Dignity Health Welfare Benefits Plan

DHMP Ventura

Plan Options

- *PPO*
- *EPO*
- *EPO R*
- *EPO R 1*

Plan Document and Summary Plan Description
Effective: January 01, 2026

TABLE OF CONTENTS

INTRODUCTION AND PURPOSE 2

GENERAL PLAN INFORMATION 4

DEFINITIONS 7

PLAN AND NETWORK OVERVIEW 33

ELIGIBILITY FOR COVERAGE 37

TERMINATION OF COVERAGE 44

CONTINUATION OF COVERAGE 46

GENERAL LIMITATIONS AND EXCLUSIONS 56

PLAN ADMINISTRATION 60

CLAIM PROCEDURES; PAYMENT OF CLAIMS 64

COORDINATION OF BENEFITS 80

MEDICARE 83

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT 84

MISCELLANEOUS PROVISIONS 89

SUMMARY OF BENEFITS 93

- SUMMARY OF BENEFITS - MEDICAL 97
- SUMMARY OF BENEFITS – PRESCRIPTION DRUG 158

MEDICAL BENEFITS AND EXCLUSIONS 166

PRESCRIPTION DRUG BENEFITS AND EXCLUSIONS 187

UTILIZATION MANAGEMENT 191

HIPAA PRIVACY 195

PARTICIPANT'S RIGHTS 201

INTRODUCTION AND PURPOSE

The purpose of this document is to provide you and your covered Dependents, if any, with summary information on benefits available under the Plan. This component Medical Plan Document is incorporated and considered part of the official Wrap Plan Document and the Summary Plan Description. These official documents can be found on MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

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 Capital Rx 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.

The Plan complies with applicable Federal civil rights 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. Detailed information regarding the Plan’s Non-Discrimination Policy and the Dignity Health Discrimination Grievance Procedure may be found in the Wrap Plan Summary Plan Description (SPD) which is located on MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

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 DHMP Ventura 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.

In the event of any inconsistency or discrepancy between the provisions of this Plan Document and the Wrap Plan document or any associated Summary Plan Description, the Plan Administrator shall have discretionary authority to interpret and construe the terms of the Plan and to resolve such inconsistency or discrepancy in a manner intended to give effect to the Plan as a whole. The Plan Administrator shall make a good faith effort to reconcile any conflicting provisions. If, after the exercise of such interpretive authority, the inconsistency or discrepancy cannot reasonably be reconciled, the terms of this Medical Plan Document shall control with respect to the self-funded medical benefits described herein.

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 Covered Persons and beneficiaries at the following location, by appointment.

CommonSpirit Health Benefits Contact Center
3900 Olympic Blvd
Suite 300
Erlanger, KY 41018

This document becomes effective on January 1, 2026.

GENERAL PLAN INFORMATION

Name of Plan:
Dignity Health Welfare Benefits Plan

Plan Sponsor:
Dignity Health

Plan Sponsor Contact Information:
Dignity Health
C/O CommonSpirit Health
3900 Olympic Blvd
Suite 300
Erlanger, KY 41018
Phone: (855) 475-4747, option 1
Website/Email: https://home.commonspirit.org/employeecentral/mybenefits

Plan Administrator and Named Fiduciary:
Dignity Health

Plan Administrator Contact Information:
Dignity Health
C/O CommonSpirit Health
3900 Olympic Blvd
Suite 300
Erlanger, KY 41018
Phone: (855) 475-4747, option 1
Website/Email: https://home.commonspirit.org/employeecentral/mybenefits

Plan Sponsor ID No. (EIN):
94-1196203

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Plan Year:
January 1 through December 31

Plan Number:
503

Plan Type:
Medical
Prescription Drug

Plan Options:
PPO
EPO
EPO R
EPO R 1

Third Party Administrator:
Benefit & Risk Management Services
80 Iron Point Circle, Suite 200
Folsom, CA 95630
Phone: 1-866-750-0576
Website/Email: www.MyHealthBenefits.com

Prescription Drug Plan Administrator:
Capital Rx
228 Park Avenue South, Suite 87234
New York, NY 10003
Phone: 1-844-306-6901
Website/Email: www.cap-rx.com

Agent for Service of Process:
CT Corporation System
7700 East Arapahoe Road, Suite 220
Centennial, CO 80112

Utilization Review Manager:
Anthem
P.O. Box 60007
Los Angeles, CA 90060-0007
Phone: 1-800-274-7767
Website/Email: www.Anthem.com/CA

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered Mental Disorder and Substance Use Disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator 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 regard 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.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to an outside traumatic event, or due to exposure to the elements.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day, or pursuant to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. 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.
6. 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.
7. 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.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

"Annual Benefit Enrollment"
"Annual Benefit Enrollment" shall mean the time frame specified by the Plan Administrator.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and 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; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless Out-of-Network benefits are otherwise provided under the Plan.

“Brand Name”
“Brand Name” shall mean a trade name medication.

“Calendar Year”
“Calendar Year” shall mean the 12 month period from January 1 through December 31 of each year.

“Cardiac Care Unit”
“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

“CDC”
“CDC” shall mean Centers for Disease Control and Prevention.

“Cell Therapy”
“Cell Therapy” is a treatment in which intact, living cells are injected, grafted, or implanted into a patient to achieve a therapeutic effect. Includes adoptive cell therapy (ACT), stem cell therapy, and cellular immunotherapy such as CAR-T, unless specifically excluded.

“Center(s) of Excellence”
“Center(s) of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third Party Administrator to initiate the Pre-certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Certified IDR Entity”
“Certified IDR Entity” shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

“Child” and/or “Children”
“Child” and/or "Children" shall mean any of the following:

- the Employee’s biological Child
- any stepchild
- legally adopted Child
- any other Child for whom the Employee has been named legal guardian or legal parent
- an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.

For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee’s physical custody in anticipation of adoption. “Child” shall also mean a covered Employee’s Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A “legal guardian” is 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.

“Child” shall also mean a covered Employee’s domestic partner’s biological child, legally adopted child, or any other Child for whom the covered domestic partner has been named legal guardian or legal parent.

“CHIP”
“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”
“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”
“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”
“Claim Determination Period” shall mean each Calendar Year.

“Claimant”
“Claimant” shall mean a Participant 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.

“Clean Claim”
A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

"CMS"
"CMS" shall mean Centers for Medicare and Medicaid Services.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

"Copayment" or "Copay"
"Copayment" or "Copay" shall mean a dollar amount per visit the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any expenses Incurred in connection with the care and treatment of, or operations 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 of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

"Covered Expense(s)"
"Covered Expense(s)" shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

"Custodial Care"
"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

"Deductible"
"Deductible" shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

"Dentist"
"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

"Dependent"
"Dependent shall mean an eligible Dependent from one of the following categories:

1. One adult from the following categories:

    a) Spouse – legally married spouse, as defined by the law of the jurisdiction where the marriage was performed.
    b) Adult Tax Dependent (ATD) – adult over age 18, residing in the same home as the Employee who is the IRS tax dependent of the Employee, is not an Eligible Dependent Child, and is not eligible for Medicare (See the Benefit Overview provided on home.commonspirit.org/employeecentral/mybenefits to determine if you are eligible to cover this type of dependent).
    c) Legally Domiciled Adult (LDA) – an individual who is not Medicare eligible, is of the same or opposite sex from the Employee, is in a committed relationship with a benefited Employee, has been domiciled with the Employee for at least one year and who is not a blood relative, and neither the LDA nor the Employee are legally married, in a civil union partnership, or in a registered domestic partnership with another individual. (See the Benefit Overview provided on home.commonspirit.org/employeecentral/mybenefits to determine if you are eligible to cover this type of dependent).

2. Dependent Children:

    a) Child – An eligible Employee's biological Children, step Children, legally adopted Children who are under age 26, Children under age 26 under the Employee's Legal Guardianship (including court approved foster Children) and/or Children of Registered Domestic Partners (if coverage for Legally Domiciled Adults and Adult Tax Dependents is offered then their Children who are under age 26 are also Eligible Dependents for medical, dental and vision). Effective date of coverage is based on the court appointed date identified for foster or Legal Guardianship of that Child. A Child becomes a legally adopted Child as soon as he or she is placed for adoption. Being placed for adoption means the earlier of either the assumption and retention of the legal obligation to support the Child in anticipation of adoption, or the actual date of adoption. The Child's placement for adoption status terminates upon the termination of this legal obligation.
    b) Disabled Child Age 26 and Older – Employee's unmarried biological, adopted, step, legal guardianship Child(ren) and/or Child(ren) of a Registered Domestic Partner who became mentally or physically disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the Employee for support (Social Security disability determination or Physician documented incapability of self-support) disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the Employee for support (Social Security disability determination or Physician documented incapability of self-support).

NOTE: Tax treatment for certain dependents. *Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.*

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

1. Can withstand repeated use.
2. Is primarily and customarily used to serve a medical purpose.
3. Generally is not useful to a person in the absence of an Illness or Injury.
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
See the Eligibility For Coverage section of this Medical Plan Document.

"Employer"
"Employer" is Dignity Health.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Use Disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

“Experimental” and/or “Investigational”
“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Family Unit"
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.

"FDA"
"FDA" shall mean Food and Drug Administration.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean 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"
"Final Post-Service Appeal" shall mean a post-service appeal, 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 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, 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).

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

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

"Gender Dysphoria"
"Gender Dysphoria" shall mean a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Gender Dysphoria is a condition where a person experiences discomfort or distress because there is a mismatch

between their biological sex and gender identity. It is sometimes known as Gender Identity Disorder (GID), gender incongruence, or transgenderism.

"Gene Therapy"
"Gene Therapy" is a medical treatment that introduces, removes, or alters genetic material within a patient's cells to treat or prevent disease, including treatments that utilize viral vectors or gene-editing technologies such as CRISPR.

"Generic Drug"
"Generic Drug" shall mean 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.

"Genetic Information"
"Genetic Information" shall mean information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.

2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all of the following requirements.
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full-time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

"Home Health Care Plan"
A "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; 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"
"Home Health Care Services and Supplies" include part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); 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 supplies; and laboratory services by or on behalf of the Hospital.

"Hospital"
"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

“Imaging”
“Imaging” shall mean the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

“Impregnation and Infertility Treatment”
“Impregnation and Infertility Treatment” shall mean services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs or semen.

“Incurred”
A Covered Expense is “Incurred” on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Independent Freestanding Emergency Department”
“Independent Freestanding Emergency Department” means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

“Injury”
“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”
“Inpatient” shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

“Institution”
“Institution” shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Disorder Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

“Intensive Care Unit”
“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit”.

“Intensive Outpatient Services”
“Intensive Outpatient Services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or

professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment”.

“Leave of Absence”
“Leave of Absence” shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

“Legal Guardian or Legal Guardianship”
“Legal Guardian or Legal Guardianship” shall mean an individual recognized by a court of law as having the duty of taking care of a person and managing the individual’s property and rights.

“Legal Separation” or “Legally Separated”
“Legal Separation” and/or “Legally Separated” shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

“Manipulation”
“Manipulation” shall mean the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

“Maintenance Care”
“Maintenance Care” shall mean care rendered and directed at relieving discomfort or preserving functions 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, or 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.

“Mastectomy”
“Mastectomy” shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Charge”
The “Maximum Allowable Charge” shall mean 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:

1. Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services [“CMS”]).
2. 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.
3. 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.
4. 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.
5. Medicare cost data as reflected in the applicable individual Provider’s cost report(s).
6. The fee(s) which the Provider most frequently charges the majority of patients for the service or supply.

7. Amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred Provider organization (PPO) network.
8. Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP).
9. Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.
10. The allowable charge otherwise specified within the terms of this Plan.
11. 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.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

1. An amount determined by an applicable all-payer model agreement; or
2. If no such amount exists, an amount determined by applicable state law; or
3. If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. 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 or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The Plan Administrator may, in its discretion, taking into consideration specific circumstances, deem a greater amount to 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"
"Medical Care Facility" shall mean a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medical Non-Emergency Care"
"Medical Non-Emergency Care" shall mean care which can safely and adequately be provided other than in a Hospital.

"Medical Record Review"
"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.

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Illness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this

Plan because they are not “Medically Necessary” does not mean that all other services are “Medically Necessary”.

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator’s own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA).
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX®.
    b. The American Hospital Formulary Service Drug Information.
    c. Medicare approved compendia.
    d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition.
3. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

“Medicare”
“Medicare” shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

“Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder”
“Mental Disorder,” “Behavioral Disorder,” or “Neurodevelopmental Disorder” shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of International Classification of Diseases, published by the U.S. 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, or other relevant State guideline or applicable sources.

“Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA”
“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

“Morbid Obesity”
“Morbid Obesity” shall mean a Body Mass Index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life- threatening) medical condition(s) exacerbated by, or caused by, obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

“National Medical Support Notice” or “NMSN”
“National Medical Support Notice” or “NMSN” shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

"Network” or "In-Network"
“Network” or "In-Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network’s Providers have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant’s identification card.

“No-Fault Automobile Insurance”
“No-Fault Automobile Insurance” shall mean the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

“Non-Network” or “Out-of-Network”
“Non-Network” or “Out-of-Network” shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

“Nurse”
“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

“Orthotics”
“Orthotics” shall mean 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.

“Other Plan”
“Other Plan” shall mean any group health plan or health insurance coverage as defined in 42 U.S. Code § 300gg-91 from which a Participant is entitled to benefits.

“Out-of-Area”
“Out-of-Area” shall mean services received by a Participant outside of the normal geographic area supported by the Plan’s Network, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

“Out-of-Pocket”
“Out-of-Pocket” shall mean the patient liability portion of the percentage co-payment, Deductible and Copayments.

“Outpatient”
“Outpatient” shall mean 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.

“Outpatient Care and/or Services”
“Outpatient Care and/or Services” shall mean 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 Outpatient Surgical Center, or the patient's home.

“Outpatient Surgical Center”
“Outpatient Surgical Center” shall mean 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 (R.N.s) and does not provide for overnight stays.

“Partial Hospitalization”
“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Use Disorder treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”
“Participant” shall mean any Employee, Dependent, individual that is covered under the Plan through COBRA continuation, who is eligible for benefits (and enrolled) under the Plan.

“Participating Health Care Facility”
“Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

“Participating Pharmacy”
“Participating Pharmacy” shall mean a licensed entity, acting within the scope of its license in the state in which it dispenses, that has entered into a written agreement with Capital Rx, and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

“Patient Protection and Affordable Care Act (PPACA)”
The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Physician”
“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist,

psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan"
"Plan" shall mean DHMP Ventura component medical program of the Dignity Health Welfare Benefits Plan.

"Plan Appointed Claim Evaluator (PACE)"
"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"
"Plan Document" shall mean this Medical Plan document.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

1. The Participant obtains a written order from the Physician.
2. The tests are approved by both the Hospital and the Physician.
3. The tests are performed on an Outpatient basis prior to Hospital admission.
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

"Prescription Drug"
"Prescription Drug" shall mean 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.

“Preventive Care”
“Preventive Care” shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

“Primary Care Physician (PCP)”
“Primary Care Physician (PCP)” shall mean family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners and physician’s assistants. All other Physicians are considered specialists.

“Prior Plan”
“Prior Plan” shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”
“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

“Privacy Standards”
“Privacy Standards” shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

“Prosthetics”
“Prosthetics” shall mean 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”
“Provider” shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State’s law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body.

The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Psychiatric Hospital of Facility"
"Psychiatric Hospital or Facility" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital", the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital".

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Qualified Individual"
"Qualified Individual" shall mean 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.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount"
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"
"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Reconstructive Surgery"
"Reconstructive Surgery" shall mean surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

“Rehabilitation”
“Rehabilitation” shall mean treatment(s) designed to facilitate the process of recovery from Injury or Illness to as normal a condition as possible.

“Rehabilitation Hospital or Facility”
“Rehabilitation Hospital” shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a “Rehabilitation Hospital”, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a “Rehabilitation Hospital”, the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Residential Treatment Facility”
“Residential Treatment Facility” shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Use Disorders or mental illness.

“Room and Board”
“Room and Board” shall mean a Hospital’s charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment’s, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

“Routine Patient Costs”
“Routine Patient Costs” shall 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 (See the Benefit Overview provided on home.commonspirit.org/employeecentral/mybenefits to determine if you are eligible to cover this type of dependent). 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.

“Security Standards”
“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time that must pass before an Employee is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time, however for purposes of satisfying a Service Waiting Period an Employee shall be considered an Active Employee for the duration of any absence from work due to a health factor as defined by HIPAA.

“Sickness”
“Sickness” shall mean a Covered Person's Illness, disease or Pregnancy (including complications).

“Skilled Nursing Facility”
“Skilled Nursing Facility” shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, Custodial Care, or educational care.
7. It is approved and licensed by Medicare.

“Sound Natural Teeth”
“Sound Natural Teeth” shall mean 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.

“Specialist”
“Specialist” shall mean a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, family practitioners, non- specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder Providers.

“Specialty Drug(s)”
“Specialty Drug(s)” shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

“Spinal Manipulation or Chiropractic Care”
“Spinal Manipulation or Chiropractic Care” shall mean skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

“Substance Use Disorder”
“Substance Use Disorder” shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

“Substance Use Disorder Treatment Center or Facility”
“Substance Use Disorder Treatment Center” shall mean an Institution whose facility is licensed, certified or approved as a Substance Use Disorder Treatment Center by a Federal, State, or other agency having legal authority to so license. Where applicable, the “Substance Use Disorder Treatment Center” must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"Summary Plan Description"
"Summary Plan Description" shall mean the Dignity Health Welfare Benefits Plan summary plan description, which is the *FlexAbility* Summary Plan Description, which can be found on MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

Surgical Center
"Surgical Center" shall mean a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

1. It provides drug services as needed for medical operations and procedures performed;
2. It provides for the physical and emotional well-being of the patients;
3. It provides Emergency services;
4. It has organized administration structure and maintains statistical and medical records.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Telehealth or Virtual Visits"
"Telehealth or Virtual Visits" allow a patient's Physician to provide health related services and information via telecommunications technologies such as video chat, rather than an in person office visit. Patients schedule a telehealth appointment with their Providers, as they would an in person office visit.

"Telemedicine"
"Telemedicine" shall mean 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.

"Third Party Administrator"
"Third Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“Urgent Care Claim”
“Urgent Care Claim” shall mean 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”
“Urgent Care Facility” shall mean 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.

“USERRA”
“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Utilization Review Manager”
“Utilization Review Manager” shall mean a team of medical care professionals selected to conduct pre-certification review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the Utilization Management section of this document.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

PLAN AND NETWORK OVERVIEW

Verification of Plan Benefits
Contact BRMS at (866) 750-0576, to verify eligibility for Plan benefits before charges are Incurred.

Cost Management
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 Management Services Organization 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 Numbers
1. Anthem Blue Cross Customer Service: (800) 274-7767 (Providers)
2. BRMS Member Customer Services: (866) 750-0576 (Members)
3. Anthem Behavioral Health: (866) 470-6244 (Providers and Members)

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 must call Anthem Blue Cross at (800) 274-7767 to receive certification of certain Cost Management Services. (Or the patient or family member must call BRMS 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.

Medical Benefits
The DHMP Ventura offers three benefit Tiers, depending on the Participant's plan election, where Out-of-Pocket costs are based on Providers of services, such as:

1. **Tier 1**: Dignity Health Preferred Network, which is made up of:

    - Select Physicians where Covered Charges are generally paid at 100% after a small copayment.
    - Anthem Behavioral Health Providers.
    - Dignity Health facilities and aligned partners where Covered Charges are generally paid at 100%.
        - Note that if a Dignity Health Preferred Network facility within the market where you work (i.e., Ventura Market) does not provide the service that you need, you may obtain the service from any Anthem PPO Provider Network facility and receive the same benefit levels that you would have received if you had obtained the services from a Dignity Health Preferred Network facility (prior authorization is required).

2. **Tier 2**: Anthem PPO Provider Network, which provides a national Anthem network of Providers.
3. **Tier 3**: Out-of-network Providers, which is any Provider or facility not in Tier 1 or Tier 2.

To find network Providers in the Dignity Health Preferred Network or in the Anthem PPO Provider Network go to brmsonline.com/dignityhealth.

Facility-based services: If you need facility-based services and procedures that are offered at a Dignity Health Preferred Network facility in your market, you must obtain facility-based care from a Dignity Health Preferred Network facility in order for the facility charges to be covered under the Plan.

If services cannot be rendered at a Dignity Health Preferred Network facility, services may be rendered at a Tier 2 facility at the Tier 1 benefit (examples: transplants, burns, NICU Level 4). Covered Persons should call BRMS Customer Service prior to those services being rendered at (866) 750-0576.

Under certain emergencies and limited circumstances where a Covered Person may not have a choice or may require involuntary use of Tier 2 or out-of-network Hospital-based services or Providers (such as anesthesiologists, radiologists, neonatologists, or pathologists) services may be covered at the Tier 1 benefit.

Examples:

1. Services provided at a Dignity Health Preferred Network facility by a Tier 2 or out-of-network Hospital-based Provider.
2. Approved services which cannot be performed at a Dignity Health Preferred Network facility rendered at a Tier 2 or out-of-network facility.

All benefits described in this Schedule 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.

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. Benefit & Risk Management Services (BRMS) – (866) 750-0576.

Out-of-Network services are not covered unless in an Emergency situation. An Emergency situation can be defined as a sudden and serious condition occurring such that a Prudent Layperson could expect the patient's life to be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Working with Your Primary Care Physician (PCP)

While you are not required to designate a PCP, it's important to establish a relationship with someone you consider to be "your doctor". Your primary doctor may coordinate your preventive care, help you with unexpected illnesses like the flu or a cold, and consult with other Providers when you need more specialized care. If you need assistance with finding a PCP, contact BRMS at (866) 750-0576.

Behavioral Health

The DHMP Ventura provides coverage for mental health services and substance abuse treatment. You may see a network mental health and substance abuse Provider without a referral from your PCP. Call

Anthem Behavioral Health at (866) 470-6244 for assistance finding a network Provider and obtaining prior authorization. Anthem will coordinate authorizing all services that require authorization.

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. In addition, with respect to services rendered by an In-Network Provider being paid in accordance with a discounted rate.

Special Reimbursement Provisions
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 network or Out-of-Network facility; services may be covered at the network benefit level.

Coordination of Benefits
When services and supplies are rendered and billed by an In-Network Provider and this Plan is the secondary payer of benefits according to the Coordination of Benefits provision and Medicare Secondary Payer rules. All benefits and Copayments will still apply.

Covered Charges
Covered Charges are the Maximum Allowable Charges that are Incurred for services and supplies. 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.

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 certain Covered Charges. Each January 1st, a new Deductible amount is required. Deductibles count toward the Out-of-Pocket Limit.

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 count toward the Out-of- Pocket Limit.

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.

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.

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, if any, 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 Plan 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 Plan 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.

Dignity Health Providers
During any time that Dignity Health Providers are not considered a Network Provider and are not under contract with Anthem Blue Cross Life and Health Insurance Company ("Anthem") to be part of the Anthem Provider network, the following special rule shall apply: All Deductibles and Coinsurance will be waived for all otherwise Covered Services provided at any Dignity Health Provider. At such time Dignity Health Providers again are contracted with Anthem, such that they are considered Network Providers all regularly applicable Deductible and Coinsurance shall be charged. Note, to the extent that Anthem and Dignity Health enter into a contract/network agreement such that Dignity Health Providers are retroactively determined to be Network Providers, claims that were processed under the no Deductible/Coinsurance provision will not be reprocessed (i.e., you will not be required to repay any previously waived Deductible or Coinsurance).

ELIGIBILITY FOR COVERAGE

Eligibility and Enrollment Procedures

You are responsible for enrolling in the manner and form prescribed by your Employer. Specific information, regarding eligibility, waiting period, and enrollment procedures shown below, can be found on MyBenefits at home.commonspirit.org/employeecentral/mybenefits under the Benefit Resources tab.

- Who is eligible for the plans?
- Who are your eligible dependents?
- Selecting your family coverage categories
- 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 CommonSpirit Health Benefits Contact Center at (855) 475-4747 and press option 1.

ACGME

Each Employee with the title of ACGME Physician Residents and Physician Fellows will become eligible for coverage under this Medical Plan with respect to himself or herself on the date of hire, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her eligibility will become effective on such later date when Employee begins work.

Reinstatement of Coverage

If your employment terminates and you are subsequently rehired, your eligibility to participate in the Medical Plan upon rehire will be determined in accordance with the Medical Plan's eligibility, enrollment, and waiting period provisions, as determined by the Employer or Plan Administrator.

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence.
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must meet all of the following requirements:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury.
2. Be Medically Necessary.
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she meets all of the following requirements:

1. Is a Dependent Child of a Participant under the terms of the Plan or coverage.
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (electronic). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the date such Employee or Dependents became eligible.
2. Coverage as Both Employee and Dependent. An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.
3. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for a period of 31 days only. Except as provided in "Newly Acquired Dependents," below, for coverage to continue beyond this period, the Employee must submit a written application to the Plan to enroll the Child within the limited 31 day period (i.e. period from the moment of birth). The application must also be accompanied by any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
4. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents and written application is made within 31 days for a Spouse or Domestic Partner, and 60 days for a Child. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 31 days (for a Spouse or Domestic Partner) or 60 days (for a Child) of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.
5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.
6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
7. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.*

Special and Annual Benefit Enrollment

Federal law requires and the Plan provides so-called "special enrollment periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse or domestic partner) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
    d. The Plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The employer contributions under the other coverage were terminated.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements is met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's electronic enrollment submission, in the case of enrollment) is received by the Plan and the request is made within 31 days from loss of coverage for a Spouse or Domestic Partner, or 60 days for a Child.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, domestic partnership, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically,

as applicable, no later than 31 days after he or she acquires the new Dependent Spouse or Domestic Partner, or 60 days for a Child. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, domestic partnership, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the special enrollment period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the date of the marriage.
2. For a domestic partnership, on the date of the domestic partnership agreement.
3. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
4. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
5. In the case of a Dependent's birth, as of the date of birth.
6. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day following the above-described additional special enrollment events.

Annual Benefit Enrollment
Prior to the start of a Plan Year, this Plan has an Annual Benefit Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Annual Benefit Enrollment Periods. Coverage for Participants enrolling during an Annual Benefit Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Annual Benefit Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Annual Benefit Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Annual Benefit Enrollment Period.

"Annual Benefit Enrollment" shall mean the time frame specified by the Plan Administrator.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of “National Medical Support Notice.”
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan’s default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
    a. Be in writing.
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

In connection with the acquisition of any company or business, the eligibility of employees of the acquired entity for coverage under this Plan will be determined by the Plan Sponsor or its delegate, in its discretion. The Plan Sponsor (or its delegate) may establish such eligibility rules, effective dates, waiting periods, service credit provisions, transition rules, and related administrative terms as it determines appropriate under the circumstances. Any prior coverage or prior satisfaction of a waiting period under another plan may be recognized, in whole or in part, to the extent determined by the Plan Sponsor (or its delegate).

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA

includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date.
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The last day of the month in which the Employee is no longer eligible for such coverage under the Plan.
5. The last day of the month in which the termination of employment occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

    a. Cessation of such disability or inability.
    b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
    c. Upon the Child's no longer being dependent on the Employee for his or her support.

6. The day immediately preceding the date such person is no longer a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section.
7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
8. A covered Employee's domestic partner's Child's (who is not the Employee's Dependent Child) coverage will end on the last day of the month in which the domestic partnership agreement has ended, or on the last day of the month in which the Child reaches the age limitation of the Plan (as outlined in the Plan's definition of "Dependent"), whichever occurs first.
9. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
10. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined

by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Contribution Treatment Upon Termination

Any Employee contributions made for periods following the termination date will be refunded on a pro-rata basis, unless otherwise elected by the Participant for COBRA continuation. This aligns with ERISA's Exclusive Benefit Rule, and ensures contributions are used solely for covered periods.

Pro-Rata Refunds for Partial-Month Coverage

If an employee's coverage ends during a coverage period and the Employee has made a contribution for the full period, the Plan will refund a pro-rata amount corresponding to the days during which the Employee is not covered. Refunds will be processed no later than 30 days from the termination of coverage, unless applied to COBRA continuation premiums at the Participant's election.

CONTINUATION OF COVERAGE

Employer Continuation Coverage

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 rules of ERISA and the Internal Revenue Code.

Please refer to the Dignity Health *FlexAbility* Summary Plan Description (SPD) located on MyBenefits at home.commonspirit.org/employeecentral/mybenefits 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).

1. Continuation of coverage.
2. Your right to convert coverage.
3. Family and Medical Leave Act (FMLA) coverage.
4. USERRA.

For questions about Continuation Coverage call the CommonSpirit Health Benefits Contact Center at (855) 475-4747 and press option 1.

Continuation During Family and Medical Leave Act (FMLA) Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care with the eligible employee(s).
- To bond with a child (leave must be taken within 1 year of the child's birth or placement) with the eligible employee(s).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Spouses employed by the same employer are jointly entitled to a combined total of 12 work weeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within 12 months of the birth or placement.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must meet all of the following requirements:

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave.*
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave
Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
U.S. Department of Labor Wage and Hour Division
WH1420a - REV 04/23

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period (if applicable), and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

To the extent the Plan does not fully or accurately reflect applicable COBRA regulations, the Plan will at all times comply with such regulations, including but not limited to continuation coverage in connection with a business reorganization or employer withdrawal from a multiemployer plan.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events
A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or Legally Separated from his or her spouse.

NOTE: Continuation coverage for domestic partners and their Dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. A domestic partner will be treated like a "qualified beneficiary" to the same extent as if the domestic partner were the Employee's spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or Legally Separated.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2. **Notice of Child's Loss of Dependent Status**: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability**: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Contents of Employee Notice of Qualifying Events
When applicable, the Employee or Qualified Beneficiary must provide to the COBRA Administrator the following substantiating documentation relative to a Qualifying Event:

1. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
2. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
3. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
4. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
5. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
6. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Notification must be provided to the COBRA Administrator, who is:

WTW BenefitConnect
Dept: COBRA
P.O. Box 981915
El Paso, TX 79998
Phone: 1-877-292-6272
Website/Email: https://cobra.ehr.com

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for Providing the Notice
For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage. For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage
The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee’s (or former Employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child’s losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage
Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage (except as stated under COBRA's special bankruptcy rules),
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, the Plan will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment
If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify the COBRA Administrator in writing immediately.

Contribution and/or Premium Requirements
The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

Additional Information
Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

WTW BenefitConnect
P.O. Box 981915
El Paso, TX 79998
Phone: 1-877-292-6272
Website/Email: https://cobra.ehr.com

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses
Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. 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.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication, even if the cause of the Illness or Injury is not related to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment arising from confinement in a prison, jail or other penal institution.

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).

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law."

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities. That meet the following requirements:

1. That are furnished to the Participant in any veteran's 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.
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: *This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care 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.*

Hazardous Pursuit, Hobby or Activity. That are of an Injury or Illness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm. **including but not limited to:** hang gliding, skydiving, bungee jumping, parasailing, use of all-terrain vehicles, rock climbing, use of explosives, automobile racing, motorcycle racing, aircraft racing, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Illegal Acts. That are for any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Illness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, or of any Schedule I substance, even if administered on the advice of a Physician and/or legal under the law of the state where the Participant lives, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions 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.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act, as amended.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

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

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. Participants that are self-employed or employed by an employer that does not provide health benefits should ensure that they have other medical benefits to provide for medical care in the event they are hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Participant does not have such coverage he or she may end up with no coverage at all.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant actually had such mandatory coverage. Benefits will be excluded to the amount of first party medical coverage required under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by applicable law.

Provider Error. That are required as a result of unreasonable Provider error.

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

Unreasonable. That are required to treat Illness or Injuries arising from and due to error(s) caused at any point in the course of treatment by any Provider, including, but not limited to, a Physician or Hospital, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, whether or not they were directly or indirectly caused by the treating Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vehicle Accident. That are for treatment of any Illness or Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Illness or Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition, even if the condition is not diagnosed before the Illness or Injury. 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.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

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. 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, in all other matters, including but not limited to, other appeals that are "not" Final Post-Service Appeals.

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 PACE's determinations will be final and binding on all interested parties, and 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.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

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.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: *The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.*

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

How to Submit a Claim – Medical and Prescription Drug

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 Medical Claim to submit for payment that person must:

1. Obtain a Claim form from BRMS − Call BRMS Customer Service at (866) 750-0576 or log on to https://www.brmsonline.com/dignityhealth/ventura.
2. Complete the Employee portion of the form. All questions must be answered.
3. Have the Provider complete the Provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. All bills must show:

    a. Name of Plan
    b. Employee's name
    c. Member ID number
    d. Name of patient
    e. Name, address, telephone number of the Provider of care
    f. Diagnosis
    g. Type of services/supplies rendered, with diagnosis and/or procedure codes
    h. Date of services or receipt of supplies
    i. Charges

5. Send the above to the Claims Administrator at this address:

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

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

1. Obtain a Claim form from Capital Rx − Call Capital Rx Customer Service at (844) 306-6901, or log on to https://app.cap-rx.com.
2. Complete the form.
3. Attach all applicable receipts.
4. Send the above to Capital Rx at this address:

   Capital Rx
   Attention Appeals Department
   9450 SW Gemini Drive, #87234
   Beaverton, OR 97008

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. 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 Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims 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.

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim". In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:
    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Claimant to provide the information.
    d. If there is an Adverse Benefit Determination, 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.

2. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. 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.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
    c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
    d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Claimant	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
    c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

5. Extensions:
    a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
    b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of Pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. Oral appeals should be submitted in writing as soon as possible after they have been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Benefit & Risk Management Services
80 Iron Point Circle, Suite 200
Folsom, CA 95630
Phone: (866) 750-0576
Website/Email: www.MyHealthBenefits.com

For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Benefit & Risk Management Services
80 Iron Point Circle, Suite 200
Folsom, CA 95630
Phone: (866) 750-0576
Website/Email: www.MyHealthBenefits.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's unique member identification number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "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".

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Final Internal Adverse Benefit Determination

Upon receipt, review, adjudication and conclusion of a Final Post-Service 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 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 determination will be final and binding on all interested parties.

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.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. 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 a Final Internal Adverse Benefit Determination. 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.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The Claimant has exhausted the Plan's internal appeal process (unless the Claimant is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review.
    d. 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 Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will 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.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
    b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

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 Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, 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 an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition Illness or Injury that is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

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 shall be made, in the Plan Administrator's discretion, to an assignee of an assignment 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 an assignment of benefits occurred.

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, 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. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider must satisfy all applicable credentialing and licensing requirements; and claims for benefits must be submitted to the Plan in English.

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 or to whom a right to benefits has been assigned, 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, Claimant 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:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. 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, as part of its assignment to benefits from the Plan, 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 for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant 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 final appeal or he or she will lose any rights to bring such an action against the Plan.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

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.

Standard Coordination of Benefits

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefits Subject to This Provision

The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness 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.

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

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay

more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

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.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the provision entitled "Application to Benefit Determinations", the rules establishing the order of benefit determination between the Plan and an Other Plan are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a Dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Covered Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(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 crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(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 agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment 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 Participant(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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(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 Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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 Participant(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 Participant(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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant 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 Participant 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 Participant(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 Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(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 or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, 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, and without regard to whether the Participant(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 and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' 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 Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant 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.

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. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

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 Participant(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 Participant(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 Illness, Injury or disability.

Participant is a Trustee Over Plan Assets

Any Participant 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 Participant understands that he or she is required to:

1. 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.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. 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 Participant disputes this obligation to the Plan under this section, the Participant 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 attorneys' 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 Participant, 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.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness 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:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(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 Participant(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 Participant(s) and all others that benefit from such payment.

Obligations

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

1. 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.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(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 Participant(s).

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

Offset

If timely repayment is not made, or the Participant 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 Participant'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 Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(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.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

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 to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, 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 Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant’s responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant’s responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator’s attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage
Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

No Waiver or Estoppel
All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration

NOTE*: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA and any other applicable State law(s).

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out-of-pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and 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 Participant 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, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the 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 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 Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If he or she has any questions about how to do this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the website address.

Primary Care Providers

This Plan generally allows the designation of a primary care Provider. The Participant has the right to designate any primary care Provider who participates in the Network and who is available to accept his or her family members.

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 Plan 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 Plan Document.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective Surgery from a specific Provider, including receipt of postoperative care with respect to the Surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Calendar Year Maximum Benefit

The following Calendar Year maximums apply to each Participant.

SUMMARY OF BENEFITS - MEDICAL

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge. This summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan.

DHMP Ventura PPO Plan MEDICAL SCHEDULE OF BENEFITS
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.
☎ = 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 Customer Service at (866) 750-0576.

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Deductible Per Calendar Year	$0	$300 per Individual $900 per Family	$1,000 per Individual $3,000 per Family
		Once the family Deductible has been met by any number of individuals, the Deductible is met for all	
Hospital Deductible	$0	$0	$500 if services are not preauthorized (waived for Emergency Services)
Copayment	$10 per Physician office visit	$15 per Primary Care Physician office visit; $35 per other Physician office visit	$0
	"Per visit" means per Provider per day. Copayments do not apply to the Tier 2 deductible.		
Hospital Copayment	Does not apply	$300	$300
Percentage Coinsurance	The Plan pays 100% of the Tier 1 Maximum Allowable Charge for most covered services and supplies. See individual service type for details.	The Plan pays 80% of the Tier 2 Maximum Allowable Charge for most covered services and supplies. The Plan pays 70% of Tier 2 Maximum Allowable Charge for most covered inpatient/outpatient facility services. See individual service type for details.	The Plan pays 50% of Maximum Allowable Charges for most covered services and supplies. See individual service type for details.

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Medical Out-of-Pocket (OOP) Limit Including Deductible and Medical Copayments, per Calendar Year	$2,000 per Individual $6,000 per Family		$4,000 per Individual $12,000 per Family
	Medical Out-of-Pocket limit does not apply to: Prescription Drug Out- of-Pocket amounts, 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 Medical 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.		
Cost Management Services Program/ Pre-certification	Providers should call Anthem prior to Hospitalizations and before specific services are rendered.		
Abortion, Voluntary or Elective	Not Covered	Not Covered	Not Covered
	Only allowed if the mother's life is endangered by the Pregnancy. Complications arising from abortion are covered same as any other Illness.		
Acupuncture	$10 Copayment, then 100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with chiropractic. Services are for treatment of disease, Illness or injury. Maintenance Care is not covered.		
Allergy Injections	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Allergy Serum	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Allergy Testing	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Ambulance (☎ Air Only)	100% of Maximum Allowable Charges after Tier 2 $300 Deductible		100% of Provider Charges after Tier 2 $300 Deductible
	Professional and volunteer ambulance, sea and air ambulance are covered. Must be Medically Necessary. Out-of-network ambulance (land and air) will be covered the same in Tiers 1 and 2.		
Ambulatory Surgical Center, Freestanding ☎	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Anesthesia	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Coverage is also available for administration of anesthesia for nonsurgical procedures when found Medically Necessary according to Plan provisions.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Autism Spectrum Disorders, Screening, Diagnosis, Treatment	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Assistive Communication Devices	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Biofeedback	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Blood and Blood Product Services	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Cardiac Rehabilitation			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Chemotherapy			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Chiropractic Care	$10 Copayment, then 100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with acupuncture. Maintenance Care is not covered.		
Clinical Trials	See type of service rendered.	See type of service rendered.	Not Covered
	Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Consultation			
• Disease Management	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment for PCP; $35 Copayment for Other Physician, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
• Inpatient Consultation	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment for PCP; $35 Copayment for Other Physician, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
• Second Surgical, Voluntary	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment for PCP; $35 Copayment for Other Physician, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Dental Care, Limited			
• Treatment of an Injury to Sound Natural Teeth	See type of service rendered.	See type of service rendered.	See type of service rendered.
• Oral surgery and Removal of Impacted Teeth ☎	See type of service rendered.	See type of service rendered.	See type of service rendered.
Coverage is available for treatment of an Injury to Sound Natural Teeth. Coverage is available for 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 are covered.			
Diabetic Education	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment for PCP; $35 Copayment for Other Physician, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
Diabetic Supplies/Equipment	Medically Necessary diabetic supplies/equipment is covered under either Durable Medical Equipment or Prescription Drug Benefits.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Diagnostic Testing			
• Genetic Testing	Not Covered	Not Covered	Not Covered
	Coverage will be available 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 and/or as required by ACA guidelines.		
• HIV/AIDS Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• HIV/AIDS Testing Other (i.e., Free standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Laboratory Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Laboratory Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Machine Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Machine Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Professional Interpretation Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Professional Interpretation Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• X-ray/Imaging Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• X-ray/Imaging Other (i.e., Free-standing, Physician office) ☎	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Dialysis			
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Durable Medical Equipment ☎	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.		
Enteral Feeding	100% of Maximum Allowable Charges	80% 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	Not Covered
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. Non-routine custom-molded foot Orthotics are covered.		
Gender Affirmation Treatment Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.	See type of service rendered.
Hearing Aid/Exam			
• Aid	Not Covered	Not Covered	Not Covered
• Exam	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible	Not Covered
Home Health Care ☎	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to 120 visits per Covered Person per Calendar Year combined In- and Out-of-Network. 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.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Hospice Care	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Bereavement counseling visits available for covered family members.		
Hospital Facility			
• Inpatient Hospital ☎	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered.		
Outpatient Hospital			
• Clinic	100% of Maximum Allowable Charges	70% 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).		
• Emergency Room for Emergency Condition and Related Charges	$50 Copayment, then 100% of Maximum Allowable Charges	$50 Copayment, then 100% of Maximum Allowable Charges	$50 Copayment, then 100% of Provider 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	Not Covered
• Outpatient Surgical Center for Surgery ☎	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Other Outpatient Hospital Services and Supplies	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Impotency Treatment	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment for PCP; $35 Copayment for Other Physician, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
	Limited to office visit charges and medications are covered under the Prescription Drug Benefits.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Infertility Services	50% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible	Not Covered
	Benefit is limited to the initial evaluation and testing for Infertility.		
In-Hospital/Facility Physician's Care for Surgery ☎	100% of Maximum Allowable Charges	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; related services are allowed per service type.		
IV (Infusion) Therapy ☎			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Home IV/Infusion therapy is covered under Home Health Care.			
Massage Therapy	Not Covered	Not Covered	Not Covered
Maternity Care			
• Initial Diagnostic Office Visit, Physician Charge	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment PCP, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
• Inpatient Hospital Facility ☎	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness. Dependent Children's Pregnancies are covered.		
• Prenatal, Delivery and Postpartum Care, Physician Charge	100% of Maximum Allowable Charges	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). If NICU services are rendered at Tier 1 facility by Tier 2 Physicians, services will be allowed at the Tier 1 benefit.		
Medical/Surgical Supplies	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Compression stockings limited to two pairs per Calendar Year.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Mental Disorder Treatment			
• Applied Behavioral Analysis Therapy	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Inpatient Facility ☎	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.		
• General Hospital or Private Proprietary Psychiatric Facility ☎	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.		
• Inpatient, Physician Charge	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment, then 100% of Maximum Allowable Charges	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	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
• Psychological Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Psychological Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Newborn Care			
• Circumcision Outpatient Hospital Facility	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
• Circumcision Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Hospital Facility	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 50% of Maximum Allowable Charges after Deductible
• Physician	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to Allowed 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, go to MyBenefits at home.commonspirit.org/employeecentral/mybenefits.		
Nursing, Private Duty	Not Covered	Not Covered	Not Covered
Nutritional Counseling (Eating Disorders Only)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Obesity Treatment, Morbid; for surgical ☎	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical treatment of for Morbid Obesity.		
Occupational Therapy			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Maintenance care is not covered			
Orthotics (non-routine)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Physical Rehabilitation Facility, Inpatient ☎	See Hospital Facility, Inpatient Care	See Hospital Facility, Inpatient Care	See Hospital Facility, Inpatient Care
Physical Therapy			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Maintenance care is not covered			
Physician Care			
• Emergency Room	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	100% of Provider Charges
• Emergency Condition and Related Charges	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	100% of Provider Charges
• Non-Emergency Condition and Related Charges	Not Covered	Not Covered	Not Covered
• Home, Office, Clinic or Elsewhere (including Telehealth/Virtual Visits)	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment PCP; $35 Copayment other Physician, then 100% of Maximum Allowable Charges	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.		
Preadmission Testing	See Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; and • Your Physician ordered 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 with Coordination of Benefits	See Prescription Drug Benefit	See Prescription Drug Benefit	See Prescription Drug Benefit

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Preventive Care (Includes all Ancillary Charges)	Please see https://www.healthcare.gov/coverage/preventive-care- benefits/ for complete listing and frequencies, unless listed below.		
• Breast Pump	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Limit to one per pregnancy.		
• Colonoscopy Screening	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
• Contraceptive Management	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, and contraceptive devices. 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	Not Covered
• Mammograms	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Must be over age 40, unless medically necessary.		
• Nutritional Counseling (for adults with risk factors and for adults and children with obesity)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Limited to twenty-six (26) wellness visits per Covered Person per Calendar Year combined all tiers.		
• Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	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	Not Covered
	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). Limited to one exam per Calendar Year, per Covered Person combined all tiers. This maximum does not apply to other screening services listed above/below. Travel immunizations are not covered.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
• Routine Child Care (up to age 19)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	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. Travel immunizations are not covered.		
• Tobacco Cessation Counseling	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Limited to two attempts per Calendar Year, combined all tiers. Each attempt includes a maximum of four intermediate or intensive sessions.		
Prosthetics ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
Pulmonary Rehabilitation			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	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)	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Radiation Therapy ☎			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Refractive Surgery	Not Covered	Not Covered	Not Covered

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Respiratory/Inhalation Therapy			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician's Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Skilled Nursing Facility (SNF)			
• Inpatient ☎	100% of Maximum Allowable Charges	70% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Limited to 120 day limit per Calendar Year from admission date combined all tiers. 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 elsewhere in this section.		
Speech Therapy			
• Freestanding Facility	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Sterilization (Female), Voluntary or Elective	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	
	Includes all related services such as anesthesia and facility charges.		
Sterilization (Male), Voluntary or Elective	Not Covered	Not Covered	Not Covered
	Medically Necessary male sterilization is covered same as surgery.		

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Substance Use Disorder Treatment			
• Detoxification	See type of service rendered.	See type of service rendered.	
• Inpatient Facility ☎	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.		
• General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program ☎	100% of Maximum Allowable Charges	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.		
• Inpatient Physician	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$15 Copayment, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
• Partial Hospitalization	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Surgical Charge Benefit ☎			
• Surgeon	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Does not apply to Infertility-related services.		
Telemedicine (through LiveHealth Online)	Not Applicable	$5 Copayment	Not Applicable
Therapeutic Injections	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
Temporomandibular Joint (TMJ) Disorder ☎	See type of service rendered.	See type of service rendered.	See type of service rendered.
	Benefits are available if conservative medical treatment has failed.		
Transgender Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.	See type of service rendered.

Plan Features DHMP Ventura PPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2	Out-of-Network Tier 3
Transplants ☎			
• Facility Charges	100% of Maximum Allowable Charges	$300 Copayment, then 70% of Maximum Allowable Charges after Deductible	$300 Copayment, then 50% of Maximum Allowable Charges after Tier 3 $300 Deductible
• Physician Charges	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
• Transplant Travel and Lodging Benefit	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges	Not Covered
	Lodging allowance limited to $50 per day for double occupancy. Total maximum for travel, meals, and lodging combined - $10,000 per each covered transplant procedure. Limited to maximums set forth by the Internal Revenue Code at the time services are rendered and must be approved in advance.		
• Unrelated Donor Searches	100% of Maximum Allowable Charges	80% of Maximum Allowable Charges after Deductible	50% of Maximum Allowable Charges after Deductible
	Only allowed when family member donor is not available.		
Urgent Care Physician/ Facility	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges	50% of Maximum Allowable Charges after Deductible
	One combined Copayment per date of service applies to all services billed by the facility/Physician.		
Vision Therapy	Not Covered	Not Covered	
Wigs	Not Covered	Not Covered	

DHMP Ventura EPO Plan MEDICAL SCHEDULE OF BENEFITS
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.
☎ = 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 Customer Service at (866) 750-0576.

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Deductible Per Calendar Year	$0	$300 per Individual $900 per Family Once the family Deductible has been met by any number of individuals, the Deductible is met for all
Copayment	$10 per Physician office visit "Per visit" means per Provider per day. Copayments do not apply to the Tier 2 Deductible.	N/A
Percentage Coinsurance	The Plan pays 100% of Maximum Allowable Charges for most covered services and supplies. See individual service type for details.	If covered, and after the Deductible is met, the Plan pays 90% of the Tier 2 Maximum Allowable Charge for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible and Medical Copayments, per Calendar Year	$2,000 per Individual $6,000 per Family	
	Medical Out-of-Pocket limit does not apply to: Prescription Drug Out- of-Pocket amounts, 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 Medical 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.	
Tier 2 Inpatient or Outpatient Facility Services	If services cannot be rendered at a Dignity Health Preferred Network facility, within the market where you work (Ventura Market) services may be rendered at a Tier 2 facility at the Tier 1 benefit. Examples: transplants, burns, NICU Level 4). Covered Persons should call BRMS customer service prior to services being rendered at (866) 750-0576.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Cost Management Services Program/Pre-certification	Providers should call Anthem prior to Hospitalizations and before specific services are rendered.	
Abortion, Voluntary or Elective	Not Covered	Not Covered
	Only allowed if the mother's life is endangered by the Pregnancy. Complications arising from abortion are covered same as any other Illness.	
Acupuncture	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with chiropractic. Services are for treatment of disease, Illness or injury. Maintenance Care is not covered.	
Allergy Injections and Services	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Serum	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Testing	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Ambulance (☎ Air Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Professional and volunteer ambulance, sea and air ambulance are covered. Must be Medically Necessary. Out-of-network ambulance (land and air) will be covered the same in Tiers 1 and 2.	
Ambulatory Surgical Center, Freestanding ☎	100% of Maximum Allowable Charges	Not Covered
Anesthesia	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Coverage is also available for administration of anesthesia for nonsurgical procedures when found Medically Necessary according to Plan provisions.	
Autism Spectrum Disorders, Screening, Diagnosis, Treatment	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges After Deductible
• Assistive Communication Devices	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Biofeedback	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Blood and Blood Product Services	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Cardiac Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chemotherapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chiropractic Care	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with acupuncture. 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.	
Consultation		
• Disease Management	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Consultation	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Second Surgical, Voluntary	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Dental Care, Limited		
• Treatment of an Injury to Sound Natural Teeth	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible
• Oral surgery and Removal of Impacted Teeth ☎	See type of service rendered.	See type of service rendered.
Coverage is available for treatment of an Injury to Sound Natural Teeth. Coverage is available for 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 are covered.		
Diabetic Education	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Diabetic Supplies/Equipment	Medically Necessary diabetic supplies/equipment is covered under either Durable Medical Equipment or Prescription Drug Benefits.	
Diagnostic Testing		
• Genetic Testing	Not Covered	Not Covered
	Coverage will be available 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 and/or as required by ACA guidelines.	
• HIV/AIDS Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• HIV/AIDS Testing Other (i.e., Free standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Laboratory Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Laboratory Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Machine Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Machine Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Professional Interpretation Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Professional Interpretation Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• X-ray/Imaging Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• X-ray/Imaging Other (i.e., Free-standing, Physician office) ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Dialysis		
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Freestanding Facility	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Physician Office	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Durable Medical Equipment ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Enteral Feeding	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Food Products (Aminoacidopathies Formula, Modified Solid Food Products)	Not Covered	Not Covered
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. Non-routine custom-molded foot Orthotics are covered.	
Gender Affirmation Treatment Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.
Hearing Aid/Exam		
• Aid	Not Covered	Not Covered
• Exam	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Home Health Care ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	<u>One HHC visit equals:</u> • 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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Bereavement counseling visits available for covered family members.	
Hospital Facility		
• Inpatient Hospital ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered.	
Outpatient Hospital		
• Clinic	100% of Maximum Allowable Charges	Not Covered
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• Emergency Room for Emergency Condition and Related Charges	$50 Copayment, then 100% of Maximum Allowable Charges	$50 Copayment, 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 for Surgery ☎	100% of Maximum Allowable Charges	Not Covered
• Other Outpatient Hospital Services and Supplies	100% of Maximum Allowable Charges	Not Covered
Impotency Treatment	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to office visit charges and medications are covered under the Prescription Drug Benefits.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Infertility Services	50% of Maximum Allowable Charges	40% of Maximum Allowable Charges after Deductible
	Benefit is limited to the initial evaluation and testing for Infertility.	
In-Hospital/Facility Physician's Care for Surgery ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay; related services are allowed per service type.	
IV (Infusion) Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Home IV/Infusion therapy is covered under Home Health Care.		
Massage Therapy	Not Covered	Not Covered
Maternity Care		
• Initial Diagnostic Office Visit, Physician Charge	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Hospital Facility ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness. Dependent Children's Pregnancies are covered.	
• Prenatal, Delivery and Postpartum Care, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Medical/Surgical Supplies	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Compression stockings limited to two pairs per Calendar Year.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Mental Disorder Treatment		
• Applied Behavioral Analysis Therapy	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• General Hospital or Private Proprietary Psychiatric Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Psychological Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Psychological Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Newborn Care		
• Circumcision Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Circumcision Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Hospital Facility	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Physician	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to Allowed 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, go to MyBenefits at home.commonspirit.org/employeecentral/mybenefits.	
Nursing, Private Duty	Not Covered	Not Covered
Nutritional Counseling (Eating Disorders Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Obesity Treatment, Morbid; for surgical ☎	100% of Maximum Allowable Charges	Not Covered
	Limited to Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical treatment of for Morbid Obesity.	
Occupational Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		
Orthotics (non-routine)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Physical Rehabilitation Facility, Inpatient ☎	See Hospital Facility, Inpatient Care	See Hospital Facility, Inpatient Care
Physical Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		
Physician Care		
• Emergency Room	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• 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 (including Telehealth/Virtual Visits)	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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.	
Preadmission Testing	See Diagnostic Testing	See Diagnostic Testing
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; and • Your Physician ordered 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 with Coordination of Benefits	See Prescription Drug Benefit	See Prescription Drug Benefit
Preventive Care (Includes all Ancillary Charges)	Please see https://www.healthcare.gov/coverage/preventive-care-benefits/ for complete listing and frequencies, unless listed below.	
• Breast Pump	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limit to one per pregnancy.	
• Colonoscopy Screening	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Contraceptive Management	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, and contraceptive devices. 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
• Mammograms	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Must be over age 40, unless medically necessary.	
• 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 twenty-six (26) wellness visits per Covered Person per Calendar Year combined all tiers.	
• 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). Limited to one exam per Calendar Year, per Covered Person combined all tiers. This maximum does not apply to other screening services listed above/below. Travel immunizations are not covered.	
• 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. Travel immunizations are not covered.	
• Tobacco Cessation Counseling	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to two attempts per Calendar Year, combined all tiers. Each attempt includes a maximum of four intermediate or intensive sessions.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Prosthetics ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Pulmonary Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% 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)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Radiation Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Refractive Surgery	Not Covered	Not Covered
Respiratory/Inhalation Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician's Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Skilled Nursing Facility (SNF)		
• Inpatient ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges, after Deductible
	Limited to 120 day limit per Calendar Year from admission date combined all tiers. 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.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• 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 elsewhere in this section.	
Speech Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Sterilization (Female), Voluntary or Elective	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Includes all related services such as anesthesia and facility charges.	
Sterilization (Male), Voluntary or Elective	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Subject to medical necessity.	
Substance Use Disorder Treatment		
• Detoxification	See type of service rendered.	See type of service rendered.
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient Physician	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
• Partial Hospitalization	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Surgical Charge Benefit ☎		
• Surgeon	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Does not apply to Infertility-related services.	
Telemedicine (through LiveHealth Online)	Not Applicable	$5 Copayment
Therapeutic Injections	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Temporomandibular Joint (TMJ) Disorder ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Benefits are available if conservative medical treatment has failed.	
Transgender Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.
Transplants ☎		
• Facility Charges	100% of Maximum Allowable Charges	Not Covered
	If services cannot be rendered at a Dignity Health Preferred Network Facility, services may be rendered at a Tier 2 facility at the Tier 1 benefit (examples: transplants, burns, NICU Level 4). Covered Persons should call customer service prior to services being rendered.	
• Physician Charges	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Transplant Travel and Lodging Benefit	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Lodging allowance limited to $100 per day for double occupancy. Total maximum for travel, meals, and lodging combined - $10,000 per each covered transplant procedure. Limited to maximums set forth by the Internal Revenue Code at the time services are rendered and must be approved in advance.	
• Unrelated Donor Searches	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Only allowed when family member donor is not available. For all charges for unrelated donor searches for covered bone marrow/stem cell transplants - $30,000 per transplant.	

Plan Features DHMP Ventura EPO	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Urgent Care Physician/ Facility	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
	One combined Copayment per date of service applies to all services billed by the facility/Physician.	
Vision Therapy	Not Covered	Not Covered
Wigs	Not Covered	Not Covered

DHMP Ventura EPO R Plan MEDICAL SCHEDULE OF BENEFITS
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.
☎ = 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 Customer Service at (866) 750-0576.

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Deductible Per Calendar Year	$0	$300 per Individual $900 per Family Once the family Deductible has been met by any number of individuals, the Deductible is met for all
Copayment	$10 per Physician office visit “Per visit” means per Provider per day. Copayments do not apply to the Tier 2 Deductible.	N/A
Percentage Coinsurance	The Plan pays 100% of Maximum Allowable Charges for most covered services and supplies. See individual service type for details.	If covered, and after the Deductible is met, the Plan pays 90% of the Tier 2 Maximum Allowable Charge for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible and Medical Copayments, per Calendar Year	$2,000 per Individual $6,000 per Family	
	Medical Out-of-Pocket limit does not apply to: Prescription Drug Out- of-Pocket amounts, 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 Medical 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.	
Tier 2 Inpatient or Outpatient Facility Services	If services cannot be rendered at a Dignity Health Preferred Network facility, within the market where you work (Ventura Market) services may be rendered at a Tier 2 facility at the Tier 1 benefit. Examples: transplants, burns, NICU Level 4). Covered Persons should call BRMS customer service prior to services being rendered at (866) 750-0576.	

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Cost Management Services Program/Pre-certification	Providers should call Anthem prior to Hospitalizations and before specific services are rendered.	
Abortion, Voluntary or Elective	Not Covered	Not Covered
	Only allowed if the mother's life is endangered by the Pregnancy. Complications arising from abortion are covered same as any other Illness.	
Acupuncture	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with chiropractic. Services are for treatment of disease, Illness or injury. Maintenance Care is not covered.	
Allergy Injections	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Serum	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Testing	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Ambulance (☎ Air Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Professional and volunteer ambulance, sea and air ambulance are covered. Must be Medically Necessary. Out-of-network ambulance (land and air) will be covered the same in Tiers 1 and 2.	
Ambulatory Surgical Center, Freestanding ☎	100% of Maximum Allowable Charges	Not Covered
Anesthesia	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Coverage is also available for administration of anesthesia for nonsurgical procedures when found Medically Necessary according to Plan provisions.	
Autism Spectrum Disorders, Screening, Diagnosis, Treatment	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges After Deductible
• Assistive Communication Devices	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Biofeedback	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Blood and Blood Product Services	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Cardiac Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chemotherapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chiropractic Care	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with acupuncture. 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.	
Consultation		
• Disease Management	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Consultation	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Second Surgical, Voluntary	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Dental Care, Limited		
• Treatment of an Injury to Sound Natural Teeth	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible
• Oral surgery and Removal of Impacted Teeth ☎	See type of service rendered.	See type of service rendered.
Coverage is available for treatment of an Injury to Sound Natural Teeth. Coverage is available for 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 are covered.		
Diabetic Education	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Diabetic Supplies/Equipment	Medically Necessary diabetic supplies/equipment is covered under either Durable Medical Equipment or Prescription Drug Benefits.	
Diagnostic Testing		
• Genetic Testing	Not Covered	Not Covered
	Coverage will be available 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 and/or as required by ACA guidelines.	
• HIV/AIDS Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• HIV/AIDS Testing Other (i.e., Free standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Laboratory Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Laboratory Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Machine Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Machine Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Professional Interpretation Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Professional Interpretation Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• X-ray/Imaging Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• X-ray/Imaging Other (i.e., Free-standing, Physician office) ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Dialysis		
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Freestanding Facility	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Physician Office	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Durable Medical Equipment ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Enteral Feeding	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Food Products (Aminoacidopathies Formula, Modified Solid Food Products)	Not Covered	Not Covered
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. Non-routine custom-molded foot Orthotics are covered.	
Gender Affirmation Treatment Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Hearing Aid/Exam		
• Aid	Not Covered	Not Covered
• Exam	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Home Health Care ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Bereavement counseling visits available for covered family members.	
Hospital Facility		
• Inpatient Hospital ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered.	
Outpatient Hospital		
• Clinic	100% of Maximum Allowable Charges	Not Covered
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• Emergency Room for Emergency Condition and Related Charges	$50 Copayment, then 100% of Maximum Allowable Charges	$50 Copayment, 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 for Surgery ☎	100% of Maximum Allowable Charges	Not Covered
• Other Outpatient Hospital Services and Supplies	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Impotency Treatment	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to office visit charges and medications are covered under the Prescription Drug Benefits.	
Infertility Services	50% of Maximum Allowable Charges	40% of Maximum Allowable Charges after Deductible
	Benefit is limited to the initial evaluation and testing for Infertility.	
In-Hospital/Facility Physician's Care for Surgery ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay; related services are allowed per service type.	
IV (Infusion) Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Home IV/Infusion therapy is covered under Home Health Care.		
Massage Therapy	Not Covered	Not Covered
Maternity Care		
• Initial Diagnostic Office Visit, Physician Charge	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Hospital Facility ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness. Dependent Children's Pregnancies are covered.	
• Prenatal, Delivery and Postpartum Care, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Related testing is covered separately per service type rendered (sonograms have no frequency limit). If NICU services are rendered at Tier 1 facility by Tier 2 Physicians, services will be allowed at the Tier 1 benefit.	

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Medical/Surgical Supplies	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Compression stockings limited to two pairs per Calendar Year.	
Mental Disorder Treatment		
• Applied Behavioral Analysis Therapy	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• General Hospital or Private Proprietary Psychiatric Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Psychological Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Psychological Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Newborn Care		
• Circumcision Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Circumcision Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Physician	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to Allowed 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, go to MyBenefits at home.commonspirit.org/employeecentral/mybenefits.	
Nursing, Private Duty	Not Covered	Not Covered
Nutritional Counseling (Eating Disorders Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Obesity Treatment, Morbid; for surgical ☎	100% of Maximum Allowable Charges	Not Covered
	Limited to Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical treatment of for Morbid Obesity.	
Occupational Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		
Orthotics (non-routine)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Physical Rehabilitation Facility, Inpatient ☎	See Hospital Facility, Inpatient Care	See Hospital Facility, Inpatient Care
Physical Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		
Physician Care		
• Emergency Room	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• 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 (including Telehealth/Virtual Visits)	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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.	
Preadmission Testing	See Diagnostic Testing	See Diagnostic Testing
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; and • Your Physician ordered 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 with Coordination of Benefits	See Prescription Drug Benefit	See Prescription Drug Benefit
Preventive Care (Includes all Ancillary Charges)	Please see https://www.healthcare.gov/coverage/preventive-care-benefits/ for complete listing and frequencies, unless listed below.	
• Breast Pump	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limit to one per pregnancy.	
• Colonoscopy Screening	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Contraceptive Management	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, and contraceptive devices. 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
• Mammograms	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Must be over age 40, unless medically necessary.	
• 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 twenty-six (26) wellness visits per Covered Person per Calendar Year combined all tiers.	
• 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). Limited to one exam per Calendar Year, per Covered Person combined all tiers. This maximum does not apply to other screening services listed above/below. Travel immunizations are not covered.	
• 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. Travel immunizations are not covered.	

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Tobacco Cessation Counseling	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to two attempts per Calendar Year, combined all tiers. Each attempt includes a maximum of four intermediate or intensive sessions.	
Prosthetics ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Pulmonary Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% 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)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Radiation Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Refractive Surgery	Not Covered	Not Covered
Respiratory/Inhalation Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician's Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Skilled Nursing Facility (SNF)		
• Inpatient ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 120 day limit per Calendar Year from admission date combined all tiers. 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 elsewhere in this section.	
Speech Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Sterilization (Female), Voluntary or Elective	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Includes all related services such as anesthesia and facility charges.	
Sterilization (Male), Voluntary or Elective	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges
	Subject to medical necessity.	
Substance Use Disorder Treatment		
• Detoxification	See type of service rendered.	See type of service rendered.
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient Physician	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
• Partial Hospitalization	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Surgical Charge Benefit ☎		
• Surgeon	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Does not apply to Infertility-related services.	
Telemedicine (through LiveHealth Online)	Not Applicable	$5 Copayment
Therapeutic Injections	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Temporomandibular Joint (TMJ) Disorder ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Benefits are available if conservative medical treatment has failed.	
Transgender Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.
Transplants ☎		
• Facility Charges	100% of Maximum Allowable Charges	Not Covered
	If services cannot be rendered at a Dignity Health Preferred Network Facility, services may be rendered at a Tier 2 facility at the Tier 1 benefit (examples: transplants, burns, NICU Level 4). Covered Persons should call customer service prior to services being rendered.	
• Physician Charges	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges

Plan Features DHMP Ventura EPO R	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Transplant Travel and Lodging Benefit	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Lodging allowance limited to $100 per day for double occupancy. Total maximum for travel, meals, and lodging combined - $10,000 per each covered transplant procedure. Limited to maximums set forth by the Internal Revenue Code at the time services are rendered and must be approved in advance.	
• Unrelated Donor Searches	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Only allowed when family member donor is not available. For all charges for unrelated donor searches for covered bone marrow/stem cell transplants - $30,000 per transplant.	
Urgent Care Physician/ Facility	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
	One combined Copayment per date of service applies to all services billed by the facility/Physician.	
Vision Therapy	Not Covered	Not Covered
Wigs	Not Covered	Not Covered

DHMP Ventura EPO R 1 Plan MEDICAL SCHEDULE OF BENEFITS
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.
☎ = 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 Customer Service at (866) 750-0576.

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Deductible Per Calendar Year	$0	$300 per Individual $900 per Family Once the family Deductible has been met by any number of individuals, the Deductible is met for all
Copayment	$10 per Physician office visit “Per visit” means per Provider per day. Copayments do not apply to the Tier 2 Deductible.	N/A
Percentage Coinsurance	The Plan pays 100% of Maximum Allowable Charges for most covered services and supplies. See individual service type for details.	If covered, and after the Deductible is met, the Plan pays 90% of the Tier 2 Maximum Allowable Charge for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible and Medical Copayments, per Calendar Year	$1,000 per Individual $3,000 per Family	$2,000 per Individual $6,000 per Family
	Expenses incurred with a Tier 1 Provider will be credited towards the Tier 1 Out-of-Pocket limit and expenses incurred with a Tier 2 Provider will be credited towards a Tier 2 Out-of-Pocket limit.	
	Medical Out-of-Pocket limit does not apply to: Prescription Drug Out- of-Pocket amounts, 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 Medical 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.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Tier 2 Inpatient or Outpatient Facility Services	If services cannot be rendered at a Dignity Health Preferred Network facility, services may be rendered at a Tier 2 facility at the Tier 1 benefit. (Examples: transplants, burns, NICU Level 4). Covered Persons should call BRMS customer service prior to services being rendered at (866) 750-0576.	
Cost Management Services Program/Pre-certification	Providers should call Anthem prior to Hospitalizations and before specific services are rendered.	
Abortion, Voluntary or Elective	Not Covered	Not Covered
	Only allowed if the mother's life is endangered by the Pregnancy. Complications arising from abortion are covered same as any other Illness.	
Acupuncture	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with chiropractic. Services are for treatment of disease, Illness or injury. Maintenance Care is not covered.	
Allergy Injections	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Serum	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Allergy Testing	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Ambulance (☎ Air Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Professional and volunteer ambulance, sea and air ambulance are covered. Must be Medically Necessary. Out-of-network ambulance (land and air) will be covered the same in Tiers 1 and 2.	
Ambulatory Surgical Center, Freestanding ☎	100% of Maximum Allowable Charges	Not Covered
Anesthesia	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Coverage is also available for administration of anesthesia for nonsurgical procedures when found Medically Necessary according to Plan provisions.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Autism Spectrum Disorders, Screening, Diagnosis, Treatment	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges After Deductible
• Assistive Communication Devices	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Biofeedback	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Blood and Blood Product Services	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Cardiac Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chemotherapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Chiropractic Care	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 20 visits per Covered Person per Calendar Year combined all tiers, combined with acupuncture. 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.	
Consultation		
• Disease Management	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Inpatient Consultation	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Second Surgical, Voluntary	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Dental Care, Limited		
• Treatment of an Injury to Sound Natural Teeth	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges after Deductible
• Oral surgery and Removal of Impacted Teeth ☎	See type of service rendered.	See type of service rendered.
Coverage is available for treatment of an Injury to Sound Natural Teeth. Coverage is available for 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 are covered.		
Diabetic Education	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Diabetic Supplies/Equipment	Medically Necessary diabetic supplies/equipment is covered under either Durable Medical Equipment or Prescription Drug Benefits.	
Diagnostic Testing		
• Genetic Testing	Not Covered	Not Covered
	Coverage will be available 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 and/or as required by ACA guidelines.	
• HIV/AIDS Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• HIV/AIDS Testing Other (i.e., Free standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Laboratory Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Laboratory Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Machine Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Machine Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Professional Interpretation Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Professional Interpretation Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• X-ray/Imaging Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• X-ray/Imaging Other (i.e., Free-standing, Physician office) ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Dialysis		
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Freestanding Facility	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Physician Office	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Durable Medical Equipment ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Excludes services covered under the Preventive Care and Infertility provisions of the Plan.	
Enteral Feeding	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Food Products (Aminoacidopathies Formula, Modified Solid Food Products)	Not Covered	Not Covered

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
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. Non-routine custom-molded foot Orthotics are covered.	
Gender Affirmation Treatment Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.
Hearing Aid/Exam		
• Aid	Not Covered	Not Covered
• Exam	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Home Health Care ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Bereavement counseling visits available for covered family members.	
Hospital Facility		
• Inpatient Hospital ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered.	
Outpatient Hospital		
• Clinic	100% of Maximum Allowable Charges	Not Covered
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• Emergency Room for Emergency Condition and Related Charges	$50 Copayment, then 100% of Maximum Allowable Charges	$50 Copayment, 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.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Emergency Room for Non-Emergency Condition and Related Charges	Not Covered	Not Covered
• Outpatient Surgical Center for Surgery ☎	100% of Maximum Allowable Charges	Not Covered
• Other Outpatient Hospital Services and Supplies	100% of Maximum Allowable Charges	Not Covered
Impotency Treatment	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to office visit charges and medications are covered under the Prescription Drug Benefits.	
Infertility Services	50% of Maximum Allowable Charges	40% of Maximum Allowable Charges after Deductible
	Benefit is limited to the initial evaluation and testing for Infertility.	
In-Hospital/Facility Physician's Care for Surgery ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay; related services are allowed per service type.	
IV (Infusion) Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Home IV/Infusion therapy is covered under Home Health Care.		
Massage Therapy	Not Covered	Not Covered
Maternity Care		
• Initial Diagnostic Office Visit, Physician Charge	$10 Copayment, then 100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Hospital Facility ☎	100% of Maximum Allowable Charges	Not Covered
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness. Dependent Children's Pregnancies are covered.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Prenatal, Delivery and Postpartum Care, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Related testing is covered separately per service type rendered (sonograms have no frequency limit). If NICU services are rendered at Tier 1 facility by Tier 2 Physicians, services will be allowed at the Tier 1 benefit.	
Medical/Surgical Supplies	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Compression stockings limited to two pairs per Calendar Year.	
Mental Disorder Treatment		
• Applied Behavioral Analysis Therapy	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• General Hospital or Private Proprietary Psychiatric Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient, Physician Charge	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Psychological Testing Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• Psychological Testing Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Newborn Care		
• Circumcision Outpatient Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Circumcision Other (i.e., Free-standing, Physician office)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Hospital Facility	100% of Maximum Allowable Charges	Not Covered
• Physician	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to Allowed 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, go to MyBenefits at home.commonspirit.org/employeecentral/mybenefits.	
Nursing, Private Duty	Not Covered	Not Covered
Nutritional Counseling (Eating Disorders Only)	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Obesity Treatment, Morbid; for surgical ☎	100% of Maximum Allowable Charges	Not Covered
	Limited to Medically Necessary (as determined by the Claims Administrator) surgical and non-surgical treatment of for Morbid Obesity.	
Occupational Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Orthotics (non-routine)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Physical Rehabilitation Facility, Inpatient ☎	See Hospital Facility, Inpatient Care	See Hospital Facility, Inpatient Care
Physical Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Maintenance care is not covered		
Physician Care		
• Emergency Room	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• 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 (including Telehealth/Virtual Visits)	$10 Copayment, then 100% of Maximum Allowable Charges	90% 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.	
Preadmission Testing	See Diagnostic Testing	See Diagnostic Testing
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital confinement; and • Your Physician ordered 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 with Coordination of Benefits	See Prescription Drug Benefit	See Prescription Drug Benefit

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Preventive Care (Includes all Ancillary Charges)	Please see https://www.healthcare.gov/coverage/preventive-care-benefits/ for complete listing and frequencies, unless listed below.	
• Breast Pump	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limit to one per pregnancy.	
• Colonoscopy Screening	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Contraceptive Management	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Medical benefits only: FDA-approved injectable contraceptives, implantable contraceptives, and contraceptive devices. 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
• Mammograms	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Must be over age 40, unless medically necessary.	
• 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 twenty-six (26) wellness visits per Covered Person per Calendar Year combined all tiers.	
• 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). Limited to one exam per Calendar Year, per Covered Person combined all tiers. This maximum does not apply to other screening services listed above/below. Travel immunizations are not covered.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
• 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. Travel immunizations are not covered.	
• Tobacco Cessation Counseling	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Limited to two attempts per Calendar Year, combined all tiers. Each attempt includes a maximum of four intermediate or intensive sessions.	
Prosthetics ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Pulmonary Rehabilitation		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% 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)	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Radiation Therapy ☎		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Refractive Surgery	Not Covered	Not Covered

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Respiratory/Inhalation Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician's Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Skilled Nursing Facility (SNF)		
• Inpatient ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Limited to 120 day limit per Calendar Year from admission date combined all tiers. 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 elsewhere in this section.	
Speech Therapy		
• Freestanding Facility	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
• Outpatient Hospital	100% of Maximum Allowable Charges	Not Covered
• Physician Office	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Sterilization (Female), Voluntary or Elective	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	Includes all related services such as anesthesia and facility charges.	
Sterilization (Male), Voluntary or Elective	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges
	Subject to medical necessity.	

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Substance Use Disorder Treatment		
• Detoxification	See type of service rendered.	See type of service rendered.
• Inpatient Facility ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• General Hospital or Certified Alcohol/Substance Use Disorder Facility Program ☎	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
	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 semiprivate room rate or 80% of its lowest daily rate if it does not have semiprivate accommodations.	
• Inpatient Physician	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Outpatient/Office	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
• Partial Hospitalization	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
Surgical Charge Benefit ☎		
• Surgeon	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Does not apply to Infertility-related services.	
Telemedicine (through LiveHealth Online)	Not Applicable	$5 Copayment
Therapeutic Injections	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
Temporomandibular Joint (TMJ) Disorder ☎	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Benefits are available if conservative medical treatment has failed.	
Transgender Services, Including Surgery ☎	See type of service rendered.	See type of service rendered.

Plan Features DHMP Ventura EPO R 1	Dignity Health Preferred Network Tier 1	Anthem PPO Provider Network Tier 2
Transplants ☎		
• Facility Charges	100% of Maximum Allowable Charges	Not Covered
	If services cannot be rendered at a Dignity Health Preferred Network Facility, services may be rendered at a Tier 2 facility at the Tier 1 benefit (examples: transplants, burns, NICU Level 4). Covered Persons should call customer service prior to services being rendered.	
• Physician Charges	100% of Maximum Allowable Charges	100% of Maximum Allowable Charges
• Transplant Travel and Lodging Benefit	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Lodging allowance limited to $100 per day for double occupancy. Total maximum for travel, meals, and lodging combined - $10,000 per each covered transplant procedure. Limited to maximums set forth by the Internal Revenue Code at the time services are rendered and must be approved in advance.	
• Unrelated Donor Searches	100% of Maximum Allowable Charges	90% of Maximum Allowable Charges after Deductible
	Only allowed when family member donor is not available. For all charges for unrelated donor searches for covered bone marrow/stem cell transplants - $30,000 per transplant.	
Urgent Care Physician/ Facility	$10 Copayment, then 100% of Maximum Allowable Charges	$10 Copayment, then 100% of Maximum Allowable Charges
	One combined Copayment per date of service applies to all services billed by the facility/Physician.	
Vision Therapy	Not Covered	Not Covered
Wigs	Not Covered	Not Covered

SUMMARY OF BENEFITS – PRESCRIPTION DRUG

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.

DHMP Ventura PPO Plan PRESCRIPTION DRUG SCHEDULE OF BENEFITS	
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 Capital Rx. Contact Capital Rx Customer Service Department toll- free at (844) 306-6901 for details.	
Any one retail or specialty Pharmacy prescription or refill is limited to a 30-day supply. The Retail 90 Network will allow up to a 90-day supply. Any one home delivery prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs are subject to quantity limits, prior authorization, and/or step therapy. During the year, your prescription may change from the Formulary to the non-formulary or vice versa. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
Prescription Drug Out-of-Pocket Maximum	**$4,600 per Individual / $7,200 per Family**
Prescription Drug Out-of-Pocket limit does not apply to Medical Out-of-Pocket amounts. 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.	
Prescription Drug Benefits (Capital Rx)	
Note: You must pay applicable Copayments. The Plan pays the balance of Maximum Allowable Charge. Copayments per prescription:	

Covered Drugs and Supplies	Network
Retail Pharmacy (30-Day Supply)*	
Tier 1 – Generic and some Brand Name Drugs	$5 Copayment
Tier 2 – Preferred Brand Name Drugs	$10 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$25 Copayment
Home Delivery (90-Day Supply)	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$50 Copayment
Specialty Drugs (up to a 30-Day Supply) filled through CommonSpirit Specialty Pharmacy, or at any CommonSpirit Health owned pharmacy	
Tier 1 – Generic and some Brand Name Drugs	$5 Copayment

Covered Drugs and Supplies	Network
Tier 2 – Preferred Brand Name Drugs	$10 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$25 Copayment

*90-day maintenance medications can be filled at a CommonSpirit Pharmacy, with Optum Home Delivery or at any network retail pharmacy for three times the 30-day copayment.

Note: When you use a drug manufacturer copay card for a Specialty Drug, that Specialty Drug may be subject to a new Copayment. This new Copayment will not impact the price you pay for the Specialty Drug and you will still benefit from using the drug manufacturer copay cards to reduce the Out-of-Pocket cost that you pay for the Specialty Drug. The drug manufacturer copay card dollars utilized to pay for the Specialty Drug will not count towards your Out-of-Pocket limit.

You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.

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.

Refer to the Prescription Drug section for details on the Prescription Drug benefit.

DHMP Ventura EPO Plan PRESCRIPTION DRUG SCHEDULE OF BENEFITS	
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 Capital Rx. Contact Capital Rx Customer Service Department toll- free at (844) 306-6901 for details.	
Any one retail or specialty Pharmacy prescription or refill is limited to a 30-day supply. The Retail 90 Network will allow up to a 90-day supply. Any one home delivery prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs are subject to quantity limits, prior authorization, and/or step therapy. During the year, your prescription may change from the Formulary to the non-formulary or vice versa. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
Prescription Drug Out-of-Pocket Maximum	**$4,600 per Individual / $7,200 per Family**
Prescription Drug Out-of-Pocket limit does not apply to Medical Out-of-Pocket amounts. 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.	
Prescription Drug Benefits (Capital Rx)	
Note: You must pay applicable Copayments. The Plan pays the balance of Maximum Allowable Charge. Copayments per prescription:	

Covered Drugs and Supplies	Network
Retail Pharmacy (30-Day Supply)*	
Tier 1 – Generic and some Brand Name Drugs	$5 Copayment
Tier 2 – Preferred Brand Name Drugs	$10 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$25 Copayment
Home Delivery (90-Day Supply)	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$50 Copayment
Specialty Drugs (up to a 30-Day Supply) filled through CommonSpirit Specialty Pharmacy, or at any CommonSpirit Health owned pharmacy	
Tier 1 – Generic and some Brand Name Drugs	$5 Copayment
Tier 2 – Preferred Brand Name Drugs	$10 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$25 Copayment

Covered Drugs and Supplies	Network
*90-day maintenance medications can be filled at a CommonSpirit Pharmacy, with Optum Home Delivery or at any network retail pharmacy for three times the 30-day copayment. Note: When you use a drug manufacturer copay card for a Specialty Drug, that Specialty Drug may be subject to a new Copayment. This new Copayment will not impact the price you pay for the Specialty Drug and you will still benefit from using the drug manufacturer copay cards to reduce the Out-of-Pocket cost that you pay for the Specialty Drug. The drug manufacturer copay card dollars utilized to pay for the Specialty Drug will not count towards your Out-of-Pocket limit. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
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.	
Refer to the Prescription Drug section for details on the Prescription Drug benefit.	

DHMP Ventura EPO R Plan PRESCRIPTION DRUG SCHEDULE OF BENEFITS	
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 Capital Rx. Contact Capital Rx Customer Service Department toll- free at (844) 306-6901 for details.	
Any one retail or specialty Pharmacy prescription or refill is limited to a 30-day supply. The Retail 90 Network will allow up to a 90-day supply. Any one home delivery prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs are subject to quantity limits, prior authorization, and/or step therapy. During the year, your prescription may change from the Formulary to the non-formulary or vice versa. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
Prescription Drug Out-of-Pocket Maximum	**$4,600 per Individual / $7,200 per Family**
Prescription Drug Out-of-Pocket limit does not apply to Medical Out-of-Pocket amounts. 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.	
Prescription Drug Benefits (Capital Rx)	
Note: You must pay applicable Copayments. The Plan pays the balance of Maximum Allowable Charge. Copayments per prescription:	

Covered Drugs and Supplies	Network
Retail Pharmacy (30-Day Supply)*	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$40 Copayment
Home Delivery (90-Day Supply)	
Tier 1 – Generic and some Brand Name Drugs	$25 Copayment
Tier 2 – Preferred Brand Name Drugs	$50 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$100 Copayment
Specialty Drugs (up to a 30-Day Supply) filled through CommonSpirit Specialty Pharmacy, or at any CommonSpirit Health owned pharmacy	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$40 Copayment

Covered Drugs and Supplies	Network
*90-day maintenance medications can be filled at a CommonSpirit Pharmacy, with Optum Home Delivery or at any network retail pharmacy for three times the 30-day copayment. Note: When you use a drug manufacturer copay card for a Specialty Drug, that Specialty Drug may be subject to a new Copayment. This new Copayment will not impact the price you pay for the Specialty Drug and you will still benefit from using the drug manufacturer copay cards to reduce the Out-of-Pocket cost that you pay for the Specialty Drug. The drug manufacturer copay card dollars utilized to pay for the Specialty Drug will not count towards your Out-of-Pocket limit. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
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.	
Refer to the Prescription Drug section for details on the Prescription Drug benefit.	

DHMP Ventura EPO R 1 Plan PRESCRIPTION DRUG SCHEDULE OF BENEFITS	
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 Capital Rx. Contact Capital Rx Customer Service Department toll- free at (844) 306-6901 for details.	
Any one retail or specialty Pharmacy prescription or refill is limited to a 30-day supply. The Retail 90 Network will allow up to a 90-day supply. Any one home delivery prescription or refill is limited to a 90-day supply. Some covered Prescription Drugs are subject to quantity limits, prior authorization, and/or step therapy. During the year, your prescription may change from the Formulary to the non-formulary or vice versa. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
Prescription Drug Out-of-Pocket Maximum	**$3,850 per Individual / $4,700 per Family**
Prescription Drug Out-of-Pocket limit does not apply to Medical Out-of-Pocket amounts. 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.	
Prescription Drug Benefits (Capital Rx)	
Note: You must pay applicable Copayments. The Plan pays the balance of Maximum Allowable Charge. Copayments per prescription:	

Covered Drugs and Supplies	Network
Retail Pharmacy (30-Day Supply)*	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$40 Copayment
Home Delivery (90-Day Supply)	
Tier 1 – Generic and some Brand Name Drugs	$25 Copayment
Tier 2 – Preferred Brand Name Drugs	$50 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$100 Copayment
Specialty Drugs (up to a 30-Day Supply) filled through CommonSpirit Specialty Pharmacy, or at any CommonSpirit Health owned pharmacy	
Tier 1 – Generic and some Brand Name Drugs	$10 Copayment
Tier 2 – Preferred Brand Name Drugs	$20 Copayment
Tier 3 – Non-Preferred Brand Name and Generic Drugs	$40 Copayment

Covered Drugs and Supplies	Network
*90-day maintenance medications can be filled at a CommonSpirit Pharmacy, with Optum Home Delivery or at any network retail pharmacy for three times the 30-day copayment. Note: When you use a drug manufacturer copay card for a Specialty Drug, that Specialty Drug may be subject to a new Copayment. This new Copayment will not impact the price you pay for the Specialty Drug and you will still benefit from using the drug manufacturer copay cards to reduce the Out-of-Pocket cost that you pay for the Specialty Drug. The drug manufacturer copay card dollars utilized to pay for the Specialty Drug will not count towards your Out-of-Pocket limit. You may call Capital Rx Customer Service at (844) 306-6901 with any questions about your Prescription Drug Benefits.	
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.	
Refer to the Prescription Drug section for details on the Prescription Drug benefit.	

MEDICAL BENEFITS AND EXCLUSIONS

Medical Benefits

These medical benefits will be payable as shown in the Summary of Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

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 fetus were to be carried to term.

Advanced Imaging. Charges for advanced imaging including: Computed Tomography (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

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

Air Ambulance (Emergency Only).

Benefits are provided for air ambulance transportation only if the Plan Administrator determines that the Participant's condition, the type of service required for the treatment of the Participant's condition, and the type of facility required to treat the Participant's condition justify the use of air ambulance instead of another means of transport. This Plan will only cover air ambulance transportation when no other method of transportation is appropriate (including emergency ground transport).

This Plan will cover rotary and fixed wing aircraft for air ambulance services.

Only charges Incurred for the first trip to a Hospital, or from one Hospital to another Hospital, shall be included.

The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available water and rail transportation, to a local Hospital, or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

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.

Aquatic Therapy. Services provided in an aquatic setting including water therapy, aquatic rehabilitation, aqua therapy, pool therapy, therapeutic aquatic exercise or hydrotherapy.

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:

1. Behavioral health treatment – that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a Covered Person.
2. Counseling and treatment programs by a licensed Provider, and
3. 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.

1. Psychiatric care by a licensed psychiatrist;
2. Psychological care by a licensed psychologist;
3. Medical care provided by a licensed Provider;
4. 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; and
5. 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.

Biofeedback. Biofeedback for urinary incontinence rendered by a practitioner in an office or facility setting via physical therapy, only when determined to be medically necessary.

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Cataracts. Cataract surgery and one set of lenses (contacts or frame-type) following the surgery.

Chemotherapy. 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).

Chiropractic Care. Spinal manipulation/chiropractic services by a licensed Doctor of Chiropractic (D.C.). 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. See the Schedule of Benefits for limitations.

Christian Science Practitioners. Services provided by a Christian Science Practitioner.

Class III Obesity. Charges related to Class III obesity (BMI is equal to or greater than 40.0 kg/m²), only when the treatment meets the Plan's Medical Necessity criteria. To include surgical treatment, non-surgical treatment, and complications from such treatment.

Clinical Trials. 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:

1. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
2. The National Institute of Health.
3. The U.S. Food and Drug Administration.
4. The U.S. Department of Defense.
5. The U.S. Department of Veterans Affairs.
6. 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:

1. 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.
2. 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.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. 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.

Contraceptives. The charges for all Food and Drug Administration (FDA) -approved, -granted, or -cleared contraceptives methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *Oral contraceptives are covered under the Prescription Drug Benefits section*.

Dental Services—Accident Only. Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

NOTE: *No charge will be covered under this Plan for dental and oral Surgical Procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.*

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

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:

1. Blood glucose monitors (standard) and blood glucose monitors for the visually impaired;
2. Test strips for glucose monitors, visual reading and urine testing, lancets and automatic lancing devices;
3. Injection aids;
4. Cartridges for the legally blind;
5. Syringes;
6. Data management systems;
7. 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:

1. Insulin;
2. Oral agents to control blood glucose;
3. Syringes;
4. 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:

1. 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;
2. 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;
3. 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 Tests, X-ray, Laboratory Services and Examinations. 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:

1. Diagnostic radiology, ultrasound, nuclear medicine, and necessary supplies.
2. Diagnostic medical services such as cardio graphic and encephalographic testing, radio isotopic studies and other procedures which may be approved when performed and billed by a Physician or covered facility.
3. Pathology tests (laboratory tests) when performed, billed for or ordered by a Physician or covered facility.
4. Coverage includes separate Physician's charges for interpretations of covered diagnostic services given by a Hospital, Skilled Nursing Facility or other covered facility.
5. Charges for the following will not be included in this section:
6. Premarital exams;
7. Routine physical exams;
8. X-ray therapy or chemotherapy; or
9. 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.

The following may be covered, when Medically Necessary:

1. Oxygen and supplies for its administration and appropriate for self-care home use.
2. Assistive communication devices.
3. Enteral feedings and formulas (see Food Products and Nutritional Supplements).

Food Products. 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.

The prescribing healthcare Provider must state in writing that the oral enteral formula is clearly Medically Necessary and has been proven effective as the disease-specific regimen for those individuals who are or will become malnourished or who suffer from disorders, which left untreated, cause chronic disability, intellectual disability or death. These specific diseases include, but are not limited to, aminoacidopathies, gastric motility disorders such as chronic intestinal pseudo-obstruction and multiple severe food allergies that if left untreated will cause malnourishment, chronic physical disability, intellectual disability, or death.

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). Diabetic shoes are covered. Medically Necessary, custom-molded foot Orthotics will be covered.

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.

Glaucoma. Treatment of glaucoma.

Habilitative Services and Therapies. These services include:

1. **Applied Behavior Analysis (ABA) Therapy.** Charges for ABA therapy.
2. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
3. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
4. **Speech-Language Pathology.** Treatment for speech delays and disorders.

See the Summary of Benefits for treatment and/or frequency limitations.

Hearing Exam. Benefits are available for a hearing exam.

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. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury 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. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.

4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

Hospice Care. Charges relating to hospice care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered hospice expenses are limited to:

1. Room and Board for confinement in a hospice.
2. Ancillary charges furnished by the hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.
10. Bereavement counseling, which is a supportive service provided by the hospice team to Participants in the deceased's Family Unit after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

    a. On the date immediately before his or her death, the terminally ill person was in a hospice care program and a Participant under the Plan.
    b. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The hospice care program must be renewed in writing by the attending Physician every 30 days. Hospice care ceases if the terminal Illness enters remission.

Hospital. 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.

1. Inpatient Hospital Care. The medical services and supplies furnished by a Hospital or a Birthing Center.

    a) The Maximum Allowable Charges for room and board are payable as described in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.
    b) 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 75% 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.
    c) Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

d) Room charges made by a Hospital having only private rooms will be paid at 75% of the average private room rate.
e) Charges for a private room will be covered if a private room is deemed to be Medically Necessary.
f) 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.

2. Clinic Services or Supplies.
3. Outpatient Emergency Medical Condition Care.
4. Outpatient Surgical Care.
5. Other Outpatient Services and Supplies such as prescription medication, vaccines, and biologicals, and supplies in conjunction with diagnostic and therapeutic services, and their administration.

Implantation of a Penile Prosthesis. Services and supplies associated with the implantation of a penile prosthesis, when medically necessary for individuals who have not responded to intracavernosal injection, intra-urethral medications, a vacuum constriction devise and oral medications, or such treatment is not acceptable to the individual or his partner and who meet criteria as defined by the Anthem Blue Cross Clinical UM Guideline SURG-12 Penile Prosthesis Implantation. 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.

In-Hospital/Facility Physician 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:

1. A charge for care not rendered in the presence of a Physician; or
2. 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.

Infertility Testing For Diagnosis. Charges for care, supplies, and services for the diagnosis of infertility.

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.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

Medical Foods. Medical foods are considered a Covered Expense if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

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:

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

Mental Health and Substance Use Disorder Benefits. Covered Charges will include Medically Necessary care, supplies and treatment of Mental Disorders and Substance Use 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 Mental Health 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 Mental Treatment
Covered Charges for care, supplies and treatment of Mental Disorders will be limited as follows:

1. Psychological testing.
2. Partial Hospitalization is covered.
3. Comprehensive psychiatric emergency programs performed on an outpatient basis.
4. Intensive Outpatient Program treatment is covered.
5. 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.
6. 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.

Covered Charges for care, supplies and treatment of Substance Use Disorders will be limited as follows:

Inpatient Substance Use Disorder 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.

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

Outpatient Substance Use Disorder 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.

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

Midwife Services. Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

Newborn Care. This 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, go to MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Counseling. Charges for nutritional counseling for the management of a diagnosed eating disorder.

Nutritional Supplements, Vitamins, and Electrolytes. Benefits are available 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.

Oral Surgery. 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:

1. 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.
2. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth within one year of the Injury.
3. Excision of benign bony growths of the jaw and hard palate.
4. External incision and drainage of cellulitis.
5. Incision of sensory sinuses, salivary glands or ducts.
6. Surgical procedure for those covered conditions directly affecting the upper or lower jawbone or associated bone joints.
7. 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.
8. 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.
9. 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.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

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

1. Performed on an outpatient basis within 14 days before a Hospital confinement;
2. Related to the condition which causes the confinement; and
3. 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.

Pregnancy Expenses. Expenses attributable to Pregnancy. Pregnancy expenses of Dependent Children are covered. Benefits for Pregnancy expenses are paid the same as any other Illness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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). 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). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

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, 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 the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

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. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraception methods and contraceptive counseling.

7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Private Duty Nursing. Benefits are available for the private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

1. Inpatient Nursing Care: Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
2. Outpatient Nursing Care: Outpatient private duty nursing care is not covered.

Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic benefits are available for the following services:

1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. The plan will pay for other medically necessary prosthetic devices, including:
    a. Surgical implants;
    b. Artificial limbs or eyes;
    c. The first pair of contact lenses or eye glasses when required as a result of a covered Medically Necessary eye surgery;
    d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
    e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

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. Coverage is available for Orthotic appliances which have been outgrown. Custom-made foot Orthotics are covered, when Medically Necessary.

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. 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.

Rehabilitative Services and Therapies. Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Autism Spectrum Disorder Treatment.** Charges for treatment of Autism Spectrum Disorder (ASD).
2. **Cardiac Therapy.** Benefits are available for cardiac rehabilitation if deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
3. **Cognitive Therapy.** Charges for cognitive therapy.

4. **Occupational Therapy.** Benefits are available for occupational therapy by a licensed 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.
5. **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.
6. **Respiratory and 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.
7. **Speech Therapy.** For the treatment necessary to correct a speech impairment resulting from disease trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function. Services must be rendered by a licensed speech therapist and ordered by a Physician.

See the Summary of Benefits for treatment and/or frequency limitations.

Routine Patient Costs for Participation in an Approved Clinical Trial. 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:

1. The clinical trial is approved by any of the following:

    1. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    2. The National Institute of Health.
    3. The U.S. Food and Drug Administration.
    4. The U.S. Department of Defense.
    5. The U.S. Department of Veterans Affairs.
    6. 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.

2. 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 Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Second Surgical Opinions. Charges for second surgical opinions.

Sexual Dysfunction Therapy or Surgery. Related to sexual dysfunctions.

Skilled Nursing Facility (SNF) Care. Charges made by a Skilled Nursing Facility or a convalescent care facility as defined in the Plan, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury for which the Participant is confined. For information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Use Disorder Benefits" in the Medical Benefits section above.

Inpatient SNF Services
The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

1. The patient is confined as a bed patient in the facility;
2. The attending Physician certifies that the confinement is needed for further care;
3. 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 Schedule 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.

Sterilization. All Food and Drug Administration (FDA) approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA).

Surgical Treatment of Jaw. Surgical treatment of Illnesses, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

Surgical Charge Benefits. Charges for the following surgical services:

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:

1. 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;
2. 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:

1. Reconstruction of the breast on which a mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3. Coverage of Prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Telehealth or Telemedicine. Advice or consultation given by or through any form of telecommunication, other than a provided by LiveHealth Online or a Telehealth/Virtual Visit claim submitted by the member's Physician. Registration is required and consultations are available via video visits from a smartphone, table 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 the time of service.

Tobacco Use Disorder and/or Nicotine Dependency. Tobacco and nicotine dependence screening, counseling, nicotine withdrawal programs, facilities, Drugs or supplies.

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 Medically Necessary, non-investigational human organ and tissue transplants for Covered Participants under this Plan, subject to all Plan limitations and maximums.

Transplants must meet the coverage criteria established by the Centers for Medicare & Medicaid Services (CMS). Procedures that are considered investigational or that do not meet applicable Medicare coverage criteria established by the Centers for Medicare & Medicaid Services (CMS) are not covered under this Plan. If CMS restricts a transplant procedure to designated or approved Hospitals, coverage under this Plan will be limited to those Hospitals.

Covered Transplant Procedures
The following human-to-human organ or tissue transplant procedures may be Covered Services when Medically Necessary and not investigational for the patient's specific condition:

- Cornea
- Kidney
- Bone marrow
- Peripheral stem cell infusion
- Heart valve
- Musculoskeletal tissue
- Parathyroid
- Heart
- Lung
- Heart/Lung
- Liver
- Pancreas
- Small bowel
- Pancreas/Kidney
- Tissue transplants

Coverage for transplant-related services includes, but is not limited to:

- Pre-transplant evaluation and testing
- Diagnostic tests and imaging performed by the transplant Hospital
- Procurement, tissue harvest, and preparation of the donor organ
- Removal of the organ from the donor
- Transplant surgery and recovery
- Post-discharge care
- Transportation of the donor organ to the transplant facility, limited to transportation within the United States or Canada

Benefits are available for both inpatient and outpatient services related to the transplant surgery.

Recipient Expenses
If you are the recipient of a covered transplant, the Plan will provide benefits for Medically Necessary services related to the transplant as described above.

Donor Expenses
Benefits may also be available for expenses incurred by a live donor related to the procurement of an organ when:

- the transplant recipient is a Covered Person under this Plan, and
- the donor has no other medical coverage available from any source for those services.

Donor expenses will be treated as part of the recipient's claim and will be limited to services deemed Medically Necessary to perform the transplant.

Coverage for the donor will not extend beyond the donor's discharge from the Hospital following the transplant procedure.

Donor charges and donor search charges will be deemed incurred on the date of the transplant, even if the services were provided before that date.

No benefits will be paid for pre-transplant testing performed in connection with a search for a donor who is not a family member.

Autologous Bone Marrow / Stem Cell Procedures
High-dose chemotherapy or radiotherapy followed by autologous bone marrow transplantation, stem cell rescue, or other hematopoietic support procedures are not covered as organ or tissue transplants except for the following conditions when they meet applicable CMS coverage guidelines and established national health and age standards:

- Acute leukemia in remission
- Resistant non-Hodgkin's lymphoma
- Hodgkin's disease
- Neuroblastoma

If CMS coverage guidelines change to add or remove coverage for these procedures, this Plan will follow those CMS determinations.

Recipient and donor expenses for covered procedures will be considered on the same basis as other covered organ transplants under this section.

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. Urgent Care Facility services are only covered by the plan if services are provided by a network Provider or a Provider who is part of the Anthem Blue Cross PPO Network.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Abortion. For or related to an abortion, except where the life of the mother is endangered by the continued Pregnancy or for medical complications that arise from an abortion.

Acupuncture. Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Cell Therapy. Expenses related to cell therapy unless otherwise stated as covered.

Dental Care. For normal dental care benefits, including any dental, gum treatments, or oral surgery, except as otherwise specifically provided herein.
Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Food Supplements. Food supplements are not covered by the Plan, unless otherwise provided for in this document.

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).

Gender Affirmation Treatment. All gender affirmation treatments and services for individuals who have not been diagnosed with gender identity disorder or Gender Dysphoria and any gender affirmation treatment or service (or portion thereof) that is not Medically Necessary.

Gene Therapy. Expenses related to gene therapy unless otherwise stated as covered.

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.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness.

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. For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

Hypnosis. Related to the use of hypnosis.

Immunizations. For immunizations and vaccinations for the purpose of travel outside of the United States.

Impregnation and Infertility Treatment. Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

Learning & Behavioral Disorders. Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

Massage Therapy. Charges related to massage therapy.

Nutritional Counseling. Charges for nutritional counseling that are not for the management of a diagnosed eating disorder.

Nutritional Supplements. Charges for nutritional supplements, unless prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition or are part of a chemotherapy regimen.

Obesity. Charges for weight control, weight loss or weight reduction surgery, including prescribed medications, food supplements, diet pills and vitamins, except as covered under the Preventive Care benefit. Medically necessary charges for Bariatric Procedures for Morbid Obesity will be covered as stated in the Schedule of Benefits section under Bariatric Surgery and Gastric Bypass Surgery.

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

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Osseous Surgery. For osseous surgery.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.

Psychiatric Care. Psychiatric care/chemical dependency benefits do not include telephone psychiatric consultations or testing for intelligence or Learning Disabilities, unless otherwise indicated as covered elsewhere in this Medical Plan Document.

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. 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.
2. 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.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. 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.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sterilization Reversal. For sterilization procedure reversal.

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.

Telehealth, Telemedicine, or Telecommunication. Advice or consultation given by or through any form of telehealth, telemedicine, or telecommunication, other than a provided by LiveHealth Online or a Telehealth Virtual Visit claim submitted by the member's Physician.

Temporomandibular Joint (TMJ) Disorder. For the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein.

Vision Care. Expenses for the following:

1. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
2. For refractive procedures or other plastic surgeries to correct vision in lieu of eyeglasses.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Vitamins. For vitamins, except as specified under Preventive Care.

Weight Control. Weight reduction surgery reversals or weight reduction programs of any sort, including prescribed medications.

Wigs. Benefits do not cover wigs for any reason.

Wilderness. Wilderness or other outdoor camps and/or programs. - Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the claims administrator.

1. Educational or Academic Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
2. Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice Unit, Skilled Nursing Facility or residential treatment center.

This exclusion includes procedures, equipment, services, supplies or charges for the following:

1. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
2. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

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 AND EXCLUSIONS

The out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Calendar Year, including the Copayments.

When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Covered Expenses for the individual or the individual and his or her Dependents for the remainder of the Calendar Year.

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments will not apply after the out-of-pocket maximum has been reached.

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. Capital Rx is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order 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 the volume buying, Capital Rx, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The Copayment is applied to each charge and is shown on the Summary of Benefits, above. The Copayment amount applies toward the medical plan out-of-pocket maximum.

Covered Expenses

The following are covered under the Plan:

Acne Control. Drugs that help manage the severity and frequency of acne outbreaks that cannot be purchased over-the-counter.

Bee Sting Kits. Charges for EpiPen and Ana Kit.

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

Contraceptives. All Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines.

Diabetes. Insulins, oral agents to control blood glucose, syringes, and test strips.

Imitrex Injection. Charges for Imitrex injections (migraine auto-injector).

Immunizations. Immunization agents, biological sera, and immunologicals (vaccines).

Impotency. A charge for impotency medication, including Viagra.

Injectables. A charge for injectables.

Legend Drugs.

1. Class V Drugs.
2. Diabetic Supplies.

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches.

Vitamins. Vitamins.

Limitations

The benefits set forth in this section will be limited to:

Dosages.

1. With respect to the Pharmacy Option, any one prescription is limited to a 30 day supply.
2. With respect to the Mail Order Option, any one prescription is limited to a 90 day supply.
3. With respect to the Specialty Drug Option, any one prescription is limited to a 30 day supply.

Refills.

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

Exclusions

In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:

Administration. Any charge for the administration of a covered Drug.

Allergy Sera. Charges for allergy sera.

Anorexiants. Anorexiants (weight loss Drugs).

Anti-Aging Products. Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter.

Appetite Suppressants/Dietary/Vitamin Supplements. A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription multivitamins including those with fluoride or iron, or otherwise required by ACA guidelines.

Consumed Where Dispensed. 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, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.

Drug Efficacy Study Implementation (DESI) Drugs. Charges for DESI Drugs.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant.

Fertility Agents. Charges for fertility agents.

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to Investigational use".

Legend Drugs.

1. Diagnostics.
2. Legend Drugs with over-the-counter equivalents.

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies.

No Charge. A charge for drugs which may be properly received without charge under local, State or Federal programs.

Non-Insulin Syringes/Needles. Charges for non-insulin syringes and needles.

Non-Prescription Drug or Medicine. A drug or medicine that can legally be bought without a prescription, except for injectable insulin.

Over-the-Counter Drugs. Charges for over-the-counter drugs, except to the extent required by the Affordable Care Act, as amended:

1. Class V Drugs.
2. Diagnostics.
3. Medical Devices and Supplies.
4. Pre-natal vitamins.
5. Vitamins.

Rogaine. Charges for Rogaine (topical minoxidil).

Steroids. Anabolic steroids.

Initial Appeal to Capital Rx
Within 180 days after you receive notice of a denial or partial denial, forward your appeal to the Claims Administrator.

The appeal must be in writing and must include the following information:

1. Name
2. Address
3. Daytime Phone Number
4. Group and ID Number
5. Provider Name and Date of Service
6. A clear statement that the communication is intended to appeal an Adverse Benefit Determination or Adverse Coverage Determination

The appeal should be sent by U.S. mail or fax to:

Capital Rx
Attention Appeals Department
9450 SW Gemini Dr., #87234
Beaverton, OR 97008
Phone: (888) 832-2779
Fax: (833) 434-0563

UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission pre-certification, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

Services that Require Pre-Certification

Pre-certification of Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided by Anthem (complete list is available upon request).

1. Air Ambulance.
2. Diagnostic Testing.
3. Durable Medical Equipment.
4. Home health care.
5. Hospitalizations.
6. IV Infusion Therapy.
7. Medical/Surgical Supplies.
8. Mental Disorder inpatient admissions.
9. Cardiac Rehabilitation/Therapy, Neuromuscular Therapy, Occupational Therapy, Physical Therapy, Respiratory/Inhalation Therapy and Speech Therapy visits over the limits in the Summary of Benefits*.
10. Orthotics.
11. Physical Rehabilitation Facility stays.
12. Prosthetics.
13. Skilled Nursing Facility stays.
14. Substance Use Disorder inpatient admissions.
15. Surgery, including Gender Affirmation Treatment surgeries.
16. Transplants, including but not limited to organ and stem cell transplants.
17. Weight reduction surgical procedures.

*If it is determined upon a medical director's review that a member is demonstrating continued progress toward measurable therapeutic goals, then additional therapies may be approved beyond the maximum of 24 visits per calendar year, per incident and combined with all other therapies. Additional therapy must have a Physician's order, be prior authorized and approved by the Plan.

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. This does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Pre-Certification Procedures and Contact Information

The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that services requiring Pre-Certification are needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-800-274-7767. The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant or an individual acting on behalf of the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:
For Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Outpatient Services:
A Participant is required to contact the pre-certification department when the Physician requests certain Outpatient procedures and services. The Summary of Benefits and the "Services that Require Pre-Certification" provision indicate which Outpatient procedures and services require Pre-Certification.

Retrospective Review
The Plan allows a review of the Medical Necessity of the health care services provided on an Emergency basis, after they have been provided. Retroactive Pre-Certification is allowed for medical non-Emergency care situations up to 90 days after the date of service without a penalty.

Alternate Course of Treatment
Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically

Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing
If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid. Benefits are available as outlined in the Summary of Benefits, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second Surgical Opinion
If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer toe repair.
8. Hemorrhoidectomy.
9. Herniorrhaphy.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay the Maximum Allowable Charge Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician. Benefits are available as outlined in the Summary of Benefits. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the

second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Pre-Surgical Approval
The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical Procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty.
2. Blepharoplasty.
3. Breast reduction or enlargement.
4. Dermabrasion.
5. Facial or nasal reconstruction.
6. Gastric bypass.
7. Lipectomy.
8. Penile implant.
9. Scar revision.
10. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical Procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information. Pre-surgical approval is not a guarantee of coverage.

Behavioral Health. Providers should call Anthem Behavioral Health for all mental health and substance abuse services requiring prior authorizations, including inpatient and intensive outpatient care.

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
Case management is a preemptive coordination of a Participant’s care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. 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.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-415-438-5500.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI without individual authorization in the minimum necessary amount only if the use or disclosure is for a Treatment, Payment, or Health Care Operations purpose as defined by HIPAA. For example, the Plan may use or disclose the Participant's PHI in the following ways:

1. To help manage the health care treatment the Participant receives: The Plan can use the Participant's PHI and share it with professionals who are treating the Participant. **Example:** A doctor sends the Plan information about your Diagnosis and treatment plan so the Plan can arrange additional services.

2. For health care operations: The Plan can use and disclose the Participant's PHI to run the Plan and may contact the Participant when necessary. **Example:** The Plan uses PHI about the Participant to develop better services for the Participant.
3. To carry out payment of benefits. **Example:** The Plan discloses PHI to other payers to coordinate benefits.
4. To administer the Plan. **Example:** The Plan discloses PHI to the Plan Sponsor to perform administrative functions and make coverage decisions.
5. If the use or disclosure falls within one of the other limited circumstances described in the rules. **Example:** The Plan makes a disclosure which is required by law or for public health activities.

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.

6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

VP National Privacy Officer/Corporate Responsibility
CommonSpirit Health
lori.lamb@commonspirit.org

HIPAA Security

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant’s PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan’s compliance with the HIPAA Privacy Rule.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, the Participant is entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About the Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Participant's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Participant's rights under ERISA.

Enforce the Participant's Rights

If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with the Participant's Questions

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

Other Plan Provisions

Additional information, shown below, can be found in the Dignity Health *FlexAbility* Summary Plan Description (SPD) which is located on MyBenefits at home.commonspirit.org/employeecentral/mybenefits.

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