

USC Verdugo Hills Hospital

Part of Keck Medicine of USC

Summary Plan Description and Plan Document

Medical and Prescription Benefits

RESTATED EFFECTIVE: January 1, 2019

The benefits described in this SPD are part of the Verdugo Hills Hospital Employee Group Medical Benefit Plan (#501); this plan is based on a January 1 – December 31 plan year. This Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act), as explained herein.

USC Verdugo Hills Hospital (“USC VHH”, the “Company” and the “Employer”) is proud to provide you with the following health care coverage:

- A **Medical** plan that provides benefits for preventive care, hospital stays, emergency room care and mental health/substance abuse treatment.
- When you enroll in the Medical plan you are also enrolled for **Prescription** benefits plan, for both short-term and long-term prescription medications.

This Summary Plan Description (SPD) is divided into three sections:

- **Eligibility and Enrollment Information** explains how to enroll for benefits, your cost for coverage and when you can change your or your dependents’ coverage.
- **Description of Benefits** covers the major features of the medical and prescription benefit plans, as well as limitations and/or exclusions of the plans.
- **General Facts** discusses how to apply for benefits, situations that may affect your benefits, how the plans operate and your legal rights under the plan.

Take time to read this material carefully and share it with your family. If you have any questions about your coverage, contact your Human Resources representative.

Note: The standards for coverage of medical expenses change from time to time. To the extent required by law, you will receive periodic notices of important changes or modifications to the plans. All changes to covered benefits are binding.

Solicitud De Informacion En Español

Este documento está escrito en inglés y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuníquese con los administradores de la: USC Verdugo Hills Hospital, 1812 Verdugo Boulevard, Glendale, CA 91208.

El horario de la oficina es: las ocho de la mañana hasta las cuatro de la tarde, lunes a viernes. Ud. también puede llamar a la oficina del administrador del plan de seguro a estos teléfonos: 1-818-952-4727, para pedir ayuda.

Foreign Language Assistance: Notice to Spanish Speaking Plan Participants

This document is written in English and continues in resume of your rights and benefits of your plan insurance. If you have difficulty in understanding any parts of this document, please communicate with the administrators at the following:

- **USC Verdugo Hills Hospital:** (818) 952-4727
- **HealthComp Administrators:** (800) 442-7247

GRANDFATHERED HEALTH PLAN STATUS

This Plan believes that the group health plan coverage provided under the Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other health plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator (see address under **Directory of Service Providers**). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he has a question or needs help.

IMPORTANT CONTACTS		
Prior Authorizations	Anthem Blue Cross	(800) 274-7767
Plan Coverage Questions	HealthComp	(800) 442-7247 www.healthcomp.com
Claim Questions	HealthComp	(800) 442-7247 www.healthcomp.com
Find a Participating Network Provider	Tier 1 Providers: Keck Medicine of USC USC Care Medical Group	Trojan Family Navigator: (323) 876-5267 www.keckmedicine.org
	Tier 2 Providers: Anthem Blue Cross of California	(800) 888-8288 www.anthem.com/ca
Prescription/Pharmacy Questions	US Script	(800) 460-8988 www.usscript.com
Vision Coverage	Vision Service Plan	(800) 877-7195 www.vsp.com
Keck Medicine at UPC	Keck Medicine of USC - UPC	(213) 821-6500
Keck Medicine at Downtown L.A.	Keck Medicine of USC - Downtown L.A.	(323) 442-8102
USC Care Medical Group	USC Care	(800) 872-2273
Lifestyle Redesign Program	USC Occupational Therapy	(323) 442-3340

Eligibility & Enrollment Information

ELIGIBILITY

EMPLOYEE ELIGIBILITY REQUIREMENTS

To be eligible for coverage under this Plan, you must be:

- a United States resident, and
- in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel), and regularly scheduled to work on a non-per diem basis for at least thirty (30) hours per week, or
- regularly scheduled to work on a non-per diem basis for at least twenty-four (24) hours per week as a member of the USC Care Emergency Department Support Staff.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified. *Note: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.*

ACTIVE EMPLOYMENT

An Employee will be deemed in active employment on:

- each day he is actually performing services for the Employer,
- on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day, and
- any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see *Non-Discrimination Due to Health Status* in the **General Plan Information** section).

An exception to this deeming applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment or deemed to be in active employment.

DEPENDENT ELIGIBILITY REQUIREMENTS

An eligible Dependent of an Employee is:

- **A legally married spouse.** A "spouse" will mean a person to whom the Employee is legally married. "Legally married" means a legal union as defined under applicable law, including, but not limited to IRS Rev. Rul. 2013-17.
- **A registered domestic partner** when the partner and Employee meet the following qualifications:
 - an opposite-sex partnership with one or both partners **over the age of 62** as long as they are registered with the Secretary of State of the State of California or their residing County of the State of California.
 - an opposite-sex partnership with both partners **under the age of 62** as long as they are registered with the Secretary of State of the State of California or their residing County of the State of California.

- a same-sex partnership **over the age of 18** as long as they are registered with the Secretary of State of the State of California or their residing County of the State of California.
- **A child up to age 26.** For these purposes a "child" will include:
 - a natural child,
 - a stepchild,
 - a child placed under the court-appointed legal guardianship of the Employee or the Employee's spouse,
 - a child who is adopted by the Employee or placed with the Employee for adoption. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun, and/or
 - a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge from the Plan Administrator). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA. A child who is the subject to a QMCSO need not be a Tax Code dependent of the Employee.
- **A disabled child age 26 or older** disabled children after age 26, as long as he/she is:
 - unmarried,
 - primarily dependent on the employee for support, and
 - continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADA):
 - a physical or mental impairment that substantially limits one or more major life activities of such individual,
 - a record of such impairment, or
 - being regarded as having such impairment.

In accordance with ADA, the term disability shall **not** include:

 - transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments or other sexual behavior disorders,
 - compulsive gambling, kleptomania or pyromania, or
 - psychoactive substance use disorders resulting from current illegal use of drugs.

PROOF OF DEPENDENT STATUS

You may be required to provide the following proof that a spouse or child is a dependent (i.e., certified marriage license, birth certificate, etc.).

For disabled children, proof must be provided to the Contract Administrator within 31 days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age. In addition, the Company reserves the right to have any such dependent examined by a physician of the Company's choice, at the plan's expense, to determine the existence of such incapacity.

Important: USC Verdugo Hills Hospital reserves the right to terminate coverage, on a retroactive basis, if there is an intentional misrepresentation of dependent status; for additional information, see *Termination for Fraud* under the *Termination of Coverage* section.

NON-ELIGIBLE INDIVIDUALS

The following individuals are not eligible:

- a grandchild of a covered employee or spouse, unless the grandchild meets the definition of eligible dependent under a legal guardianship designation,
- a spouse following a:

- court order as part of a legal separation that specifies termination of health care benefits, or
- final decree of dissolution or divorce,
- any person who is on active duty in a military service, to the extent permitted by law,
- any person who resides outside of the United States,
- any person who is covered as a Dependent of another USC Verdugo Hills Hospital Employee.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

WHEN YOU CAN ENROLL AND EFFECTIVE DATE OF COVERAGE

The following chart outlines when you and your dependents can enroll for benefits, as well as when coverage begins (Effective Date of Coverage):

When You Can Enroll	Effective Date of Coverage
New Hire	On the first day of active employment in an eligible status if you complete and return the enrollment form within 31 days of the effective date.
During the Year , if you have a qualifying: <ul style="list-style-type: none"> ▪ change in status event, or ▪ event that provides you with special enrollment rights <p>See <i>Changing Elections During the Year</i> for details</p>	The date of your qualifying event if you complete and return the enrollment form within 31 days of the event. <i>Note: A non-benefits eligible employee working less than twenty-four (24) hours per week or thirty (30) hours per week, whichever is applicable to that employee, whose hours are increased to an eligible status, or a per diem employee who changes to an eligible status, will have coverage effective upon commencement of his eligibility if the employee enrolls within thirty-one (31) days of becoming eligible.</i>
Annual Open Enrollment	January 1 if you complete and submit all required documentation within the timeframe established for the Annual Open Enrollment period.
Dependents	A dependent who is eligible and enrolled when the employee enrolls, will have coverage effective on the same date. Dependents acquired later may be enrolled within 31 days of their eligibility date (see <i>Special Enrollment Rights</i> on for additional information-coverage will be effective on the date required under the HIPAA Special Enrollment rules). Otherwise, a dependent can be enrolled as described under <i>During the Year</i> . <i>Note: In no instance will a dependent's coverage become effective prior to the employee coverage effective date.</i>

As a new hire and during open enrollment, you will receive an enrollment form listing all of the plans for which you are eligible to enroll. When you experience a qualifying event, you must contact Human Resources to receive a status change form. Specific information about each enrollment opportunity is provided below and on the following pages.

DECLINING COVERAGE

If an Employee does not wish to participate in the Plan, he must decline coverage, in writing, by completing a waiver form. If neither an enrollment card nor a waiver card is submitted, a declination of coverage is assumed.

NEW HIRE

As a new hire, to receive the coverage you want, **you have 31 days from your date of hire to:**

- enroll yourself and your eligible dependent(s), and
- submit all required documentation.

If you **do not complete the entire process within 31 days of your hire date**, your next opportunity to enroll will be at open enrollment unless you experience a qualifying event during the year. An Employee or Dependent enrolled in and covered under the Plan is referred to as a “Covered Person.”

DURING THE YEAR

You may experience certain events during the plan year that would allow you to change your medical coverage but only if the change is “consistent” with the event under IRS rules and requirements, as determined by USC VHH. If such an event occurs, **you must change your benefit coverage within 31 days of the event.**

If you do not change your coverage within 31 days, your next opportunity to make a change will be during the annual open enrollment period.

There are two sets of regulations, established by the Federal government, that control the types of coverage changes you can make during a plan year. The regulations, as outlined on the following page, classify the changes as follows:

- **Change in Status Events** (as provided by the Internal Revenue Code). As a result of allowing you to pay for benefits on a before-tax basis, the government has established rules that control when you can change or enroll for coverage. Based on your situation, you may be able to:
 - **change** your coverage during the plan year (i.e., add or remove dependents to your existing coverage), or
 - **late enroll**, which refers to enrolling yourself and/or your dependents for coverage during the plan year, even though you declined coverage when you were first eligible or during a previous open enrollment period. **Note:** *You must enroll for coverage in order to enroll your dependents.*
- **Special Enrollment Rights** (as provided by the Health Insurance Portability and Accountability Act (HIPAA)). Under certain circumstances, even if you or your eligible dependents are not currently enrolled in a plan, the government requires that you and your eligible dependents be allowed to **late enroll** – enroll during the plan year even though you declined coverage when you were first eligible or during a previous open enrollment period. **Note:** *You must enroll for coverage in order to enroll your dependents.*

<p>Important: The information on the following page is a summary of when you can change coverage during the year; specific requirements and regulations can be found under Section 125 of the Internal Revenue Code.</p>

Changing Coverage During the Year

Change In Status Events: As provided by the Internal Revenue Code

Enrollment Requirements: You must change (enroll/drop) coverage **within 31 days** of the following events:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse/domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse/domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents, as described under *Who Is Eligible*, including age.
- A change in the place of residence or worksite of you or your spouse/domestic partner (**Note:** This move must affect your coverage options).
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- If the plan receives a decree, judgment or court order, including a QMCSO pertaining to your dependent, you may add the child to the plan (if the decree, judgment or court order requires coverage) or drop the child from the plan (if the ex-spouse/domestic partner is required to provide coverage).
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner's employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights: As provided by HIPAA

Enrollment Requirements:
You must change (enroll/drop) coverage within:

- | | |
|--|----------------------|
| <ul style="list-style-type: none"> ▪ You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan* | 31 days of the event |
| <ul style="list-style-type: none"> ▪ Occurrence of certain events such as birth, adoption, placement for adoption or marriage** | 31 days of the event |
| <ul style="list-style-type: none"> ▪ Eligibility for state premium subsidies under Medicaid or the Children's Health Insurance Program | 60 days of the event |
| <ul style="list-style-type: none"> ▪ Loss of coverage under Medicaid or the Children's Health Insurance Program | 60 days of the event |

* *Loss of coverage means:*

COBRA coverage has been exhausted for reasons other than non-payment of premiums or fraud, or loss due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.

** *There is no requirement that protected individuals in this category must have had other coverage prior to the existence of their special enrollment rights.*

ANNUAL OPEN ENROLLMENT

You can make new decisions about your and your dependent's insurance, once a year during the annual open enrollment period. Unless you experience an event that would allow you to change your coverage during the year, your new elections will become effective on January 1 and will remain in effect until December 31.

REINSTATEMENT / REHIRE

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage you may be entitled to coverage due to reinstatement/rehire in the following circumstances if you return to active employment and eligible status following an approved leave of absence in accordance with:

- The Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any Dependents who were covered at the point contributions ceased). The Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.
- the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage hereunder immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.
- COBRA Continuation Coverage, after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the COBRA Continuation Coverage, such person will be reinstated to active status and will have uninterrupted coverage hereunder. That is, a new waiting period requirement will not be applied and, in determining the Plan's preexisting condition limits, the Plan will take into account the period of time covered under this Plan and prior creditable coverage, if applicable.

Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

TRANSFER OF COVERAGE

If a husband and wife are both eligible Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

COVERAGE LIMITATIONS FOR PRE-EXISTING CONDITIONS

Pre-existing conditions are injuries or illnesses for which medical advice, diagnosis, care or treatment was recommended or received before your or your dependents enrollment date. **There are no pre-existing condition limitations under this plan.**

TERMINATION OF COVERAGE

For information about continuing medical benefits after termination, see *Extension of Coverage* and/or *COBRA Continuation Coverage*. **Important:** An employee or dependent otherwise eligible and validly enrolled under the plan shall not be terminated from the plan solely due to his/her health status or need for health services.

EMPLOYEE COVERAGE TERMINATION

An Employee's coverage hereunder will terminate at midnight on the last day of the month upon the earliest of the following:

- termination of the Plan or termination of these Plan benefits by USC VHH,
- termination of participation in the Plan by the Employee,
- the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than 31 days. See the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information,
- the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost),
- when the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section,
- the date the Employee dies, or
- the date selected by USC VHH, in its sole discretion

Important: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

DEPENDENT COVERAGE TERMINATION

A Dependent's coverage hereunder will terminate at midnight on the last day of the month upon the earliest of the following:

- termination of the Plan or discontinuance of Dependent coverage under these Plan benefits by USC VHH,
- termination of the coverage of the Employee,
- when the Dependent ceases to meet the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee,
- the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination, or
- the date selected by USC VHH, in its sole discretion, subject to applicable law, including, but not limited to, the Affordable Care Act.

TERMINATION FOR FRAUD

An individual's Plan coverage or eligibility for coverage may be terminated if:

- the individual submits any claim that contains false or fraudulent elements under state or federal law,
- a civil or criminal case finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law,
- an individual has submitted a claim which, in good faith judgment and investigation, he/she knew or should have known, contained false or fraudulent elements under state or federal law, or
- it is determined that the Employee or dependent intentionally misrepresented a material fact that resulted in:
 - enrolling a non-eligible dependent for coverage, or
 - failing to remove a non-eligible child for coverage.

In the situations outlined above, you or your dependent's coverage will terminate retroactively to the date of the initial fraudulent act. In addition, if a dependent's coverage is terminated as a result of fraud or intentionally misrepresentation of material fact, an Employee's employment may be in jeopardy; see the Verdugo Hills Hospital Policy and Procedure Manual for additional information.

Also see *Misstatement/Misrepresentation (Intentional)* under *Administrative Information* in the *General Facts* section.

EXTENSION OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date (as listed above and on the previous page) in the circumstances identified in this section. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases. For information about continuing medical benefits after an extension of coverage ends, see *COBRA Continuation Coverage*.

Important: An employee or dependent otherwise eligible and validly enrolled under the plan shall not be terminated from the plan solely due to his/her health status or need for health services. In addition, all extended coverage allowances will be provided on a non-discriminatory basis.

DURING ABSENCE FROM WORK

If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverage for himself and his dependents. *Note: The Employee may be required to pay the full cost of coverage during such absence.*

Leaves of absence fall into one of three different categories:

- Family and Medical Leave Act (FMLA),
- FMLA and Service members and
- All Others (Non-FMLA).

FMLA

To the extent that the Employer is subject to FMLA, it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period (except as noted otherwise). Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child,
- the placement of a child with the Employee for adoption or foster care,
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition,
- Employee's own serious health condition that makes him/her unable to perform the functions of his or her job, or
- the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. This information is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

FMLA AND SERVICE MEMBERS

An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties).

NON-FMLA

If a leave of absence is not taken in accordance with an FMLA provision, coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other employee communications, if any,
- the end of the period for which the last contribution was paid, if such contribution is required, or
- the date of termination of the Plan or these benefits of the Plan.

DURING U.S. MILITARY SERVICE

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

- **NOTICE REQUIREMENTS:** To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Sponsor will continue coverage for the first 30 days after Employee's departure from employment due to active military service. The Plan Sponsor will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled *Maximum Period of Coverage* (on the following page), then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back-premium charges from the date Plan coverage terminated.

- **COST OF USERRA CONTINUATION COVERAGE:** The Employee must pay the cost of coverage (herein premium). The premium may not exceed 102% of the actual cost of coverage and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan sponsor will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Sponsor will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back-premium charges owed.
- **MAXIMUM PERIOD OF COVERAGE:** The maximum period of USERRA continuation coverage is the lesser of:
 - 24 months, or
 - the duration of Employee's active military service.
- **REINSTATEMENT OF COVERAGE FOLLOWING ACTIVE DUTY:** Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less, or
- within 14 days of completion of military service for military leave of 31-180 days, or
- within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

YOUR COST

The Company pays a major portion of the cost required to provide medical coverage, including prescription benefits; you are responsible for paying a portion of the cost of coverage you elect, if any. Your share of the cost of the benefits you elect will be paid automatically through payroll deductions on a before-tax basis. The cost of each option is shown on your enrollment form and depends on:

- the plan you elect, and
- the number of dependents you enroll (i.e., the coverage tier you elect).

Your payroll deductions will begin when your coverage begins.

Please **review your paycheck** after you enroll to make sure that the appropriate deductions are being processed. If you have any questions, contact your Human Resources representative.

EFFECT ON OTHER BENEFITS

Paying for your benefits on a **before-tax** basis means that you pay no federal income or Social Security taxes, and in most cases no state taxes, on the amount deducted to pay the premiums. This method of payment may reduce your future Social Security benefits. Depending on the state in which you work, Unemployment or Worker's Compensation benefits may also be slightly reduced if you become eligible for them.

DOMESTIC PARTNER STATUS

In general, both the company and Employee's cost of providing domestic partner benefits is considered taxable income by the IRS. When an employee enrolls a domestic partner or the partner's child in company-sponsored health care plan, the employee's contribution and the company's contribution for that coverage are the same as for a spouse and spouse's child. However, due to IRS regulations, these contributions for domestic partners are taxable income and will be added to the employee's pay as additional wages. This will be reported on the employee's annual Form W-2 and increases the employee's taxable gross income for federal and state income taxes as well as for FICA (Social Security and Medicare) taxes withheld from paychecks. The amount of the additional taxable income depends upon the plan in which the employee is enrolled and the resulting level of coverage (employee/spouse, employee/child, family).

Description of Benefits

MEDICAL BENEFIT SUMMARY

NETWORK COVERAGE ONLY

In order to be covered by the Plan, ALL health care services must be received from approved providers and must satisfy all other requirements under the Plan. There are two choices of network providers (different benefit levels may apply):

- USC Verdugo Hills Hospital, Keck Medicine of USC, and USC Care Medical Group
- Anthem Blue Cross contracted providers.

The Plan Sponsor will provide a Plan participant, without charge, with information about how he can access directories of Network providers for his service area. The Anthem Blue Cross directories are available online; see the **Directory of Service Providers** for contact information.

WHEN A NETWORK PROVIDER CANNOT BE USED

In the following situations, when a network provider cannot be used, out-of-network provider services may, in certain circumstances, be covered at the in-network benefit levels as follows:

- **Emergency Care:** If a covered person requires care for a medical emergency and must use the services of an out-of-network provider, any such expenses will be paid at Anthem Blue Cross network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined below) until the patient's condition has been stabilized to the point that he/she could be transferred to a network provider. In the case of an emergency non-Network Hospital admission, once the patient is stabilized and able to be transferred to a Network Hospital, benefits will cease if the transfer does not immediately occur. However, the Plan reserves the right to determine benefits if the confinement is out of the area of any Network Hospital or if necessary services are not available at a Network Hospital.
- **No Choice of Provider:** If, while receiving treatment in a covered network facility, a covered person receives ancillary services from an out-of-network provider in a situation in which the patient has no control over provider selection (such as in the selection of an emergency room physician, an anesthesiologist or a provider for diagnostic services), such out-of-network services will be covered at the Anthem Blue Cross network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined below).
- **Out of Area:** If a Covered Person normally resides over thirty-five (35) miles from any Network provider, charges of a non-Network provider outside that thirty-five-mile distance will be covered at the Anthem Blue Cross Network provider benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined below).
- **Lab Referrals:** If a network provider submits a specimen to an out-of-network laboratory, such services will be covered at the USC VHH network benefit levels (of the Usual, Customary and Reasonable (UCR) rate as defined below). This exception will not apply if the covered person and/or the provider selected (or had the opportunity to select) a network provider and exercised the right to receive services from an out-of-network provider.

IMPORTANT:

In some rare instances, as determined by USC VHH in its sole discretion, services may be rendered when a Network provider is not available or able to render the required services. In such instances, the Plan reserves the right to negotiate costs and determine the benefit level on a case-by-case basis. The Plan also reserves the right to supersede Plan benefits and/or to negotiate separate provider contracts and to direct care when deemed appropriate.

USUAL, CUSTOMARY AND REASONABLE (UCR)

A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term area as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges. UCR will be determined by USC VHH and/or the Claims Administrator, in its, or their, sole discretion and all such determinations, will be final and binding.

With regard to charges made by a provider of service participating in the Plan's Network program, UCR will mean the provider's negotiated rate; however, it is not to exceed the actual charge or the Out-of-Network UCR allowance unless such lesser amount is not permitted under the terms of the Network agreement.

MEDICAL NECESSITY: DETERMINATION OF COVERED EXPENSES

Approval of a claim is subject to the determination of the medical necessity of provided services. Medical necessity is a broadly accepted professional term meaning services were essential to treatment of the illness or injury. Any health care treatment, service or supply, in order to be medically necessary must be:

- ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury,
- the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition,
- furnished by a provider with appropriate training and experience, acting within the scope of his or her license,
- provided at the most appropriate level of care needed to treat the particular condition,
- consistent with symptoms or diagnosis and treatment of the condition, disease, ailment illness or injury,
- appropriate with regard to standards of good medical practice,
- not primarily for the conveniences of the patient, the physician or other Provider, and
- the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient's medical symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

The Plan Administrator will determine whether the above requirements have been met based on:

- published reports in authoritative medical and scientific literature,
- regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS),
- listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*, and
- other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Your benefits are paid by taking the amount of covered expense for all medically necessary services, subtracting any applicable deductible and paying the remaining at the percentage payable, less any applicable copays, up to the benefit maximum. A covered expense is subject to the exclusions, conditions and limitations stated within this Summary Plan Description. Services and supplies must be ordered by a physician and be furnished by an eligible Provider and be medically necessary.

Important: The Company and/or the Claims Administrator has the final authority, in its sole discretion, to determine whether any benefit is covered under the plan, and its determinations are conclusive, final and binding on all participants and dependents. See the *General Facts* section for more information about filing claims and administration of the plan.

EXPENSES THAT ARE NOT MEDICALLY NECESSARY

The fact that a procedure or level of care is prescribed by a physician does not mean that it is a covered expense under the plan and shall not bind the Company in determining the liability under the plan. Services which are not reasonable and necessary shall include, but are not limited to, **procedures** that:

- are experimental, of unproven value or of questionable current usefulness,
- tend to be redundant when performed in combination with other procedures,
- are unlikely to provide a physician with additional clinical information when the procedures are used repeatedly, or
- can be performed with equal efficiency at a lower level of care.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

UTILIZATION MANAGEMENT PROGRAM (UMP)

Unnecessary medical care and hospital stays, or stays that last longer than necessary, cause medical costs to increase. Sometimes, individuals are hospitalized for procedures that can be performed safely, effectively and more comfortably in an alternative setting, such as a hospital's outpatient department or physician's office. As a result, the Company has contracted with an independent organization to provide:

- **MANDATORY: Certification** to approve medical necessity when you or your dependent requires certain care or services (as listed on the following page) or if you need to continue a stay beyond the period initially certified.
- **RECOMMENDED: Case Management** is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs. Case management provides quality outcomes by gathering input and support from the patient, their support system such as family and friends, all care providers, vendors and other suppliers involved in the care and treatment to achieve agreed upon goals for the patient. *Note: The Company expressly reserves the right to make modifications to plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.*

The name and phone number of the Utilization Management Program is shown on the employee's coverage identification card, as well as under **Directory of Service Providers**.

MANDATORY: CERTIFICATION

It is the employee's or covered person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an employee should contact the review organization to make certain that the facility or attending physician has initiated the necessary processes.

Additional information about when certification/notification is required, including timeframes and penalties for non-compliance is outlined on the following pages.

Important: Certification is **not a guarantee of coverage**; the *Utilization Management Program* is designed ONLY to determine whether or not a proposed setting and course of treatment is medically necessary and appropriate. Benefits under the plan will depend upon the person's eligibility for coverage and the plan's limitations and exclusions. Nothing in the *Utilization Management Program* will increase benefits to cover any confinement or service that is not medically necessary or that is otherwise not covered under the plan.

The Plan Sponsor has contracted with an independent organization to provide Certification. The name and phone number of the organization is shown on the Employee's coverage identification card.

WHEN PRIOR AUTHORIZATION/NOTIFICATION IS REQUIRED

You are responsible for prior authorization or notification in the following situations, unless there is an inability to obtain approval based on circumstances beyond your control, as outlined below the chart.

Important:

- If you have any questions as to whether a particular medical procedure is covered under current standards, **you should always verify benefits before incurring the expense**, even if the mandatory review program does not apply. See the *Directory of Service Providers* section for UMP contact information.

Care or Services	Timeframe To Complete	Penalty for Non-Compliance
Prior authorization by and Notification to Anthem Blue Cross		
<p>Scheduled / NON-EMERGENCY Inpatient Hospital Stays</p> <p>Including inpatient care for:</p> <ul style="list-style-type: none"> Inpatient Mental Health and/or Substance Abuse Skilled Nursing Facility Hospice Care <p>For information about a maternity inpatient stay, see <i>To Continue a Stay Beyond the Period Certified</i> below.</p>	<p>At least 3 business days prior to the admission or before the patient is discharged.</p> <p>If contact is not made prior to discharge, the admitting facility will have to file a "Retrospective Review" request with the Utilization Management Organization.</p>	<p>A 20% increase in your coinsurance amount*</p>
<p>Non-Scheduled / EMERGENCY Inpatient Hospital Stays</p> <p>Including inpatient care for:</p> <ul style="list-style-type: none"> Inpatient Mental Health and/or Substance Abuse Skilled Nursing Facility Hospice Care <p>For information about a maternity/inpatient stay, see <i>To Continue a Stay Beyond the Period Certified</i> below.</p>	<p>Within 48 hours of an admission</p>	<p>A 20% increase in your coinsurance amount*</p>
<p>To Continue a Stay Beyond the Period Initially Certified</p> <p>Maternity Stay: When a maternity stay needs to be extended beyond 48/96 hours (depending on the type of birth), prior authorization will be required. See <i>Pregnancy and Maternity Care</i> under <i>Eligible Medical Expenses</i> for additional information.</p>	<p>Before the original timeframe expires</p>	<p>A 20% increase in your coinsurance amount*</p>
<p>Other Procedures/Care</p> <ul style="list-style-type: none"> Home Health Care Home Injectables Hospice Care (Outpatient) Infusion Therapy PKU-Related Formulas or Special Food Products Potentially Cosmetic/Investigative Services Transplants Weight Loss Surgery 	<p>Prior to care, treatment or admission</p>	<p>A 20% increase in your coinsurance amount*</p> <p>OR</p> <p>Benefits may be denied</p>

* See the Summary of Medical Benefits for additional information about coinsurance. This 20% increase in your coinsurance will apply to the facility, Physician and all related charges.

INABILITY TO NOTIFY OR RECEIVE PRIOR AUTHORIZATION

The plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining prior authorization impossible or where application of the prior authorization process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

DELAY RECEIVING PRIOR AUTHORIZATION

If a covered person does not receive the preauthorized services within 60 days of the authorization, a new authorization will be required.

FAILURE TO NOTIFY OR RECEIVE PRIOR AUTHORIZATION

In addition to the penalties listed in the chart under *when prior authorization/Notification is required* on the previous page, the following consequences will also be imposed if you do not receive prior authorization when required:

- expenses for treatment or hospital stays that are not considered medically necessary will not be covered, and
- any additional share of expenses which becomes the covered person's responsibility for failure to comply with these requirements will **not** be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the plan.

See the *Pre-Service Claims* section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

RECOMMENDED: CASE MANAGEMENT SERVICES

The Utilization Management Organization provides case management for catastrophically ill or injured Covered Persons who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Covered Persons who have been accepted into the case management program.

To achieve this objective, the case management program works in collaboration with the Covered Person's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.

Once a Covered Person is identified for potential case management, the Covered Person is contacted for program enrollment. The case manager will introduce and describe the program. The Covered Person can ask questions and agree or decline to participate. If the Covered Person declines to participate, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

Important: Case Management is voluntary. There are no reductions of benefits or penalties if the patient chooses not to participate. Also, 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.

SCHEDULE OF MEDICAL BENEFITS

This chart below applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the medical plan. See *Eligibility and Effective Dates* section for more information.

Summary of Deductibles, Out-of-Pocket and Lifetime Maximums

The chart below shows what portion of expenses you will be responsible for, as well as how maximums are determined.

Type of Benefit	Member Responsibility	
	TIER 1	TIER 2
	VHH/Keck Medicine of USC/USC Care Medical Group	Anthem Blue Cross Prudent Buyer Network (No non-network benefits)
<p>Deductible (Calendar Year) The portion of covered eligible expenses you pay each year before the plan pays benefits.</p> <ul style="list-style-type: none"> ▪ Employee Only Coverage ▪ Family Coverage Each member contributes toward the family deductible until it is satisfied. 	<p>No Deductible</p> <p>No Deductible</p>	<p>\$500</p> <p>\$750</p>
<p>Out-of-Pocket Maximum (Calendar Year): Medical Only As added protection for you, the plan places a limit on how much co-insurance you have to pay for covered medical expenses each year. Once the limit is met, the plan pays 100% of the remaining covered expenses for that calendar year.</p> <ul style="list-style-type: none"> ▪ Employee Only Coverage ▪ Family Coverage <p>The following expenses will not be applied toward the out-of-pocket maximum:</p> <ul style="list-style-type: none"> ▪ services or care not covered by the plan, ▪ expenses which become the covered person's responsibility for failure to receive prior authorization, ▪ amounts applied or paid to satisfy any Deductible or copay requirements, ▪ amounts over Usual, Customary and Reasonable (UCR). ▪ services rendered by non-contract providers, 		<p>\$ 5,000</p> <p>\$10,000</p>
Individual Lifetime Maximum	No lifetime maximum	

MEDICAL BENEFIT SUMMARY

This section outlines Eligible Medical Expenses covered by the medical plan. In reviewing this chart, keep in mind the following important terms:

- **Copay** (shown as a **dollar amount**): Refers to the amount **you pay**, at the time covered care or services are received.
- **Coinsurance** (shown as a **percentage**): Refers to the amount **you pay** (i.e., the amount you or your dependents will be billed for) after covered care or services are received.
- This is a summary only. See the **Eligible Medical Expenses** and **Medical Limitations and Exclusions**, as well as the **General Exclusions** sections for more information.

Note: All Tier 2 expenses are subject to the deductible unless specifically stated that the deductible is waived.

Eligible Medical Expenses	Member Responsibility	
	TIER 1	TIER 2
	VHH/Keck Medicine of USC/USC Care Medical Group (USCCMG)	Anthem Blue Cross Prudent Buyer Network (No non-network benefits)
Allergy Testing & Treatment,		
▪ Testing	30%	30%
▪ Serum/Allergens	30%	30%
▪ Injection, per visit	\$10 copay per visit; (USCCMG only)	\$25 copay per visit; (deductible waived)
Ambulance	20%	20%
Ambulatory Surgical Center	0%	30%
Birth Center	0%	30%
Blood	10%	30%
Cardiac Rehabilitation	0%	30%
Chemotherapy	0%	30%
Chiropractic Care	\$10 copay per visit; (USCCMG only)	\$25 copay per visit; (deductible waived)
Diagnostic Lab & X-ray (Outpatient)	0% first \$400; 10% thereafter	30%
Diabetes		
▪ Counseling/Education (Dietician); maximum of \$100/calendar year	0%	30%
▪ Equipment and Supplies	10%	30%
<i>Note: Insulin covered under the Prescription Benefit Plan</i>		
Dialysis	20%	30%
Durable Medical Equipment	10%	30%
Hearing Exams & Hearing Aids		
Cochlear Implants are covered under Durable Medical Equipment up to a maximum of \$4,000/lifetime.	30%	30%
Home Health Care		
Limited to 50 visits per Calendar Year Prior authorization/Notification Required	30%	30%
Hospice Care		
Prior authorization/Notification Required	20%	20%

Medical Benefit Summary, continued

Note: All Tier 2 expenses are subject to the deductible unless specifically stated that the deductible is waived.

Eligible Medical Expenses	Member Responsibility	
	TIER 1	TIER 2
	VHH/Keck Medicine of USC/USC Care Medical Group (USCCMG)	Anthem Blue Cross Prudent Buyer Network (No non-network benefits)
Hospital Services & Supplies <ul style="list-style-type: none"> ▪ Inpatient Care* Prior authorization/Notification Required ▪ Emergency Room Use: Prior authorization/Notification Required if admitted <ul style="list-style-type: none"> ▪ for an Accidental Injury or Medical Emergency ▪ for a Non-Emergency Sickness ▪ Outpatient Surgical Services & Supplies ▪ Other Outpatient Services and Supplies 	<p style="text-align: center;">0%</p> <p style="text-align: center;">\$75 copay per visit</p> <p style="text-align: center;">\$75 copay + 10%</p> <p style="text-align: center;">0%</p> <p style="text-align: center;">10%</p>	<p style="text-align: center;">30%</p> <p style="text-align: center;">\$100 copay per visit (deductible waived)</p> <p style="text-align: center;">\$100 copay + 30%</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">30%</p>
Infusion Therapy Prior authorization/Notification Required	0%	30%
Massage Therapy	Not Covered	Not Covered
Maternity Office Visits (Employee and Spouse Only)	\$10 copay per visit (USCCMG only)	\$25 copay per visit; (deductible waived)
Medical Supplies	20%	30%
Mental Health Care <ul style="list-style-type: none"> ▪ Home & Office / visit ▪ Inpatient Care (facility and professional services) * Prior authorization/Notification Required ▪ Day Treatment (facility and professional services) ▪ Residential Prior authorization/Notification Required ▪ Testing 	<p style="text-align: center;">\$10 copay per visit; (USCCMG only)</p> <p style="text-align: center;">0%</p> <p style="text-align: center;">\$10 copay per visit; (USCCMG only)</p> <p style="text-align: center;">Not available</p> <p style="text-align: center;">See <i>Diagnostic Lab & X-ray (Outpatient)</i></p>	<p style="text-align: center;">\$25 copay per visit; (deductible waived)</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">\$25 copay per day; (deductible waived)</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">See <i>Diagnostic Lab & X-ray (Outpatient)</i></p>
Occupational Therapy	10%	30%
Orthotics (When prescribed by a physician)	Not Available	30%
Physical Therapy	10%	30%

Medical Benefit Summary continued

Note: All Tier 2 expenses are subject to the deductible unless specifically stated that the deductible is waived.

Eligible Medical Expenses	Member Responsibility	
	TIER 1	TIER 2
	VHH/Keck Medicine of USC/USC Care Medical Group (USCCMG)	Anthem Blue Cross Prudent Buyer Network (No non-network benefits)
Physician Services		
<ul style="list-style-type: none"> ▪ Inpatient Care (facility and professional services) ▪ Home & Office /visit ▪ Other Services 	0%	30%
	\$10 copay per visit; (USCCMG only)	\$25 copay per visit; (deductible waived)
	10%	30%
PKU-Related Formulas or Special Food Products Prior authorization/Notification Required	10%	30%
Pre-Admission Testing	0% first \$400; 10% thereafter	30%
Preventive Care		
<ul style="list-style-type: none"> ▪ Adult Physical Exam (Employee & spouse only); including but not limited to age appropriate screenings such as bone density and colonoscopy tests ▪ OB/GYN ▪ Exam-Related X-rays & Laboratory Tests ▪ Well Child Check-Ups, Etc., per visit ▪ Ancillary Services by a Network Facility 	0%	0% (deductible waived)
Prosthetic Devices	30%	30%
Pulmonary Therapy	0%	30%
Respiratory Therapy	0%	30%
Second (& 3rd) Surgical Opinion	0%	0%
Skilled Nursing Facility / Rehabilitation Center* Prior authorization/Notification Required	0%	30%
* Skilled Nursing Facility care is limited to 120 days		
Sleep Disorders (Testing) Note: Any related equipment, see Durable Medical Equipment	30%	30%
Speech Therapy	0%	30%

Medical Benefit Summary continued

Note: All Tier 2 expenses are subject to the deductible unless specifically stated that the deductible is waived.

Eligible Medical Expenses	Member Responsibility	
	TIER 1	TIER 2
	VHH/Keck Medicine of USC/USC Care Medical Group (USCCMG)	Anthem Blue Cross Prudent Buyer Network (No non-network benefits)
Substance Abuse Care <ul style="list-style-type: none"> ▪ Home & Office / visit ▪ Inpatient Care (facility and professional services) * Prior authorization/Notification Required ▪ Day Treatment (facility and professional services) ▪ Residential Prior authorization/Notification Required ▪ Testing 	\$10 copay per visit; (USCCMG only) 0% \$10 copay per visit; (USCCMG only) 30% See Diagnostic Lab & X-ray (Outpatient)	\$25 copay per visit (deductible waived) 30% \$25 copay per day; (deductible waived) 30% See Diagnostic Lab & X-ray (Outpatient)
Urgent Care Facility	Not Available	\$50 (deductible waived)
Weight Loss Surgery Prior authorization/Notification Required Bariatric surgery only; once per lifetime	\$2,000	Not Covered
Wigs Covered only when hair loss is a result of a covered medical condition or the treatment of a covered medical condition. See Hair Restoration in the list of Medical Limitations and Exclusions.	30% up to a lifetime maximum of \$500	30% to a lifetime maximum of \$500

ELIGIBLE MEDICAL EXPENSES

This section must be read in conjunction with the *Summary of Medical Benefits* to understand how plan benefits are determined (application of deductible requirements and benefit sharing percentages, etc.). **Important:** If the benefit in the *Summary of Medical Benefits* section shows not covered, then the benefit information in this section is not applicable. All medical care must be received from or ordered by a Provider.

To be **eligible** (i.e., covered) under the medical plan, expenses related to services, supplies and/or care **must be:**

- medically necessary for the care and treatment of a **covered:** sickness, Accidental Injury, pregnancy or other health care condition,
- the Usual, Customary and Reasonable charges for the items specifically listed in this Summary Plan Description,
- incurred while the person is covered by this plan, **and**
- approved by a physician or other appropriate Provider.

Keep in mind:

- Only those medical services, supplies and conditions which are covered by the plan are outlined in this section.
- An individual who meets the eligibility requirements as contained herein (e.g., a covered employee, a covered dependent, a Qualified Beneficiary (COBRA), etc.) is considered a covered person.

For benefit purposes, medical expenses will be deemed to be incurred on the:

- Date a purchase is contracted, or
- Actual date a service is rendered.

Important: Eligible medical expenses are subject to the definitions, limitations and exclusions and all other provisions of the plan; specific guidelines are outlined in this section, as well as the *Summary of Medical Benefits*, *Medical Limitations and Exclusions* and *General Exclusions*.

Accident-Related Injury: Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination. This benefit is:

- payable only if treatment begins within 48 hours of the accident and
- limited to services provided within 90 days of the accident.

Expenses eligible for the benefit are limited to charges for Hospital services, Physician services, diagnostic lab and X-ray services and professional ambulance services. Other expenses will be covered in the same manner as a Sickness and will be based on the types of expenses incurred. *Note: Any Copay that would apply to a non-accident-related expense will also apply before the accident benefit is available. For example, if treatment involves a visit to an Urgent Care Facility, that Copay will apply before the accident-related expense benefit is determined.*

Alcoholism: See *Substance Abuse Care*

Allergy Testing & Treatment: Allergy testing and treatment, including allergy injections.

Ambulance: Professional ground or air ambulance service when used to transport the Covered Person from the place where he is injured or stricken by a Sickness to the nearest Hospital where treatment can be given.

Ambulatory Surgical Center:

Services and supplies provided by an *Ambulatory Surgical Center* in connection with a covered Outpatient surgery. An Ambulatory Surgical Center is any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located,
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures,
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility, and
- does not provide services or other accommodations for patients to stay overnight.

Anesthesia:

Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birth Center:

Services and supplies provided by a *Birth Center* in connection with a covered Pregnancy. A birthing center is a special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located,
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients,
- has organized facilities for birth services on its premises,
- provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology,
- has 24-hour-a-day registered nursing services, and
- maintains daily clinical records.

Blood:

Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Cardiac Rehabilitation:

A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease. Services rendered must be under the direction of a Physician and provided at a medical facility. *Note: Maintenance care will not be covered.*

Chemical Dependency: See *Substance Abuse Care*

Chemotherapy:

Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care:

Musculoskeletal manipulation and modalities (hot & cold packs, etc.) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Contraceptives:

Contraceptive supplies and related Physician services provided in connection with the fitting, administration or placement of contraceptive devices, injectables, implants, etc., (e.g., Depo-Provera, intrauterine devices (IUDs), diaphragms, and Norplant). See also "Prescription Drugs". *Note: Contraceptives that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies, etc.) or contraceptives that do not require the services of a Physician are not covered.*

Convalescent Hospital: See *Skilled Nursing Facility*

Cosmetic & Reconstructive Surgery (Prior authorization/Notification Required):

Is only covered under the following circumstances:

- services necessitated by an Accidental Injury,
- treatment necessary to repair damage due to a medical complication resulting from a surgical procedure,
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient, and
- treatment necessary to correct a congenital abnormality (birth defect).

Covered Provider:

An individual who is:

- licensed to perform certain health care services that are covered hereunder and who is acting within the scope of his license, or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association, and
- a/an:
 - Audiologist
 - Certified Registered Nurse Anesthetist (CRNA)
 - Chiropractor (DC)
 - Dentist (DDS or DMD)
 - Licensed Clinical Psychologist (PhD or EdD)
 - Licensed Clinical Social Worker (LCSW)
 - Licensed Practical Nurse (LPN)
 - Licensed Vocational Nurse (LVN)
 - Marriage Family and Child Counselor (MFCC)
 - Midwife (Certified or Registered Nurse)
 - Nurse Practitioner
 - Occupational Therapist (OTR)
 - Optometrist (OD)
 - Physical Therapist (PT or RPT)
 - Physician - see definition of "Physician"
 - Physician Assistant (PA)
 - Podiatrist or Chiropodist (DPM, DSP, or DSC)
 - Psychiatrist (MD)
 - Registered Nurse (RN)
 - Respiratory Therapist
 - Speech Pathologist

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered hereunder:

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.,
- licensed Outpatient mental health facilities,
- freestanding public health facilities,
- hemodialysis and Outpatient clinics under the direction of a Physician (MD),
- enuresis control centers,
- prosthetists and prosthetist-orthotists,
- portable X-ray companies,
- independent laboratories and lab technicians,
- diagnostic imaging facilities,
- blood banks,
- speech and hearing centers, and
- ambulance companies.

A Covered Provider does not include:

- a Covered Person treating himself or any relative or person who resides in the Covered Person's household; see "Relative or Resident Care" in the list of **General Exclusions**, or
- any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Dental Services, Accident Only: Dental services when all of the following are true:

- treatment is necessary because of Accidental Injury,
- dental services are received from a Doctor of Dental Surgery (DDS) or doctor of Medical Dentistry (DMD), and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within seventy-two (72) hours of the accident.

Benefits are available only for treatment of a sound natural tooth. The Physician or dentist must certify that the injured tooth was:

- an untreated or unrestored tooth, or
- a tooth that has no decay, no filling on more than two (2) surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be:

- started within three (3) months of the accident, and
- completed within twelve (12) months of the accident.

Note: Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an Accidental Injury and repair of such damage is not covered.

Diagnostic Lab & X-ray, Outpatient: Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis: Services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital freestanding dialysis center or other appropriate Covered Provider

Durable Medical Equipment:

Rental of durable medical or surgical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury

"Durable medical equipment" includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., that:

- can withstand repeated use,
- are primarily and customarily used to serve a medical purpose,
- generally are not useful to a person in the absence of Sickness or Accidental Injury and
- are appropriate for use in the home.

Note: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.

Emergency: See *Medical Emergency*

Foot Care (Non-Routine):

Limited to only the removal of nail roots, other podiatry surgeries or foot care services necessary due to a metabolic or peripheral-vascular disease).

Hearing Exams & Hearing Aids:

Hearing exams and hearing aids or the fitting of hearing aids when ordered by a Physician and with documented history of hearing loss.

Home Health Care (Prior authorization/Notification Required):

Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of home health care.

Home health care services and/or supplies must be provided through a Home Health Care Agency. Covered home health care services and supplies include:

- services of a registered nurse (RN) or a licensed vocational nurse (LVN),
- services of a certified nursing assistant,
- services of a home health aide,
- services of a physical, occupational or speech therapist, and
- medical supplies and materials.

Note: Covered home health care expenses will not include infusion therapy or rental of durable medical equipment. See Infusion Therapy and Durable Medical Equipment for coverage information.

Home Health Care Agency:

An agency or organization that:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services,
- has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided,
- provides for full-time supervision of its services by a Physician or by a registered nurse,
- maintains a complete medical record on each patient, and
- has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice Care (Prior authorization/Notification Required):

Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Hospice care must be certified by the attending Physician every thirty (30) days. Hospice care includes care in either the patient's home or a facility or both and includes:

- services of a registered nurse (RN) or licensed vocational nurse (LVN),
- services of a certified nursing assistant,
- respite care*, and
- materials and supplies.

*Respite care means Inpatient or home care services provided to the patient to temporarily relieve the family or regular non-professional caregivers from the stress of caring for the patient.

Note: See Mental Health Care for bereavement counseling coverage.

Hospice or Hospice Agency:

An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital:

An institution that is:

- providing Inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under the supervision of a staff of doctors and with a 24-hour-a-day nursing service, or
- accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

A "Hospital" does not include a nursing home, or an institution or part of an institution used mainly as a facility for convalescence, nursing, rest of the aged or the care of drug addicts or alcoholics, except as provided for the rehabilitation of alcoholism or drug addiction.

Hospital Services & Supplies:

Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies. Inpatient room and board is limited to a semi-private room or necessary use of an Intensive Care Unit. However, a private room will be allowed if isolation is required or if a private room is requested by the attending Physician and required for medical reasons.

Infusion Therapy (Prior authorization/Notification Required):

Professional services of an appropriate Covered Provider for the intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered in a Covered Person's home, Physician's office or at a Covered Provider facility.

Infusion therapy supplies including injectable prescription drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

Injectables (Prior authorization/Notification Required):

Injectables that are not available through the prescription drug program and professional services for their administration if they cannot be self-administered.

Inpatient (Prior authorization/Notification Required):

A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit

(Prior authorization/ Notification Required):

A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Medical Emergency (Prior authorization/Notification Required for Inpatient Hospital Stays):

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) 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 the health of the individual (and in the case of a pregnant woman, her unborn child) to be in serious jeopardy, cause serious impairment of bodily functions, or cause a serious dysfunction of any body part or organ.

Medical Supplies:

Medical supplies such as surgical dressings, catheters, colostomy bags and related supplies. Syringes and testing materials for diabetes.

Medicines:

Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health Care (Prior authorization/Notification Required for inpatient and residential treatment):

Inpatient, day treatment, residential, testing and outpatient home and office treatment of mental health conditions. Outpatient treatment will also include bereavement counseling services following the death of a family member. For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders and disorders of infancy, childhood and adolescence.

A mental health condition or covered mental health care will **not** include:

- learning and behavior disorders including attention deficit disorder,
- hyperkinetic syndrome,
- autism,
- mental retardation,
- hypnotherapy,
- marriage and family counseling,
- sex counseling or sex therapy, or
- vocational testing or training.

Mental Health Facility:

An institution that is licensed by the state and accredited by the Joint Commission on Accreditation of Healthcare Organizations or an institution that is a licensed Community Mental Health Agency. A Mental Health Facility must be able to provide acute medical care to its patients or maintain a contract or agreement with a Hospital in the area to provide acute medical care to a patient should a Medical Emergency arise.

Midwife:

Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy; see *Pregnancy Care* for additional information.

Newborn Care:

Medically Necessary services and supplies, as listed herein, for a covered newborn who is sick or injured. See *Pregnancy Care* for routine well-newborn expenses.

Occupational Therapy:

Occupational therapy services when rendered by a Physician or by an occupational therapist upon written orders of a Physician.

Orthotics:

Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and custom made. The initial purchase of orthopedic shoes and/or appliances when obtainable only with a prescription from a Physician. Replacement is covered only if required due to a change of prescription.

Outpatient:

Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Oxygen: See *Durable Medical Equipment*

Physical Therapy:

Physical therapy services when rendered by a Physician or by a physical therapist upon written orders of a Physician.

Physician Services:

Medical and surgical treatment by a Physician (MD or DO) who is licensed to practice medicine or osteopathy where the care is provided, including office, home or Hospital visits, clinic care and consultations. See *Second* (& *3^d*) *Surgical Opinion* for requirements applicable to surgery opinion consultations. Also see *Covered Providers*.

PKU-Related Formulas or Special Food Products (Prior authorization/Notification Required):

PKU is the abbreviation for a metabolic disorder called phenylketonure in which a portion of protein, called phenylalanine, is not processed correctly. Benefits are provided for formulas and Special Food Products that are medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

Pregnancy Care: Prior authorization/Notification Required only when a maternity stay needs to be extended beyond 38/96 hours (dependent on the type of birth).

Pregnancy-related expenses of a **covered Employee or covered Dependent spouse**. Pregnancy-related expenses include the following, but may include other services that are deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care,
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy,
- genetic testing or counseling when deemed Medically Necessary by a Physician, and
- newborn Hospital and pediatric services, including newborn circumcision, provided during the mother's confinement for delivery. This will not apply, however, if the newborn has a medical problem, is a Covered Person, and the charges are covered as the newborn's own claim.

In compliance with the *Newborns' and Mothers' Health Protection Act of 1996*, the plan also provides that:

- hospital stays will be covered for at least 48 hours following a normal vaginal delivery, or at least 96 hours following a Cesarean section,
- the attending physician does not need to obtain authorization from the plan to provide the mother and newborn with this length of hospital stay, and
- shorter hospital stays are permitted if the attending health care provider, in consultation with the mother, determines that this is the best course of action.

Pregnancy coverage will not include:

- Lamaze and other charges for education related to pre-natal care and birthing procedures,
- adoption expenses,
- planned homebirths or any expenses related to complications resulting for the mother and/or child from a planned homebirth delivery,
- expenses of a surrogate mother who is not a Covered Person, or
- pregnancy-related expenses of a Dependent daughter.

Prescription Drugs: Drugs and medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. Also see the **Prescription Drug Benefit** section.

Preventive Care: Preventive Care includes:

- **Adult Physical Exam:** This benefit is available to an Employee and an Employee's spouse.
- **Exam-Related X-rays & Laboratory Tests** - The following tests provided in conjunction with a physical exam of an Employee or an Employee's spouse:
 - Bone Density Screening (Over Age 55)
 - Complete Blood Count (CBC)
 - CHEM Panel
 - Chest X-Ray
 - Electrocardiogram
 - Ldl, Hdl
 - Mammograms
 - Occult Blood
 - Pap Smear
 - Prostate Specific Antigen
 - Purified Protein Derivative
 - Sigmoidoscopy (Over Age 55)
 - Thyroid Stimulating Hormone
 - Triglycerides
 - Urinalysis
- **Human Papillomavirus (HPV) Vaccinations**
- **Well Child Check-Ups:** Periodic well child check-ups for a child through age 18, including Physician services, diagnostic testing and immunizations
- **Ancillary Services:** Ancillary services provided in conjunction with the above preventive care services.

Prosthetics: Includes coverage for:

- Initial purchase of an artificial limb, eye or other prosthetic appliance required to replace or perform the function of a natural limb, eye or other body part. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.
- Necessary repair or adjustment of a prosthetic.
- Replacement of a prosthetic when necessary due to a prescription change or long term wear and deterioration.

Prosthetics do not include:

- penile implants unless required as a result of irreversible vascular or neurologic disease that prevents normal male sexual function,
- any type of communicator, voice enhancement, voice prosthesis or any other language assistive device,
- external and internal power enhancements or power controls for prosthetic limbs and terminal devices, or
- myoelectric prostheses and peripheral nerve stimulators.

Radiation Therapy: Radium and radioactive isotope therapy.

Rehabilitation Center: A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

- carries out its stated purpose under all relevant state and local laws,
- is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities, or
- is approved for its stated purpose by Medicare.

Also see *Skilled Nursing Facility* or *Rehabilitation Center*

Respiratory Therapy: Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second (& 3rd) Surgical Opinion: A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be a Network provider and qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery. A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be a Network provider and qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Semi-Private Room Charge: The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness: Bodily illness or disease (including mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility or Rehabilitation Center (Prior authorization/Notification Required): Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is prescribed by a Physician for a condition requiring treatment by a Physician. Inpatient room and board is limited to a semi-private room unless a private room is medically required. *Note: Benefits are not available for custodial care or for care of chronic brain syndrome, mental retardation, senile deterioration, except for Alzheimer's disease.*

Skilled Nursing Facility: An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations,
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons,
- is under the full-time supervision of a Physician or a registered nurse,
- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician,
- has established methods and procedures for the dispensing and administering of drugs,
- has an effective utilization review plan,
- is approved and licensed by Medicare,
- has a written transfer agreement in effect with one or more Hospitals, and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Speech Therapy: Services by a qualified speech therapist, but **only** when used to restore or rehabilitate a speech loss or impairment caused by Accidental Injury or Sickness or surgery performed for a Sickness or Accidental Injury. *Note: Speech therapy performed for any functional nervous disorder, mental or emotional disorder, autism, learning disability or any similar condition is not covered.*

Sterilization Procedures: A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female). *Note: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.*

Substance Abuse Care (Prior authorization/Notification Required for inpatient and residential treatment): Inpatient, day treatment, residential, testing and outpatient home and office treatment of substance abuse and addiction. For Plan purposes, "substance abuse and addiction" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Substance Abuse Facility: A facility that:

- is licensed by the state to treat alcoholism or drug addiction and provides treatment by or under a medical doctor and maintains medical records for each patient, or
- is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A Substance Abuse Facility must be able to provide acute medical care to its patients or maintain a contract or agreement with a hospital in the area to provide acute medical care to a patient should a Medical Emergency arise.

Transplant-Related Expenses (Prior authorization/Notification Required): Eligible Expenses for a vital human organ or tissue transplant that is not experimental or investigational, subject to the following conditions:

- a second opinion must be obtained prior to any transplant procedure. The opinion must concur with the attending Physician's findings regarding Medical Necessity. If the second opinion and that of the attending Physician do not agree, a third opinion must be obtained. The Physician rendering the second or third opinion must be qualified to render such an opinion either through experience, special training or education, or similar criteria and must not be affiliated in any way with the Physician who will perform the transplant surgery,
- when only the transplant recipient is a Covered Person, benefits will be provided for Eligible Expenses of the recipient and expenses of the donor to the extent that benefits to the donor are not provided under any other form of coverage (i.e., this Plan will be secondary to the donor's plan). Benefits paid will be applied to reduce benefit maximums as though all expenses were incurred by the Covered Person recipient,
- if the donor is covered hereunder but the recipient is not, the Plan will provide benefits if no benefits are available through the recipient's plan. If coverage does exist through the recipient's plan, this Plan will provide secondary coverage, and
- when the transplant recipient and the donor are both Covered Persons, benefits will be provided separately for each in accordance with his respective Eligible Expense.

The Plan reserves the right to determine if benefits will be made available for tissue obtained from a cadaver or tissue bank or charges for services or supplies or a surgeon or any facility used to remove, store or transfer such tissue. The Plan also reserves the right to provide a benefit for transportation costs for donor and/or recipient if it is determined that such coverage would be in the best interest of the individual and is the most cost effective for the Plan.

Urgent Care Facility: A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times, and
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Weight Control (Prior authorization/Notification Required): In general, weight control is not covered; however, bariatric surgery may be considered if the Covered Person meets all of the following criteria:

- body mass index (BMI) between 40 and 60, or body mass index (BMI) of 35 or greater with significant co-morbid conditions including, but not limited to: diabetes mellitus, sleep apnea, high cholesterol and hypertension,
- the Covered Person has tried weight reduction diets and/or medications under a Physician's care or professionally supervised and has failed to maintain weight loss and can provide proof of same, and
- a letter of Medical Necessity for bariatric surgery is submitted, including duration of morbid obesity and determination that there is no treatable cause for the obesity.

See *Medical Limitations and Exclusions* for more information.

Wigs: Purchase of wigs or hair pieces only when hair loss is a result of a covered medical condition or the treatment of a covered medical condition. *Note: Other hair restoration services/supplies are not covered; see Hair Restoration in the list of Medical Limitations and Exclusions.*

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for the following expenses (see *General Exclusions* for other limitations on benefits):

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

Acupuncture / Acupressure: Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Air Purification Units, Etc.: Air conditioners, air-purification units, humidifiers and electric heating units.

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

Complications of Non-Covered Treatment: Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Cosmetic & Reconstructive Surgery, Etc.: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered displeasing or unsightly, except for:

- services necessitated by an Accidental Injury,
- treatment necessary to repair damage due to a medical complication resulting from a surgical procedure,
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient, and
- treatment necessary to correct a congenital abnormality (birth defect).

Examples of surgeries that are considered cosmetic and **not** covered include, but are not limited to:

- surgical excision of any sagging skin on any part of the body,
- services in connection with the enlargement, reduction or change in appearance of the body unless deemed Medically Necessary or expressly covered,
- services in connection with chemical face peels or abrasion of the skin, or
- services or treatment to alter physical characteristics to those of the opposite sex.

Custodial & Maintenance Care: Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental Care: Dental care except as described under "Dental Services – Accident Only" in the list of **Eligible Medical Expenses**.

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

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

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

Exercise Equipment / Health Clubs: Exercising equipment, vibratory equipment, swimming or therapy pools, as well as enrollment in health, athletic or similar clubs.

Foot Care, Routine: Routine and non-surgical foot care services and supplies including, but not limited to:

- trimming or treatment of toenails,
- foot massage,
- treatment of corns, calluses, metatarsalgia or bunions, and
- treatment of weak, strained, flat, unstable or unbalanced feet.

This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Gambling Addiction

Genetic Counseling or Testing: Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a Pregnancy that is covered by the Plan.

Growth Hormones / Growth Hormone Therapy

Hair Restoration: 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. *Note: The purchase of a wig(s) or hair piece(s) are covered for hair loss ONLY when resulting from a covered medical condition or the treatment of a covered medical condition; see Wigs under Eligible Medical Expenses.*

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

Hypnotherapy: Treatment by hypnotism.

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

Infertility Testing or Treatment: Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

Learning & Behavioral Disorders, etc.: Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism. Treatment of chronic brain syndrome or senile deterioration, except for Alzheimer's disease.

Maintenance Care: See *Custodial & Maintenance Care*

Massage Therapy: The manipulation of superficial layers of muscle and connective tissue. Massages, massage therapy, Rolfing (holistic tissue manipulation and movement), acupressure and/or aromatherapy are not covered even if provided in conjunction with covered Physical, Occupational or Chiropractic Therapy.

Nicotine Addiction: Nicotine withdrawal programs, facilities, drugs or supplies.

Non-Prescription Drugs: 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 - except as may be included in the prescription coverages of the Plan. Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed: Any services or supplies that are:

- not Medically Necessary, and
- not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Nursing Services, Private Duty: Private duty or special nursing services.

Orthognathic Surgery: Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to:

- air conditioners, air purifiers, or vacuum cleaners,
- motorized transportation equipment, escalators, elevators, ramps,
- waterbeds or non-hospital adjustable beds,
- hypoallergenic mattresses, pillows, blankets or mattress covers,
- cervical pillows,
- swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs,
- home blood pressure kits,
- personal computers and related equipment, televisions, telephones, or other similar items or equipment,
- food liquidizers, or
- structural changes to homes or autos.

Pregnancy Coverage: The following services are not covered during a pregnancy/birth:

- Lamaze and other charges for education related to pre-natal care and birthing procedures,
- adoption expenses,
- planned homebirths or any expenses related to complications for the mother and/or child resulting from a planned homebirth delivery,
- expenses of a surrogate mother who is not a Covered Person, or
- pregnancy-related expenses of a Dependent daughter.

Preventive or Routine Care: Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

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

Sex-Related Disorders: Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: medications, implants, hormone therapy, surgery and other medical treatment.

TMJ / Jaw Joint Treatment: Services or supplies provided in connection with a diagnosis of temporomandibular joint dysfunction syndrome (TMJ) or rendered in connection with any TMJ treatment program or any services in connection with TMJ splinting or surgery.

Vaccinations: Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see the **Medical Benefit Summary**), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Vision Care: There is no coverage for:

- eye examinations for the purpose of prescribing corrective lenses,
- vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment, or
- orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery or keratoconus surgery.

Vitamins or Dietary Supplements, Etc.: Prescription or non-prescription vitamins, except for pre-natal vitamins. Dietary or nutritional supplements or any other form of special food product, regardless if such supplement or food is prescribed by a Physician, unless Medically Necessary or dispensed through infusion therapy. Services or supplies rendered by a dietary counselor or nutritionists or services or supplies rendered for dietary planning or nutrition.

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

Weekend Admissions: Hospital expenses incurred on a weekend that coincides with admission to a Hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless:

- the admission occurs one day prior to a scheduled surgery,
- the Covered Person is admitted on an emergency basis, or
- the admission is for Pregnancy delivery.

Weight Control, Etc.: Weight loss programs of any kind, whether or not prescribed by a Physician, or any other services, surgery or supplies rendered in connection with a diagnosis of obesity.

Wigs or Wig Maintenance: See *Hair Restoration*

PRESCRIPTION DRUG BENEFITS

When you enroll in the medical plan, you automatically receive prescription coverage. Benefits for Prescription Drugs are available from:

- **USC VHH Pharmacies:** Up to a 90-day supply.
- **US Script Network Pharmacy:** Up to a 30-day supply. For a list of participating pharmacies contact the US Script network at the web address listed in the **Directory of Service Providers**. There is no coverage for non-network pharmacies.

When filling a prescription, keep in mind:

- **Deductible:** There is no deductible for prescription drug benefits
- **Out-of-Pocket Maximum:** There are separate out-of-pocket maximums for Medical and Prescription Drug Benefits. The prescription drug out-of-pocket maximum is the most you will pay in Prescription Drug copays and coinsurance during a single calendar year. The USC VHH Prescription Drug Plan includes a calendar year out-of-pocket maximum that is separate from the USC VHH Medical PPO Plan. For example, expenses that apply toward your Prescription Drug Plan out-of-pocket maximum do not apply toward your Medical PPO Plan out-of-pocket maximum. Once a covered family member reaches the individual out-of-pocket maximum shown below in the Prescription Benefit Summary, the Plan pays 100% of that person's covered prescription drug charges for the rest of the calendar year. When your family's combined out-of-pocket expenses satisfy the family out-of-pocket maximum, the Plan pays 100% of the family's covered prescription drug charges for the remainder of the calendar year
- **Coinsurance** (shown as a **percentage**): Refers to the amount **you pay** (i.e., the amount you or your dependents will be billed for) after covered care or services are received.
- **Prior Authorization is required:**
 - From USC VHH Pharmacy: For any drug where the cost to the Plan will exceed **\$2,500**.
 - From US Script Network Pharmacy: For any drug where the cost to the Plan will exceed **\$500**.

A list of covered and excluded drugs is available from US Script, see the *Directory of Service Providers* for contact information.

Prescription Benefit Summary

Prescription Drugs	Member Responsibility	
	USC VHH Pharmacies	US Script Pharmacies (No non-network benefits)
Out-of-Pocket Maximum	\$1,600 individual / \$3,200 employee and all covered dependents	
Prescription Drugs (Outpatient)	Up to 90-day supply (Available at USC VHH Pharmacies Only)	Up to a 30-day supply
<ul style="list-style-type: none"> ▪ Formulary: <ul style="list-style-type: none"> ▪ Generic Drug ▪ Brand-Name Drug (Preferred) ▪ Non-Formulary Brand-Name Drug (Non-Preferred) 	10% up to \$5 maximum 20% 30%	20% up to \$10 maximum 30% 50%

Important Terms

This section describes covered services and terms that have significant meaning under the prescription benefit plan.

Formulary: The formulary is a preferred list of the most commonly prescribed medications that have been selected by doctors, pharmacists and other healthcare professionals. The formulary includes brand-name and generic medications that have been approved by the FDA as safe and effective. The medications listed on the formulary are clinically equivalent and possibly more cost effective than other non-formulary medicines.

- **Generic:** When a patent on a brand-name medicine expires, the generic equivalent can be made by other manufacturers without the initial start-up costs. As a result, the medicines can be made available to consumers, with the identical chemical composition of the equivalent brand-name medicine, at much lower costs.
- **Brand Name:** Brand-name medicines are manufactured by a Company under a registered trademark. Medications are generally more expensive due to the research, development and marketing that is required for introducing a new medicine to the public.

The formulary applies only to prescription medications dispensed to outpatients by participating pharmacies. The formulary does not apply to inpatient medications or to medications obtained from, and/or administered by, a physician.

Non-Formulary: Non-formulary medicines are not preferred for coverage by the carrier and as a result, require a higher copayment.

Covered Prescriptions

Coverage for outpatient drugs that are obtained from a licensed pharmacy **with a valid prescription** include:

- drugs and medicines that are not expressly excluded and that are:
 - lawfully obtainable only upon the written prescription of a Physician, and
 - prescribed for a covered Sickness, Accidental Injury or Pregnancy that has been diagnosed and is currently being treated by a Physician, such as drugs prescribed for acid reflux or high cholesterol,
- insulin, and
- prescription contraceptives.

USC VHH Pharmacy Coverage Only

The following prescriptions are covered only when they are received from a USC VHH Pharmacy:

- Humira, and
- Enbrel.

Expenses Not Covered Under the Prescription Plan

Exclusions to the prescription drug coverage include, but are not limited to:

- **Administration:** Any charge for the administration of a covered drug.
- **Aero chambers**
- **Allergens**
- **Blood, Blood Plasma and Biological Sera**
- **Contraceptives:**
 - topical,
 - those that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies, etc.), or
 - implants (e.g., Norplant) and intrauterine devices (IUD). *Note: Coverage is provided under the medical plan when inserted/placed during a doctor's office visit.*
- **Cosmetic Drugs:** Drugs with cosmetic indications, except for Retin-A.
- **Devices:** Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- **Excess Refills:** Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.
- **Experimental and Non-FDA Approved Drugs:** Experimental drugs and medicines, even though a charge is made to the covered person. Drugs not approved by the Food and Drug Administration.
- **Fluoride Preparations**
- **Growth Hormones / Growth Hormone Therapy**

- **Hair Loss Drugs:** Any drug used for the treatment of hair loss (i.e., Minoxidil or Rogaine).
- **Holistic, Homeopathic or Naturopathic Medicine:** Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment. Legend or non-Legend homeopathic drugs.
- **Immunizations Agents:** Serums, toxoids, vaccines.
- **Infertility Drugs:** Drugs to correct infertility or to restore or enhance fertility.
- **Investigational Drugs:** A drug or medicine labeled: Caution – limited by federal law to investigational use.
- **No Charge:** A prescribed drug that may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.
- **Non-Home Use:** Drugs and medicines that are dispensed and administered to a Covered Person during an Inpatient confinement (Hospital, Skilled Nursing Facility, etc.) or during a Physician's office visit.
- **Over-The-Counter (OTC) Products or Equivalents:** A drug or medicine that can legally be bought without a written prescription (i.e., drugs that are available over-the-counter or that have an over-the-counter equivalent. *Note: This does not apply to insulin or Cheratussin AC.*
- **Outside the United States:** Drugs obtained outside of the United States.
- **Pregnancy Tests**
- **Reusable Needles & Syringes (Non-Insulin)**
- **Vitamins or Dietary Supplements, Etc.** – Prescription or non-prescription vitamins, except for pre-natal vitamins. Dietary or nutritional supplements or any other form of special food product, regardless if such supplement or food is prescribed by a Physician, unless Medically Necessary or dispensed through infusion therapy.
- **Weight Management (anti-obesity) Drugs**

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

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

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

Excess Charges: Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

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

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law,
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses, and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

Forms Completion: Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities: Services furnished to the Covered Person 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. 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, or
- where otherwise prohibited by law.

Late-Filed Claims: Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

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

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

Never Events: The following list was developed by the National Quality Forum (NQF). Never events are medical errors that should never happen, but when they do, typically cause serious consequences for the patient. By excluding these events, the plan reduces unnecessary costs and eliminates payment for expenses which should not have been incurred. *Note: This exclusion does not apply to USC VHH.* Never events include:

- **Surgical Events:**
 - surgery performed on the wrong body part,
 - surgery performed on the wrong patient,
 - wrong surgical procedure on a patient,
 - retention of a foreign object in a patient after surgery or other procedure, or
 - intraoperative or immediately post-operative death in a normal, healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative).
- **Product or Device Events:**
 - patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility,
 - patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended, or
 - patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
- **Patient Protection Events:**
 - infant discharged to the wrong person,
 - patient death or serious disability associated with patient elopement (disappearance) for more than four hours, or
 - patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.
- **Care Management Events:**
 - patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration),
 - patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products,
 - maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility,
 - patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility,
 - death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates,
 - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, or
 - patient death or serious disability due to spinal manipulative therapy.
- **Environmental Events:**
 - patient death or serious disability associated with an electric shock while being cared for in a healthcare facility,
 - any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances,
 - patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility,
 - patient death associated with a fall while being cared for in a healthcare facility, or
 - patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
- **Criminal Events:**
 - any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider,
 - abduction of a patient of any age,
 - sexual assault on a patient within or on the grounds of a healthcare facility, or
 - death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

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

Not Listed Services or Supplies: Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Plan Administrator.

Nuclear Energy Release: Any injury or illness resulting from the non-therapeutic release of nuclear energy.

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

Outside United States: Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies. Also excluded are any medical expenses related to such services (i.e., complications arising out of any services intentionally received outside the United States), even if such services are received within United States. *Note: This exclusion will not apply to a Covered Person who obtains emergency services while traveling outside the United States or to a child who would normally be living in the United States but may be living abroad while attending school.*

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

Prior Coverages: Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

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

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

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

Telecommunications: Advice or consultation given by or through any form of telecommunication.

Travel: Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

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

Work-Related Conditions: Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

General Facts

COORDINATION OF BENEFITS (COB)

All health care benefits provided hereunder are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

Definitions

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

- **Other Plan:** Any plan providing benefits or services for medical, dental or vision care or treatment when provided by group insurance or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis. An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them. If another Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
- **This Plan:** The coverage provided under this Plan.
- **Allowable Expense:** A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.
- If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.
- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., Prior authorization of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

- **Claim Determination Period:** A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").
- **Custodial Parent:** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Effect On Benefits Under This Plan

When Other Plan Does Not Contain a COB Provision

If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision

When another Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE another Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER another Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

Normal Liability

The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment

A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery

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

Order Of Benefit Determination Rules

Whether This Plan is the "primary" plan, or a "secondary" plan is determined in accordance with the following rules.

Note: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

Medicare as an "Other Plan"

Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent

The benefits of a plan that covers the Claimant **other than** as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if:

- the child's parents are married,
- the parents are not separated, whether or not they have ever been married, or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

Court Decree

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

Separated Parents

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent,
- the plan of the spouse of the Custodial Parent,
- the plan of the noncustodial parent, and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee

The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee

If a Claimant is a COBRA enrollee under This Plan, another Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage

If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

SUBROGATION AND REIMBURSEMENT PROVISIONS

A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of Benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole". In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving Benefits under the Plan, the Covered Person agrees that acceptance of Benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;
3. Within 10 business days, reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other Benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.
6. When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future Benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, out of any Recovery without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Covered Person" means anyone covered under the Plan, including minor Dependents.

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible (or who is alleged or claimed to be liable or legally responsible) to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

"Another Party" shall include the party or parties who caused the injuries or illness (or are alleged or claimed to have caused the injuries or illness); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible (or is alleged or claimed to be liable or legally responsible) for payment in connection with the injuries or illness.

“Recovery” shall mean the specific fund of any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

“Reimbursement” shall mean repayment from the Recovery to the Plan for medical or other Benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this Benefit amount.

“Subrogation” shall mean the Plan’s right to pursue the Covered Person’s claims for medical or other charges paid by the Plan against Another Party.

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of Benefits and as a condition to any payment of future Benefits for other illnesses or injuries. Additionally, the Covered Person’s attorney must recognize and consent to the fact that the Plan precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person’s attorneys’ fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan for Reimbursement under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed out of the Recovery.

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s representative has access or control of the Recovery.

When a Covered Person 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 Covered Person 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. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and future expenses for treatment of the illness or injury, which is the cause of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are incurred related to an illness or injury for which a Recovery has been made. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply.

Offset

Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan’s discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status

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

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

Discretionary Authority of The Plan Administrator

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/or law relating to the Plan, to determine whether benefits are payable under the Plan and if so, in what amount, decide appeals of disputed claims, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator has delegated such discretionary authority to the Claims Administrator. All decisions, actions, interpretations and determinations by the Plan Administrator and/or the Claims Administrator shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator and/or Claims Administrator acted arbitrarily and capriciously.

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.

Assignments To Providers

All Eligible Expenses reimbursable hereunder will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

No covered Employee or Dependent may, at any time, either while covered hereunder or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

Network Providers

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due hereunder, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request. **Important:** In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

Medicaid

Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable hereunder.

CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, those regulations shall control.

Types of Claims

There are four types of claims: Pre-Service (Urgent and Non-Urgent), Concurrent Care and Post-service:

1. **Pre-Service Non-Urgent Claims:** A claim for a benefit under the Plan where the Plan conditions approval of the benefit in advance of obtaining medical care. However, if the Plan does not **require** the Covered Person to obtain approval of a medical service **prior** to getting treatment, then there is no "Pre-Service Claim." The Covered Person simply follows the Plan's procedures with respect to any notice, which may be required after receipt of treatment, and files the claim as a Post-Service Claim.
2. **Pre-Service Urgent Care Claim:** Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could:

- seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or
- in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Important: If a Covered Person needs medical care for a condition, which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

The Plan **requires** the Covered Person or a representative to contact the Anthem Prudent Buyer Plan within 72 hours of an emergency medical admission. The Covered Person must follow the Plan's procedures with respect to any notice, which may be required after receipt of treatment, and files the claim accordingly.

Prior authorization 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 Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-Service Claim.

3. **Concurrent Claims.** Claims that arise when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either the:
 - Plan determines that the course of treatment should be reduced or terminated, or
 - Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not **require** the Covered Person to obtain approval of a medical service **prior** to getting treatment, then there is no need to contact the Claims Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice, which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

4. **Post-Service Claims.** A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered.

Filing

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 made and received by HealthComp Administrators in accordance with the Plan's procedures.

A Post-Service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92 within 90 days after the date services or treatment has been rendered and except in the absence of legal capacity of the Covered Person, **not later than 365 days from the date of service**, the:

- date of service,
- name, address, telephone number and tax identification number of the provider of the services or supplies,
- place where the services were rendered,
- diagnosis and procedure codes,
- amount of charges, which reflect any applicable PPO repricing,
- name of the Plan,
- name of the covered employee, and
- name of the patient.

Medical or surgical procedures that have been specifically pre-authorized by the Anthem Prudent Buyer Plan must be performed within 90 days of the authorization. If the services are rendered in excess of that 90-day period of time, the physician or Covered Person must contact the Anthem Prudent Buyer Plan to re-establish medical necessity, verify eligibility and Plan benefits before performing the procedure.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. HealthComp Administrators will determine if enough information has been submitted to enable proper consideration of the claim. If additional information is required, HealthComp Administrators must receive this information within the following timeframes:

- **Pre-Service Non-Urgent Care Claims:** Within **45 days** from receipt by the Covered Person of the request for additional information.
- **Pre-Service Urgent Care Claims:** Within **48 hours** from receipt by the Covered Person of the request for additional information.

Important: Failure to file a claim properly may result in claims being denied or reduced.

Timing of Claim Decisions

The Claims Administrator shall notify the Covered Person, 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

- If the Covered Person has provided all of the information needed to process the claim, as soon as possible but no later than 72 hours after receipt of the claim.
- If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person 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. The Covered Person shall be afforded a reasonable amount of time taking into account the medical circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify the Covered Person of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of: (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Covered Person to provide the specified additional information.

2. **Pre-Service Non-Urgent Care Claims:**
 - If the Covered Person 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.
 - If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the claim. The Covered Person 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 Claims Administrator and the Covered Person (if additional information was requested during the extension period).
3. **Concurrent Claims:**
 - **Plan Notice of Reduction or Termination.** If the Claims Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - **Request by Covered Person Involving Urgent Care.** If the Claims Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, 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 Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person 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.
 - **Request by Covered Person Involving Non-Urgent Care.** If the Claims Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is 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).
4. **Post-Service Claims:**
 - If the Covered Person 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.
 - If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person 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 Covered Person will be notified of the determination by a date agreed to by the Claims Administrator and the Covered Person.

Extensions

- **Pre-Service Non-Urgent Care Claims.** This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, 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.
- **Post-Service Claims.** This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, 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.

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 Claims Administrator or its delegate shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

1. a reference to the specific portion(s) of the Summary Plan Description upon which a denial is based,
2. specific reason(s) for a denial,
3. a description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary,
4. a description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action following an adverse benefit determination on final review,
5. a statement that the Covered Person 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 Covered Person's claim for benefits,
6. 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),
7. 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 Covered Person, free of charge, upon request), and
8. 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 Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

Appeal of Adverse Benefit Determinations: A Full and Fair Review of All Claims

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

1. Covered Persons at least 180 days following initial adverse benefit determination within which to appeal the determination.
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by USC Verdugo Hills Hospital or its delegate, 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.
4. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
5. 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.
6. For the identification 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.

7. That a Covered Person will be provided, upon request and free of charge:

- reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits in possession of the Plan Sponsor or the Claims Administrator,
- information regarding any voluntary appeals procedures offered by the Plan,
- any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, and
- an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

Important: The Plan Sponsor has the final discretionary authority (and any party to whom the Plan Sponsor or Plan Administrator has delegated such final authority), in its sole discretion, to determine eligibility for any benefit under the Plan, as well as all other matters relating to the Plan, and its determinations are conclusive and binding on all persons.

Requirements for Appeal

The Covered Person must file an appeal from the denial of a claim in writing within 180 days following an adverse benefit determination. To file an appeal in writing, the Covered Person's appeal must be addressed as follows:

Pre-Service MEDICAL Claims	Post-Service MEDICAL Claims	Post-Service PHARMACY
<p align="center">Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007</p>	<p align="center">HealthComp Administrators P.O. Box 45018 Fresno, CA 93718-5018</p>	<p align="center">US Script, Inc. Attn: USC VHH Administrative Review 2425 W. Shaw Ave Fresno, CA 93710 Fax: (866) 399-0929</p>

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- the name of the Employee/Covered Person,
- the Employee/Covered Person's social security number,
- the group name or identification number,
- all facts and theories supporting the claim for benefits. **Important:** Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal,
- a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim, and
- any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Claims Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

- **Pre-Service Urgent Care Claims:** As soon as possible but not later than 72 hours **after** receipt of the appeal.
- **Pre-Service Non-Urgent Care Claims:** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 business days after receipt of the appeal.
- **Concurrent Claims:** The response will be made in the appropriate time period based upon the type of claim – Pre-Service Urgent (72 hours), Pre-Service Non-Urgent or Post-service.
- **Post-Service Claims:** Within a reasonable period of time, but not later than 60 business days after receipt of the 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 Claims Administrator shall provide a Covered Person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- the specific reason or reasons for the denial,
- reference to the specific portion(s) of the Summary Plan Description on which the denial is based, the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice,
- a statement that the Covered Person 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 Covered Person's claim for benefits,
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request,
- if the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request,
- a statement of the Covered Person's right to file a final appeal with USC Verdugo Hills Hospital, and
- a statement of the Covered Person's right to bring a legal action following an adverse benefit determination on final review by USC Verdugo Hills Hospital.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Claims Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Deemed Denial If No Response

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth in this section, the Covered Person may assume that the appeal has been denied.

Final Appeal

If after exhausting the above claims and appeals procedures, you are not satisfied with the Claims Administrator's decision on review of your claim, you may submit a final appeal to the Plan Sponsor. Your appeal must be in writing and include all relevant information or additional proof that supports your appeal. Your appeal should be submitted within **90 days** after the date of your receipt of the Claims Administrator's adverse decision on your request for review (or after the date your appeal to the Claims Administrator is deemed denied for lack of response). The appeal should be submitted to:

Pre-Service MEDICAL Claims	Post-Service MEDICAL Claims	Post-Service PHARMACY
Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	HealthComp Administrators P.O. Box 45018 Fresno, CA 93718-5018	US Script, Inc. Attn: USC VHH Administrative Review 2425 W. Shaw Ave Fresno, CA 93710 Fax: (866) 399-0929

USC Verdugo Hills Hospital, the Plan Sponsor, has delegated final review authority to the Medical Review Committee ("Committee"). The Committee will review your appeal and notify you in writing of its final and binding decision within 90 days of its receipt of your appeal. If the Committee denies your appeal in whole or in part, the notification of the Committee's decision will include the applicable information listed under *Manner and Content of Notification of Adverse Benefit Determination on Review*.

Legal Action

Important: All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his/her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form, which can be obtained from the Plan Sponsor or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Sponsor, in writing, to the contrary.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an **approved** benefit must be provided only for Pre-Service benefit determinations.

CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when medical coverage stops, you or your Covered Dependents may be eligible to continue your benefits at your own expense for a temporary period. To be eligible, you and your Covered Dependents must:

- experience a qualifying event that causes the loss of coverage, and
- make an election to continue coverage through COBRA within 60 days of the date shown at the top of the COBRA notification letter (see *Applying for Coverage*).

The following chart lists qualifying events (but only if the event results in a loss of coverage under the Plan), who is eligible to continue medical coverage and how long benefits may continue. Qualifying Event (The reason coverage stopped)	Who May Continue	Continuation Period*
Your employment stops for any reason other than gross misconduct	You and your eligible dependents	18 months
You no longer meet eligibility requirements due to a reduction in your hours See <i>Who Is Eligible</i> for more information	You and your eligible dependents	18 months
You divorce or legally separate	Ex-spouse/domestic partner and/or eligible dependent children	18 months
Your dependent children no longer meet the eligibly requirements	Former eligible dependents	36 months
You become entitled to Medicare	Eligible dependents	36 months
You die	Eligible dependents	18 months

* A second qualifying event may allow a longer benefit period; see Multiple Qualifying Events on the following page for additional information.

A qualified beneficiary is:

- you, your spouse* and dependent child(ren) enrolled for medical coverage on the day before the qualifying event, and
- a child born, adopted or placed for adoption during the COBRA coverage period.

* Under federal law, domestic partners are not eligible for COBRA coverage.

Qualified beneficiaries who purchase COBRA coverage are able to make changes to their medical coverage during the annual benefits enrollment period. However, if you had only single coverage in effect when you became eligible for COBRA coverage, you may not change to family coverage until the next annual enrollment period unless you experience an event that would allow you to change your coverage during the year (see *Changing Coverage During the Year* for more information).

The benefits provided under COBRA will be the same as those provided to eligible employees, spouses, domestic partners or eligible children who are covered under the USC Verdugo Hills Hospital plan. If the plans change, benefits under COBRA will also change.

Multiple Qualifying Events

A disabled individual, and all other Covered Dependents, may continue coverage for an additional 11 months, for up to a total of 29 months, if an employee or a dependent is disabled (as defined by the Social Security Administration) within 60 days of a qualifying event and notifies USC Verdugo Hills Hospital (USC VHH) within 60 days of the latest of the date:

- of determination,
- of the qualifying event,
- coverage is lost, and
- the date the qualified individual is informed of the obligation to provide a notice of disability determination.

That notification must also be provided to USC VHH before the end of the 18-month period of COBRA coverage. If the Social Security Administration determines that the disability no longer exists, you or your dependents must notify Human Resources within 31 days. During the extra 11-month period of coverage, premiums may be increased up to 150% of the regular cost of coverage.

If coverage is continued because of a qualifying event for which the continuation period is 18 months, this 18-month period can be extended to 36 months, in the event of a second qualifying event that provides for up to 36 months of extended coverage. For example, an employee terminates employment and purchases continuation coverage for his/her family for up to 18 months. Two months later, one of his/her children reaches the maximum eligibility age. That former dependent child can now purchase continuation coverage for 34 months (36 months minus the two months already received).

If the second qualifying event is that you have become entitled to Medicare, eligible dependents can continue coverage up to 36 months from the date of the first qualifying event.

Applying for Coverage

If one of your dependents loses coverage due to your divorce or legal separation or a dependent no longer meets the eligibility requirements, it is your or your dependent's responsibility to notify USC Verdugo Hills Hospital within 60 days of the event. If a COBRA election is not made within the 60-day election period, COBRA coverage will not be available.

Notice for the qualifying events described above must be sent **in writing** (describing the qualifying event and the date it occurred) to:

HealthComp Administrators
Eligibility Department
P.O. Box 45018
Fresno, CA 93718-5018

Contact HealthComp Administrators at (800) 442-7247 with any questions regarding the COBRA procedures.

In the event of your termination, reduction in your work hours or death, USC Verdugo Hills Hospital must notify the COBRA Administrator of the qualifying event within 30 days of any of these events. The COBRA Administrator has 14 days to send you a more detailed COBRA Election Notice and Application. To continue coverage under COBRA, you must complete and return the application to the Administrator within 60 days from the later of the date the application is sent to you or the date your coverage would otherwise terminate.

Important: The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

Cost of Coverage

If you or your dependents choose to continue coverage, you will have to pay the full cost of the coverage plus 2% for administrative costs. Your premiums are due on the first of each month. Your first premium payment is due within 45 days of the date you elect COBRA coverage. There is a 30-day grace period for payment of regularly scheduled premiums. If the premium is not paid before the expiration of the grace period, COBRA benefits will end and may not be reinstated.

WHEN COBRA COVERAGE ENDS

Continuation coverage will stop before the maximum continuation period shown at the beginning of this section if one of the following events occurs:

- you or your dependents fail to make timely payments,
- you or your dependents become entitled to Medicare after the date COBRA is elected,
- you or your dependents reach your maximum period allowed under COBRA,
- coverage starts under another group health plan after the date COBRA is elected, unless coverage is delayed or denied because of a pre-existing condition limitation and you do not have creditable coverage to offset the pre-existing condition, or
- USC Verdugo Hills Hospital discontinues all medical and prescription benefit plans offered to employees.

This Plan will remain in compliance with all applicable laws or any future Internal Revenue Services (IRS) guidance, even if it conflicts with Plan provisions and any such conflicting Plan provisions shall be automatically to the extent necessary for the Plan to comply with applicable law.

GENERAL PLAN INFORMATION

Requirements	Detailed Information
Name of Plan	USC Verdugo Hills Hospital Employee Group Medical Benefit Plan
Plan Sponsor / Plan Administrator (“Administrator”)	USC Verdugo Hills Hospital (“USC VHH”, the “Company” and the “Employer” 1812 Verdugo Boulevard Glendale, CA 91208 (818) 952-3514
Employer	USC Verdugo Hills Hospital
Plan Sponsor ID Number (EIN)	95-1642394
Plan Number	501
Original Effective Date of Plan	July 1, 1972
Plan Year	January 1 through December 31
Named Fiduciary	USC VHH 1812 Verdugo Boulevard Glendale, CA 91208
Agent for Service of Legal Process (Legal process may be served upon the Plan Administrator or a Fiduciary)	Chief Financial Officer (“CFO”) USC Verdugo Hills Hospital 1812 Verdugo Boulevard Glendale, CA 91208
Type of Plan	This is an employee welfare benefit plan providing group benefits
Plan Benefits Described Herein	Self-Funded Medical and Prescription Benefits. Benefits are funded from the Plan Sponsor’s general assets.
Type of Administration	Contract Administration See Administrative Provisions for additional information
Applicable Collective Bargaining Agreement(s)	None
Contract Administrators	<ul style="list-style-type: none"> ▪ Medical Benefits: HealthComp Administrators (the “Claims Administrator”) P.O. Box 45018 Fresno, CA 93718-5018 (800) 442-7247 ▪ Prescription Drugs Benefits US Script, Inc. 2425 W. Shaw Ave Fresno, CA 93710 (800) 460-8988

ADMINISTRATIVE PROVISIONS

ALTERNATIVE TREATMENT PLAN

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan Sponsor reserves the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate any benefits under the Plan,
- alter or postpone the method of payment of any benefit,
- amend any provision of these administrative provisions,
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA, and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time

Note: Any modification, amendment or termination action will be reflected in a document signed or approved by a duly authorized officer of the Plan Sponsor. There are no vested rights or benefits under the Plan.

ANTICIPATION, ALIENATION, SALE OR TRANSFER

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

CLERICAL ERROR

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

CONTRACT ADMINISTRATOR

A Contract Administrator is a company that performs all functions reasonably related to the general management, supervision and administration of certain Plan benefits in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor. The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

The Contract Administrator is not a named fiduciary of the Plan. The Contract Administrator is not an insurer of Plan benefits is not responsible for Plan financing and does not guarantee the availability of benefits hereunder.

CREDITABLE COVERAGE CERTIFICATES

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

FACILITY OF PAYMENT

Every person receiving or claiming Plan benefits will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming Plan benefits is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefor.

PLAN ADMINISTRATOR

The administration of the Plan shall be under the supervision of the Administrator, which is USC VHH. The Administrator shall be the named fiduciary of the Plan for purposes of ERISA with the discretionary authority to control and manage the operation and administration of the Plan. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to the applicable requirements of law. For this purpose, the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- (b) To decide all questions concerning the Plan and the eligibility of any persons to participate in the Plan;
- (c) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing and in accordance with applicable requirements of law; and
- (d) To the fullest extent permitted by law, the Administrator shall have the discretion to determine all matters relating to eligibility, coverage or benefits under the Plan and the Administrator shall have the discretion to determine all matters relating to the interpretation and operation of the Plan.

Any determination by the Administrator, or its authorized delegate (such as the Claims Administrator), shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

FORCE MAJEURE

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

FUNDING

Plan benefits described herein are paid through a trust arrangement with the Employer.

GENDER AND NUMBER

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

ILLEGALITY OF PARTICULAR PROVISION

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who formerly served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

LEGAL ACTIONS

No Employee Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

LOSS OF BENEFITS

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer,
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner,
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces),
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party, or
- a claim for benefits is not filed within the time limits of the Plan.

MATERIAL MODIFICATION

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

MEDICARE

Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

MISSTATEMENT / MISREPRESENTATION (INTENTIONAL)

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

MISUSE OF IDENTIFICATION CARD

If an Employee or covered Dependent permits any person who is not a covered member 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 at the end of thirty-one (31) days from the date written notice is given.

NON-DISCRIMINATION DUE TO HEALTH STATUS

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence),
- claims experience,
- receipt of health care,
- medical history,
- evidence of insurability,
- disability, or
- genetic information.

PHYSICAL EXAMINATION

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

PLAN ADMINISTRATOR DISCRETION & AUTHORITY

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Claims Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

PRIVACY RULES & SECURITY STANDARDS & INTENT TO COMPLY

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

PURPOSE OF THE PLAN

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

REIMBURSEMENTS

- **Plan's Right to Reimburse Another Party:** Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.
- **Plan's Right to be Reimbursed for Payment in Error:** When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.
- **Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability:** The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

RIGHTS AGAINST THE PLAN SPONSOR OR EMPLOYER

Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

TITLES OR HEADINGS

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

WORKERS' COMPENSATION

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

YOUR RIGHT TO BENEFITS

The Employee Retirement Income Security Act of 1974 (ERISA) spells out certain rights and duties for benefit plans. ERISA is a federal law that sets standards and defines procedures for employee benefit plans. The information that follows explains your ERISA rights.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

As a participant in the Company's benefit plan, ERISA entitles you to certain rights and protection. ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Company's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy 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 Company, copies of documents governing the operation of a plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Company may make a reasonable charge for the copies.
- Receive a summary of a plan's annual financial report. The Company is required by law to furnish each participant with a copy of this summary annual report.
- Continue medical coverage for yourself, your spouse or eligible dependents if there is a loss of coverage under a plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan for the rules relating to your COBRA continuation coverage rights.
- Receive a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
 - you lose coverage under a plan,
 - you become entitled to elect COBRA continuation coverage, or
 - your COBRA continuation coverage ceases.

A certificate of creditable coverage should be provided if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date with your next coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the Summary Plan Description or the latest annual report from the plan and do not receive them within 31 days, you may file suit in a federal court. In such a case, the court may require the Company to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Company.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, provided that you have first complied with a plan's claim and appeal procedures. In addition, if you disagree with a plan's decision or lack of a decision concerning the qualified status of a medical child support order, you may file suit in federal court.

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

HELP WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Company. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Company, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll free at 1-866-444-EBSA (3272).

OTHER FEDERAL HEALTH CARE LAWS

Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP")

A group health plan is required to provide special enrollment periods during which certain individuals who previously declined coverage are allowed to enroll (without having to wait until the Plan's next open enrollment period). Consequently, if you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, the following special enrollment periods are also applicable to your employer's plan. The plan must permit you, or your dependent child, who is eligible for, but not enrolled in, the employer's plan to enroll in the plan if:

- You or your dependent child is covered under Medicaid or a state CHIP program and such coverage is terminated due to a loss of eligibility, provided that you request enrollment in your employer's plan no later than 60 days after the Medicaid/CHIP coverage terminates; or

- You or your dependent child becomes eligible for Medicaid or a state CHIP program, provided that you request enrollment in your employer's plan no later than 60 days after you or your dependent child, as applicable, is determined to be eligible for premium assistance under the Medicaid or state CHIP program.

YOUR RIGHTS WITH NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 ("NMHPA")

Under NMHPA, group health plans, insurance companies and health maintenance organizations (HMOs) offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum period of time. For example, NMHPA provides that coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child. However, NMHPA 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). NMHPA also provides that group health plans, insurance companies and HMOs may not require that a provider obtain authorization for prescribing a length of maternity stay not in excess of the above periods.

YOUR RIGHTS WITH WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 ("WHCRA")

WHCRA provides that, in the case of a participant or beneficiary who is receiving benefits under a group health plan in connection with a mastectomy and who elects breast reconstruction, coverage under the plan will be provided in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Under WHCRA, coverage of breast reconstruction benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

As required by ERISA, the Plan recognizes qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A QMCSO must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Sponsor receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

A copy of the Plan's QMCSO procedures are available, free of charge, upon written request.

HIPAA COMPLIANCE

To the extent required by law, the Plan and the Administrator shall fully comply with 45 C.F.R., Part 164, Security and Privacy (the "Regulation"), including but not limited to §164.504(f) in all respects as of the date the Regulation requires such compliance by the Plan.

(a) Notwithstanding anything in the Plan to the contrary, any disclosure of protected health information (PHI), as defined in the Regulation, shall be limited to such disclosure as permitted by the Regulation.

(b) The Plan may disclose summary health information, as defined in the Regulation, to the Employer if the Employer requests summary health information for the purpose of (A) obtaining premium bids from health plans for providing health insurance coverage under the Plan or (B) modifying, amending or terminating the Plan.

(c) To the extent permitted by the Regulation, the Employer may use PHI for the administration of the Plan in accordance with the provisions of the Plan, such Plan administration to include quality assurance, claims processing (including the review of denied claims), auditing, monitoring and management of carve-out plans.

(d) The Plan will disclose PHI to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to include this Section and the Employer agrees to:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or health and welfare plan of the Employer;

(4) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(5) Make available PHI in accordance with Regulation §164.524;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Regulation §164.526;

(7) Make available the information required to provide an accounting of disclosures in accordance with Regulation §164.528;

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Regulation;

(9) If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information 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 information infeasible; and

(10) Ensure that adequate separation exists between the Plan and the Employer as set forth below.

(A) The following employees or classes of Employees or other persons under the control of the Employer will be given access to the PHI to be disclosed: Employees involved in the administration of the Plan, including but not limited to (a) providing, or arranging for the provision of, covered services under the Plan, or (b) paying or arranging for payment of covered services, or (c) conducting quality assurance (including audits) relating to Plan, or (d) evaluating claims and deciding appeals of denied claims, or (e) responding to questions from, or on behalf of, participants and beneficiaries

about the Plan, or (f) such activities relating to the operation and administration of the Plan as the Employer may from time to time delegate to such Employees.

(B) The access to and use by the Employees and other persons described above shall be restricted to the Plan administration functions that the Employer performs for the Plan.

(C) Any issues of noncompliance by the Employees and other persons described above shall be dealt with promptly by the Employer's designated privacy officer or any other duly authorized officer taking immediate steps to (i) investigate the alleged noncompliance, (ii) if noncompliance has occurred, correct the noncompliance in accordance with applicable law, (iii) initiate appropriate disciplinary actions against the individuals responsible for the noncompliance, and (iv) institute procedures to ensure that such noncompliance does not recur.

(D) The Plan may disclose PHI to the Employer to carry out Plan administrative functions that the Employer performs only consistent with the Regulation.

(E) A health insurance issuer or HMO with respect to the Plan shall not disclose PHI to the Employer except as permitted by the Regulation.

(F) The Plan shall not disclose and may not permit a health insurance issuer or HMO to disclose PHI to the Employer as otherwise permitted by the Regulation unless a statement required by Regulation §164.520(b)(1)(iii)(C) is included in the appropriate notice, and shall not disclose PHI to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or health and welfare plan of the Employer.

(e) To the extent required by 45 C.F.R. §164.314(b), except when the only electronic PHI disclosed to the Employer is disclosed pursuant to 45 C.F.R. §164.504(f)(1)(ii) or (iii), or as authorized under 45 C.F.R. §164.508, the Employer will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan. In accordance with the foregoing, the Employer shall:

(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 the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom the Employer provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(4) Report to the Plan any security incident of which it becomes aware.

(f) To the extent required by subpart D of the Regulation, following the discovery of a breach of unsecured PHI occurring on or after September 23, 2009, the Plan shall provide any required notification:

(1) to individuals in accordance with Regulation §164.404;

(2) to media outlets in accordance with Regulation §164.406; and

(3) to the Secretary of HHS in accordance with Regulation §164.408.

(g) To the extent the Plan fails to comply with the Regulation, the Plan shall be deemed to be automatically amended to so comply and the Plan shall in any event be administered in accordance with any and all such deemed automatic amendments.

hj) This Section on compliance with HIPAA shall apply only to the extent the Regulation applies to the Plan.

Plan Sponsor certifies that it agrees to the provisions outlined above and shall comply with those provisions. The Plan shall be administered in accordance with the provisions of HIPAA applicable to the Plan and if any provision of the Plan conflicts with any such provision of HIPAA, such conflicting Plan provision shall be automatically amended to comply with HIPAA.

FUTURE OF THE PLAN-NO VESTED RIGHTS OR BENEFITS

The Company reserves the right to amend, modify, suspend or terminate the medical and prescription benefit plans at any time.

Amendments or modifications to the plan may be adopted by resolution of the Board of Directors of the Company or any person to whom the Board has delegated authority. In addition, changes to the cost, amount or type of benefits provided, or to administrative procedures under a plan, may be adopted by Human Resources and communicated to employees without formal Board approval.

AN IMPORTANT NOTE

This booklet describes the major provisions of the medical and prescription benefit plans and constitutes the Plan Document for the Plan under Section 402(a) of ERISA. The Plan Sponsor reserves the right to amend or terminate the Plan at any time by a written instrument signed or approved by a duly authorized officer of the Plan Sponsor. There are no vested rights or benefits under the Plan.

You have the right to examine a copy of the official Summary Plan Description (including insurance contracts) during regular business hours and to receive a copy of this Summary Plan Description; the Company may make a reasonable charge for providing copies.

Benefit provisions and eligibility for coverage do not constitute a contract of employment with any individual. The Company reserves all rights to end an employment relationship at any time for any reason.

ADOPTION OF THE DOCUMENT

ADOPTION

The Plan Sponsor hereby adopts this Plan Document on the date shown below. This document replaces any and all prior statements of the Plan benefits that are described herein.

PURPOSE OF THE PLAN

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby automatically amended to conform to such law.

PARTICIPATING EMPLOYERS

Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

RESTATEMENT / REPLACEMENT OF BENEFITS

This document replaces prior benefits offered by the Plan Sponsor, but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

ACCEPTANCE OF THE DOCUMENT

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2019.

USC VERDUGO HILLS HOSPITAL ("USC VHH" AND THE "COMPANY")

By: _____

Title: _____

WITNESS:

By: _____

Title: _____