, that was used in denying the claim;

- Specific Plan provisions on which the denial is based;

- A description of any additional material or information necessary for the claim to be completed, as well as an explanation of why the material or information is necessary;

- A description of the Plan's internal appeal procedures, their time limits, and how to initiate an appeal, as well as the availability of an external review, and your right to bring a civil action in court following a claims denial on review;

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes; and

- For a claim denial involving an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If you receive no response within these time frames, you may consider the request denied.

CLAIM APPEAL PROCESS

If your claim for benefits is wholly or partially denied, you, or someone on your behalf, are entitled to file a request for review with the Claims Administrator for your benefit plan. The steps in the review process are outlined below:

- **First Appeal.** Within 180 days after receiving a notice that your claim has been denied or within 180 days of the date you were entitled to consider your request denied, if you do not receive a denial notice), you or your authorized representative may submit a written request for review of the denial to the Claims Administrator. During the appeal process, you have the right to present evidence and testimony pertaining to the claim and you have the right to review your claim file. You should submit all of the issues, comments, additional information, and relevant documents that you want considered with your request for review to the Claims Administrator.

  The Claims Administrator will make a full and fair review of your request and may ask for additional information. Your request for review of the denial will be conducted by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial benefit determination nor a subordinate of such individual. The review of the denied claim will not afford that denial any deference.

  If the Claims Administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of your claim, you will be provided, free of charge, with this new or additional evidence. The evidence will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new evidence.

  Similarly, if the Claims Administrator relies upon any new or additional rationale when deciding your appeal, you will be provided, free of charge, with this new or additional rationale. The rationale will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new rationale.

  You will receive written notification of the decision on your appeal within:

  - 72 hours, for Urgent Care Claims 15 days, for pre-service claims that are not Urgent Care Claims and require prior authorization, pre-admission certification or continued stay approval before medical care is received
  - 30 days for all other claims (those that are neither urgent nor require prior approval)
  - See charts above for details.

  If your appeal is denied, the notice will explain:

  - Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to you as soon as practicable, along with their corresponding meaning;
  - A statement of the specific reason(s) for the decision, including (i) the Plan's denial code and its corresponding meaning and (ii) the Plan's standard, if any, that was used in denying the claim;
  - The Plan provisions on which it is based;
  - A statement describing the availability of and how to initiate a second appeal, the availability of an external review and your right to obtain information about such procedures;
  - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes; and

- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

- **Second Appeal.** Within 180 days of receiving a notice from the Claims Administrator (or within 180 days of the date you were entitled to consider your request denied, if you do not receive a denial notice from the Claims Administrator) that your claim has been denied, you or your authorized representative may submit a written request for review of the denial to the Claims Administrator. During the appeal process, you have the right to present evidence and testimony pertaining to the claim and you have the right to review your claim file**.**

    - If the Claims Administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of your claim, you will be provided, free of charge, with this new or additional evidence. The evidence will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new evidence.

    - Similarly, if the Claims Administrator relies upon any new or additional rationale when deciding your appeal, you will be provided, free of charge, with this new or additional rationale. The rationale will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new rationale.

    - The Claims Administrator will perform a second full and fair review of your request and may ask for additional information. (If your second appeal is a post-service appeal, then the Claims Administrator may delegate the authority to perform this review to the PACE.) You will receive written notification of the decision on your appeal, within:

        - 72 hours, for Urgent Care Claims 15 days, for pre-service claims that are not Urgent Care Claims and require prior authorization, pre-admission certification or continued stay approval before medical care is received

        - 30 days for all other claims (those that are neither urgent nor require prior approval)

    - If your appeal is denied, this is your Final Internal Adverse Benefit Determination and you will be given a notice explaining:

        - Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to you as soon as practicable, along with their corresponding meanings;

        - A statement of the specific reason(s) for the decision, including (i) the Plan's denial code and its corresponding meaning and (ii) the Plan's standard, if any, that was used in denying the claim;

        - The Plan provisions on which it is based;

        - A statement describing the availability of an external review, any voluntary appeal procedures offered by the Plan, your right to obtain information about such procedures, and how to initiate a voluntary appeal;

        - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes;

- A statement that "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and

- A statement of your right to bring a civil action following a claim denial on review.

Voluntary Appeal

If your prior two appeals have been denied in whole or in part, you have the right to seek a voluntary appeal, as explained below, or you may initiate an external review if you qualify for such a review or you can file a civil suit against the Plan.

Within 180 days of receiving a notice from the Claims Administrator (or within 180 days of the date you were entitled to consider your request denied, if you do not receive a denial notice from the Claims Administrator) that your claim has been denied, you or your authorized representative may submit a written request for review of the denial to the Plan Administrator: Dignity Health Employees Benefits Administrative Committee, Employee Service Center, 3033 N. 3rd Avenue, Phoenix, AZ 85013. During the appeal process, you have the right to present evidence and testimony pertaining to the claim and you have the right to review your claim file. You should submit all of the issues, comments, additional information, and relevant documents that you want considered with your request for review to the Plan Administrator.

This is a voluntary appeal. This means that you may choose to have the Plan Administrator review your claim that was denied by the Claims Administrator OR you may bring a civil action instead. If you choose to follow the procedures of this voluntary 3rd level of appeal, you continue to have the right to bring a civil action if your claim is denied by the Plan Administrator.

If the Plan Administrator relies upon any new or additional evidence that was considered, relied upon, or generated during the review of your claim, you will be provided, free of charge, with this new or additional evidence. The evidence will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new evidence.

Similarly, if the Plan Administrator relies upon any new or additional rationale when deciding your appeal, you will be provided, free of charge, with this new or additional rationale. The rationale will be provided to you sufficiently in advance of the Plan's final decision to allow you a reasonable opportunity to respond to the new rationale.

You will receive written notification of the final decision on your appeal from the Plan Administrator on the following basis:

- 72 hours, for Urgent health Care Claims

- 15 days, for pre-service claims that require prior authorization, pre-admission certification or continued stay approval before medical care is received

- 30 days for all other claims (those that are neither urgent nor do require prior approval)

If you receive no response within these time frames, you may consider the appeal denied. If your appeal is denied, the notice will explain:

- Information sufficient to identify the claim involved, including, if applicable: the date of service, the health care provider, the claim amount, and upon request the diagnostic and treatment codes will be provided to you as soon as practicable, along with their corresponding meaning, and the treatment code and its corresponding meaning;

- A statement of the specific reason(s) for the decision, including (i) the Plan's denial code and its corresponding meaning and (ii) the Plan's standard, if any, that was used in denying the claim;

- The Plan provisions on which it is based;

- A statement that you are entitled to receive, upon request and free of charge, all records relevant to your claim, whether or not such records were considered in the appeals decision;

- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes; and

- A statement of your right to an external review and to bring a civil action following a claim denial on review.

Deemed Exhaustion of Internal Claims Procedures and De Minimis Exception

- **Final Internal Adverse Benefit Determination.** Upon receipt, review, adjudication and conclusion of a the Second Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a Final Internal Adverse Benefit Determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the internal claim will be deemed exhausted.

- **Exception to the Deemed Exhaustion Rule.** A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

  If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Avoiding Conflicts of Interest

The Plan Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of Plan benefits. Additionally, any person deciding an appeal will be different from (and not subordinate to) any individual who decided the initial claim or previous appeal, and any medical expert consulted regarding an appeal will be different from (and not subordinate to) any expert consulted in connection with the initial claim or previous appeal.

External Review

As required by the Patient Protection and Affordable Care Act, the Plan complies with the federal external review process. This means that for any claims initiated after September 20, 2011, you are eligible to have claim and appeal denials concerning medical judgment or rescission of coverage reviewed by an independent review organization and the decision reached through the external review is binding on the Plan. Rescission of coverage means a retroactive termination of medical plan coverage. Examples of decisions concerning medical judgment are determining whether care should be provided on an outpatient or in patient basis, whether treatment by a specialist is medically necessary, or whether treatment involves emergency care or is Urgent Care. The independent review organization will determine if your request qualifies for an external review. Even though the Plan reserves the right to seek court action following the decision of the external reviewer, your benefit claims will be paid in the meantime while the Plan seeks this judicial review. The Plan will pay the cost of external reviews; however, you may be required to pay a filing fee of no more than $25. That filing fee will be refunded to you if your claim denial is reversed through the external review. Also, the filing fee will be waived if payment of the fee would impose an undue financial hardship. If the Plan imposes a filing fee for external reviews, the annual limit on filing fees will be $75.

The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of claim or appeal denial. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days following the date of receipt of the external review request, the independent review organization will complete a preliminary review of the request to determine whether:

- Your request is eligible for external review;
- The Claimant has exhausted the Plan's internal appeal process or if the Claimant is deemed to have exhausted the internal appeals process; and
- The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the independent review organization will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

The Plan will permit, in a medically urgent situation, such as an Urgent Care Claim, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting Direct Payment, requiring a release of information, or requesting completion a similar form. A Permission for Direct Payment by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Direct Payment and its limitations under this Plan are described below.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment may be made, in the Plan Administrator's discretion, directly to a Provider pursuant to a Permission for Direct Payment of Benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether a Permission for Direct Payment of Benefits occurred.

Direct Payment

A Claimant may give to a Provider permission to submit claims for payment to the Plan, and receive payment from the Planvia a Permission for Direct Payment of Benefits, if and only if the Provider accepts said Direct Payment as consideration in full for services rendered. If benefits are paid, however, directly to the Claimant – despite there being Permission for Direct Payment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether a Permission for Direct Payment of Benefits is valid; and the Claimant shall retain final authority to revoke such Permission for Direct Payment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the Provider unless a written request not to honor the Permission for Direct Payment of Benefits, signed by the Claimant, has been received.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. This prohibition applies to Providers as well.

A Provider which accepts a Direct Payment, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be paid directly to such Provider, whether or not a written Permission for Direct Payment of Benefits was executed. Notwithstanding any permission or non-permission to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any permission or request.

Providers and any other person or entity accepting payment from the Plan or to whom a Permission for Direct Payment of Benefits has been granted , in consideration of services rendered, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer .

Except for as provided above, a Covered Person cannot assign or alienate (voluntarily or involuntarily) his or her rights under or interest in the Plan, including but not limited to the payment of benefits, asserting claims and appeals rights or bringing a legal action in any forum and every such attempt to do so is void and will not be recognized by the Plan. Compliance with these restrictions is a condition for the payment of Plan benefits.

The Plan is not intended to benefit any person other than the individuals covered by the Plan and the Plan does not establish or permit any rights under the Plan for any third party not directly covered as a participant or beneficiary. For purposes of Plan administration, Direct Payments may be made to Providers, but any such payment is not an assignment of the covered individual's benefit rights under the Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

- In error.
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
- With respect to an ineligible person.
- In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.

- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

    - The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall abstain from billing the Claimant for any outstanding amount(s).

Medicaid Coverage

A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan until the Claimant exhausts or is deemed to have exhausted all of the Plan's internal claim and appeal procedures. If a Claimant fails to meet the required deadlines in the claims and appeals procedures, then the Claimant will forfeit his/her right to sue the Plan in State or federal court.

If the Claimant wants to bring a legal action against the Plan, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan.

A Claimant cannot bring any legal action against the Plan for any other reason unless he or she first timely completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when you or your dependents have health care coverage under more than one Plan. Plan, for purposes of this COB section, is defined below. However, claims for covered dependents where the Plan Payment is $1,000 or less, per claim, will be processed as though the Plan is Primary, without applying the COB provision.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. When this plan is the Secondary plan it will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions

A. A Plan, for purposes of this COB section, is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. Plan includes self-funded employee health plans, group and non group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans unless permitted by law.

   Each arrangement for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. Plan means, in a COB provision, the part of the arrangement providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the arrangement providing health care benefits is separate from this Plan. An arrangement may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when you and/or your dependent has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and will reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses:

   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, pre-certification or prior authorization of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When you or your dependent are covered by two or more Plans the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph (2) a Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary unless the provisions of both Plans state the complying plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of the benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

      If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      - The Plan covering the Custodial parent;
      - The Plan covering the spouse of the Custodial parent;
      - The Plan covering the non-custodial parent; and then
      - The Plan covering the spouse of the non-custodial parent.

   c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child (nor the stepparents of the child), the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C (1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law, or otherwise is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C (1) can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provisions of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and the other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. The plan administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The plan administrator need not tell, or get the consent of any person to do this. Each person claiming benefits under this plan must give any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this plan. If it does, the plan administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The plan administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

MEDICARE

The health benefit plan components of this Plan will at all times be maintained and administered in a manner that is consistent with the "Medicare Secondary Payer" rules of the Social Security Act which are set forth at 42 U.S.C. Section 1395y(b).

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

If this Plan is primary coverage for your health care, Medicare regulations allow you to delay Medicare enrollment until this Plan becomes secondary according to the Medicare Secondary Payer rules. However, to avoid the potential of balance billing for outpatient dialysis charges you should enroll in Medicare Part B when first eligible for Medicare benefits under end stage renal disease (ESRD) (Medicare 30-month ESRD coordination period). Your local Social Security Office can provide details on enrollment requirements and any penalties for late enrollment.

THIRD PARTY RECOVERY PROVISON

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and by accepting the Plan's conditional payment the, Covered Person(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees to maintain 100% of any payment, judgment or settlement from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to immediately notify the Plan or its authorized representative of any potential claim against a third party for causing an Injury, Sickness, Disease or disability and the Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed. The Plan has no obligation to trace or identify amounts owed to the Plan; all amounts are recoverable by the Plan regardless of whether they have been dissipated or commingled with other assets.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means

arising from any Injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

- Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

- Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

- Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

- The responsible party, its insurer, or any other source on behalf of that party.

- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

- Any policy of insurance from any insurance company or guarantor of a third party.

- Workers' compensation or other liability insurance company.

- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the

Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
- To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
- To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

In accordance with the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), your Employer, as sponsor of the Plan is required to comply with the health care continuation coverage rues of ERISA and the Internal Revenue Code. Please refer to the Dignity Health FlexAbility Summary Plan Description (SPD) located on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards for detailed information on all aspects related to continuation coverage.

Information regarding the following topics is also covered under the Continuation Coverage section in the Dignity Health *FlexAbility* Summary Plan Description (SPD).

- Continuation of coverage.
- Your right to covert coverage
- Family and Medical Leave Act (FMLA) coverage.
- USERRA.

For questions about Continuation Coverage, call the Dignity Health Employee Service Center at 1-855-475-4747 and press 1 for benefits.

OTHER PLAN PROVISIONS

Specific information, shown below, can be found in the Dignity Health *FlexAbility* Summary Plan Description (SPD) which is located on the My Total Rewards portal at https://employee.dignityhealth.org/totalrewards.

- Plan Administrator
- Amending and Terminating the Plan
- Federal Laws
- HIPAA Privacy Policy
- Your Rights Under ERISA

Discretionary Authority

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose), in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of and in consultation with the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. All other matters, including but not limited to other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by and make determination(s) in accordance with the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

Duties And Rights Of The Pace

When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination, regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Misrepresentation/Fraud

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your dependents or a Provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, such claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a Provider. The Plan Administrator may terminate Plan coverage for the submission of a fraudulent claim. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

Plan Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the terms of this document, to determine all questions of fact and law arising under this document, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan, the Summary Plan Description, and/or this document at any time without notice.

Severability

In the event that any section of this document is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this document, the Plan, or the Summary Plan Description. The sections shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in this document, the Plan, or the Summary Plan Description.

Exception To Medicaid

In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling in an individual in the Plan or making a determination about the payments for benefits by a Covered Person under this Plan.

GENERAL PLAN INFORMATION

Type of Administration

The Plan is a self-funded group health Plan. Dignity Health is the Plan Administrator and the Plan Sponsor. Dignity Health has retained the services of independent third party administrators to process claims and handle other duties for the Plan. These are listed below under "Claims Administrators.". The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

Plan Name:	Dignity Health Welfare Benefits Plan
Component Plan:	PHC HDP/HSA
Plan Number:	503
Employer Id Number:	94-1196203
Component Plan Effective Date:	January 1, 2019
Plan Year Ends:	December 31
Employer Information participating subsidiaries/DBAs of:	Dignity Health 185 Berry Street, Ste. 300 San Francisco, CA 94107 1-415-438-5500
Plan Sponsor:	Dignity Health 185 Berry Street, Ste. 300 San Francisco, CA 94107 1-415-438-5500
Plan Administrator:	Dignity Health 185 Berry Street, Ste. 300 San Francisco, CA 94107
Named Fiduciary:	Dignity Health 185 Berry Street, Ste. 300 San Francisco, CA 94107
Agent For Service Of Legal Process:	Dignity Health 185 Berry Street, Ste. 300 San Francisco, CA 94107
Claims Administrators:	**Health:** Benefit & Risk Management Services (BRMS) PO Box 2140 Folsom, California 95673 1-866-750-0578 **Prescription (PBM):** Express Scripts PO Box 52136 Phoenix, AZ 85072-2136 1-844-547-4402