Using Your Handbook

For questions and assistance with your benefits
or information in this section, contact the
HealthySteps Benefits Service Center at
855-278-7157 (Monday – Friday, 5:00 a.m. – 5:00 p.m. PT).

Lucile Packard Children's Hospital Stanford is a participating employer in the
Stanford Health Care Employee Health and Welfare Benefit Plan.

For Non-Represented and SEIU-UHW Represented Employees

Effective January 1, 2020

Stanford HEALTH CARE

Lucile Packard Children's Hospital Stanford

HealthySteps

Understanding Your Benefits Program

For the purposes of this Handbook, Stanford Health Care as the plan sponsor and Lucile Packard Children's Hospital Stanford as a participating employer are referred to as "the hospital" or collectively as "the hospitals."

The hospitals want you to understand how your benefits program works. This section provides you with information about how to use your Handbook, a summary of your benefits, eligibility information, when benefits begin and end, and when you may enroll or make changes.

Table of Contents

Understanding Your Benefits Program 2
Welcome to Your Benefits Handbook 8
How Your Benefits Program Was Developed 8
Who Is Eligible 9
Eligible Dependents — A Definition of Dependents 9
Coverage If Both You and Your Spouse/Eligible Domestic Partner Work at the Hospitals 10
Working Spouse/Eligible Domestic Partner Access Fee 11
Summary of Your Benefits 11
Your Benefits 11
Survivor Protection 18
Your Survivor Benefits 18
Who Is Eligible 18
Your Beneficiary 18
Coverage If Both You and Your Spouse/Eligible Domestic Partner Work at the Hospitals . 19
Life Insurance Benefits 19
Enrolling 19
More Information 19
Supplemental AD&D Insurance 20
Enrolling 20
More Information 20
Other Options When Life Insurance Coverage Ends 20
Income Protection 20
Who Is Eligible 21
Beneficiary Benefits 21
Your executor or administrator of your estate. More Information 21
State Disability Benefits 22
More Information 22
Supplemental Short-Term Disability (STD) Benefits 22
More Information 22
Long-Term Disability (LTD) Benefits 23
More Infomation 23
California Paid Family Leave 23
More Infomation 23
Additional Benefits 24
Voluntary Benefits Program 24
Auto and Home & Renters Insurance 24
Identity Theft Protection 24
Pet Insurance 25
Purchasing Program 25
Legal Plan 25

Enrollment 26
Other Benefits 27
Default Coverage 28
Supporting Documentation Needed 28
Special Enrollment Period 30
Cost of Coverage 30
Paying for Eligible Domestic Partner Coverage 30
Changing Your Benefits 31
Health Coverage Changes 32
Annual Open Enrollment Period 35
When Coverage Ends 36
For Your Covered Dependents 36
Options When Coverage Ends 37
Benefits Coverage During Layoff 37
Other Important Provisions 38
Coverage During an Approved Leave of Absence (LOA) 38
Your Handbook and Health Booklets 44
Your Health Plans 45
What's Offered 45
Types of Plans 45
Using Your Plan 45
How the Plans Work 46
Medical Plan Coverage 47
Aetna Choice POS II with HSA 47
Schedule of Benefits 49
What the Plan Covers 57
What the Plan Does Not Cover 60
Stanford Health Care Alliance (SHCA) 64
Schedule of Benefits 66
What the Plan Covers 72
What the Plan Does Not Cover 75
Kaiser Permanente HMO 81
Schedule of Benefits 81
Prescription Drug Benefits 81
Aetna Choice POS II with HSA 81
Specialty Injectable Drugs — CVS/specialty 85
Prior Authorization 86
Quantity Level Limits 87
Step Therapy 87
Drugs Not Covered 88
SHCA 89
Specialty Injectable Drugs — Aetna Specialty Pharmacy 92

Prior Authorization ... 93
Quantity Level Limits ... 94
Step Therapy ... 94
Drugs Not Covered ... 95
Kaiser Permanente HMO ... 96
HealthySteps to Wellness ... 96
Employee Assistance Program (EAP) ... 96
Dental Plan ... 97
Your Dental Plan Choices ... 97
Vision Plan ... 97
What's Offered ... 97
Filing and Appealing Medical Claims ... 97
Filing Medical Claims ... 97
Adverse Benefit Determination (Denied Claims) ... 100
Filing a Claim or Appeal for Prescription Benefits ... 102
Filing a Pharmacy Claim or Appeal — Aetna ... 102
Filing a Pharmacy Claim or Appeal — CVS/Caremark ... 102
Coordination of Benefits ... 103
How Coordination of Benefits Works ... 103
Order of Benefit Determination Rules ... 104
If You Are Covered by Medicare ... 105
Expenses for Which a Third Party May Be Responsible (Subrogation) ... 106
COBRA Continuation of Coverage ... 109
Introduction ... 109
Qualifying Life Events ... 110
Notification and Responsibilities ... 111
COBRA Survivor Benefit for Children ... 112
Electing COBRA Coverage ... 112
Alternative to COBRA Coverage ... 117
Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? ... 117
Getting the Most for Your Money ... 119
Your Tax-Advantaged Savings Account and Health Reimbursement Account Options ... 119
Enrolling in a Tax-Advantaged Savings Account and Health Reimbursement Account ... 126
Appeals for Dependent Care FSA, Health Care FSA and Health Reimbursement Account (HRA) Claims ... 128
Your Handbook and Health Booklets ... 131
Retiree Medical Insurance ... 131
Retiree Medical Insurance Eligibility ... 131
Retiree Groups ... 131
Continuous Service ... 131
Predecessor Employer ... 132

Breaks in Service 132
How to Determine Your Retiree Group 134
Which Plans Are You Eligible for? 134
Group A 135
Group B, C or D 135
Cost Sharing 136
Retiree Group A 136
Retiree Group B 136
Retiree Group C 137
Retiree Group D 138
Enrolling in Retiree Medical Insurance 139
Initial Enrollment 139
Assess Your Retiree Medical Needs Early 140
When Retiree Medical Coverage Begins 140
Eligible Dependents 141
If You Have Other Coverage 141
If Both You and Your Spouse/Eligible Domestic Partner Worked for the Hospitals 142
When You Become Eligible for Medicare 142
When Family Members Become Eligible for Medicare 143
Enrolling in Medicare 144
Annual Open Enrollment Versus Medicare's Enrollment Period 145
When Coverage Ends 145
How to Obtain More Information About Retiree Medical Benefits 146
Getting Information 148
Your Privacy Rights Under HIPAA 148
The Plan's Duties with Respect to Health Information about You 148
How the Plan May Use or Disclose Your Health Information 148
How the Plan May Share Your Health Information with the Hospitals 149
Other Allowable Uses or Disclosures of Your Health Information 150
Your Individual Rights 152
Changes to the Information in This Notice 154
Complaints 154
For More Information 154
Your Rights and Privileges Under ERISA 155
Overview 155
Statement of Participant Rights 155
Receive Information about Your Plan and Benefits 155
Continue Group Health Plan Coverage 156
Require Prudent Actions by Plan Fiduciaries 156
Enforce Your Rights 156
Assistance with Your Questions 157
Rights and Authority of the Plan Administrator 157

How to Appeal a Denied Claim 159
Overview 159
Request for Appeal 159
Special Rules 159
ERISA Claims and Appeal Procedures for Medical Claims 160
Claims for Benefits 160
Notice of Adverse Benefit Determination 162
Appeals of Claim Denials 163
Timing of Notification of Benefit Determination on Review 164
Appeal Process 164
Appeals Determinations 165
Manner of Notification of Final Internal Adverse Benefit Determination 166
ERISA Claims Procedures for Retirement Benefits 168
Claims Procedures for Disability Benefits 168
More Information about Your Medical Benefits and Your Rights 170
Statement of Rights under the Newborns' and Mothers' Health Protection Act 170
Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act of 1998) 171
Additional Rights for Mental Health and Substance Abuse Benefits 171
Genetic Information Nondiscrimination Act 172
Other Information 172
Official Plan Documents Govern 172
Amendment and Termination of the Plans 173
Plan Administrator's Discretion 173
Support Order Procedures 173
Administrative Information 173
Retiree Medical Coverage Contribution Methodology 173
Group Insurance Plans 175
Retirement Savings Plan 176
When You Have Questions 177
Intent of the Handbook 177
Health Plans 178
Other Benefit Plans 181
Glossary of Terms 184

Welcome to Your Benefits Handbook

The 5 sections below constitute your Benefits Handbook. All topics are covered within this document.

- ***Your Health Care Benefits*** — information on your medical, pharmacy, life and accidental death and dismemberment insurance (AD&D), Employee Assistance Program (EAP) benefits and more
- ***Tax-Advantaged Savings Accounts*** — accounts to save tax-free money to pay for eligible health care and dependent care expenses
- ***Retiree Medical*** — when you leave the hospitals on or after age 55
- ***Administrative Information*** — information and resources to help you

These sections are designed to help you learn about your benefits so you can use them effectively. Because benefits are a major part of your total compensation, it is important to the hospitals that you understand and get the most from your benefits program.

How Your Benefits Program Was Developed

Before we begin, we would like to share our strategy in the development of this competitive benefits program. First, we considered the *organization's missions and values* to care, educate and discover. This commitment includes providing a comprehensive benefits program to the hospitals' employees and their families that is flexible enough to meet their changing needs. Next, we considered the *competitive marketplace* in which the hospitals operate. In addition, the program also recognizes our *shared responsibility* of keeping the costs of benefits moderate and manageable for all.

The hospitals contribute toward the cost of your health coverage. The remainder is deducted from your paycheck on a pre- or post-tax basis, depending on the benefit plan(s) you select. For pre-tax plans, this lowers your taxable wages and results in greater take-home pay for you. For post-tax plans, such as life insurance and disability, by paying the tax up front, the benefits you or your beneficiaries receive won't be subject to taxes.

In summary, your benefits program offers you:

Choice

The opportunity to design your package of benefits — a package that reflects personal choices and individual needs for coverage.

Flexibility

The freedom to adjust your benefit selections as your lifestyle changes.

Value

A carefully considered approach, so that the hospitals can give you the best value for the money we spend.

Competitiveness
The chance for the hospitals to reward you with a package of benefits that is progressive and competitive in Northern California.

Who Is Eligible

Employees who work at least 40 hours per pay period are eligible for some or all of the benefits described in this Handbook, as outlined in the table below:

If you are an employee in this group …	You are eligible for these benefits …
Regular (Non-Represented/SEIU-UHW Represented **Fixed Term (Non-Represented/SEIU-UHW Represented)**	• Medical/Vision • Health Savings Account (HSA) • Dental • Life insurance (Basic, Supplemental, Spouse/Eligible Domestic Partner and Dependent Child Life and Accidental Death and Dismemberment (AD&D) • Disability Insurance (Supplemental Short-Term Disability (STD), Basic and Supplemental Long-Term Disability (LTD) • Flexible spending accounts (Health Care and Dependent Care Flexible Spending Accounts (FSAs) • Health Reimbursement Account (HRA) • Employee Assistance Program (EAP) • Business Travel Accident Insurance • Back-up Care • Adoption Assistance • Voluntary Benefits • Retirement Savings Plan (RSP)[1]

[1] Must meet the criteria outlined in the *Retirement Savings Plan* section to be eligible for the Basic Contribution. Please see the *Retirement Savings Plan* section at www.healthysteps4u.org for more details.

Eligible Dependents — A Definition of Dependents

The following dependents are eligible for benefits:

- Legally married spouse.
- Eligible domestic partner. Domestic partners are defined as same-sex and different-sex couples who are registered with any state or local government domestic partner registry and who satisfy any other eligibility requirements established by the Plan.
- Eligible children:

- Your children (including natural children, adopted children or children for whom you have initiated legal adoption proceedings prior to age 18, stepchildren, children for whom you are the legal guardian up to age 18, and children for whom you are required to provide health coverage resulting from a Qualified Medical Child Support Order (QMCSO) up to age 26.

- Unmarried children, of any age, who are incapable of self-support and principally dependent on you or your spouse/eligible domestic partner, as a result of physical or mental disabilities that began before age 19. A disabled child may be covered past age 26 if the medical plan provider approves. In order to be eligible for coverage, your over-age disabled child(ren) must be claimed as a tax dependent by you or your spouse/eligible domestic partner and be dependent upon the same for support (50% or more).

  Application for coverage beyond age 26 due to disability must be made to the medical plan provider 60 days prior to the date coverage is to end due to the child reaching limiting age. The plan may periodically request proof of continued disability, but not more than once a year after the initial certification, depending on the medical plan provider requirements.

  If you are a newly hired employee with a disabled child over age 26, or if you acquire a disabled child over age 26 (through marriage or eligible domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 19. You must contact the medical plan provider for the process of disabled dependent certification. If approved by the carrier, coverage will be added for the dependent retroactive to the coverage beginning date.

Coverage If Both You and Your Spouse/Eligible Domestic Partner Work at the Hospitals

In most cases, plan rules do not allow for duplicate coverage.

Employees

You cannot be covered in the hospitals' sponsored plan both as an employee and as an eligible dependent of a hospital employee at the same time:

- **If you are currently enrolled as an employee and as a dependent:** The initial enrollment election for your coverage will remain in force and the second one will be cancelled.
- **If you are covered as an eligible dependent and later become eligible for coverage as an employee:**
  - You and your spouse/eligible domestic partner can each select coverage as employees. In this case, only one of you can cover your eligible children as dependents, or
  - You can opt out of your own employee coverage and be covered as a dependent under your spouse/domestic partner's coverage.

Dependent Children

If you and your spouse/eligible domestic partner both work at the hospitals and you both enroll in benefits separately, you can each enroll your eligible children in dental plan coverage. Duplicate coverage under other plans (e.g., life insurance) is not allowed.

Retirees

With regard to retiree medical benefits, when both spouses work for the hospitals and are eligible under different categories, please contact the HealthySteps Benefits Service Center at 855-278-7157 to determine the appropriate classification at least five years prior to retiring. Special rules apply for retiree medical coverage. Visit **www.healthysteps4u.org** for additional information.

Working Spouse/Eligible Domestic Partner Access Fee

If your spouse/eligible domestic partner has access to other employer coverage but decides not to elect that coverage, and elects to join the hospitals' sponsored plan instead, you will be required to contribute a monthly access fee of $50 on a pre-tax basis through payroll deductions. The fee applies if you meet **all** the following criteria:

- Your spouse/eligible domestic partner is employed outside of the hospitals
- Your spouse/eligible domestic partner is offered health coverage from his/her employer as a part of his/her benefits package
- Your spouse/eligible domestic partner declines that coverage
- You enroll your spouse/eligible domestic partner in the hospitals' plan
- You earn $37.04 or more per hour as of September 8, 2020, or your date of hire, whichever is later

[2] This amount is subject to change each year and is based on August 31 of the previous plan year.

Note: The Working Spouse/Eligible Domestic Partner Access Fee is deducted on a pre-tax basis. However, if you do not claim your eligible domestic partner on your federal taxes, the access fee is subject to federal tax withholding. Contact your tax advisor for details on how to report this on your income tax return.

Summary of Your Benefits

The following chart serves as a brief illustration of the components of your benefits program. Certain limitations may apply. Read this Handbook, the "Your Health Care Benefits" booklet and your health plan's Health booklet for complete information about your benefits.

Your Benefits

	Your Choices	Cost Sharing
Health Insurance		

	Your Choices	Cost Sharing
Medical	• Aetna Choice POS II with Health Savings Account (HSA) • Stanford Health Care Alliance (SHCA) • Kaiser Permanente HMO • Waive coverage[3]	• You share the cost depending on which plan you pick and whom you cover
Prescription Drug	• For Aetna Choice POS II with HSA members: CVS/Caremark • For SHCA members: CVS/Caremark • For Kaiser Permanente HMO members: Kaiser Permanente HMO	• Included with medical coverage
Mental Health/Substance Abuse Insurance	• For Aetna Choice POS II with HSA members: Aetna • For SHCA members: Aetna • For Kaiser Permanente HMO members: Kaiser Permanente Pharmacies	• Included with medical coverage
Vision	• VSP	• Included with medical coverage
Working Spouse/Eligible Domestic Partner Access Fee	• All hospital-sponsored Medical Plans[4]	• Employee paid[4]
Dental	• Delta Dental Basic PPO • Delta Dental Buy-Up PPO • DeltaCare® USA DHMO • Waive coverage[3]	• You share the cost depending on which plan you pick and whom you cover
Survivor Protection		
Basic Life Insurance	• One times your annual base salary or $50,000, whichever is lower	• Employer paid
Supplemental Life Insurance	• You choose one to six times your annual salary up to $3 million (combined with Basic Life)	• Employee paid (based on employee's age)

	Your Choices	Cost Sharing
	• Evidence of Insurability (EOI) is required for coverage that exceeds three times your annual salary • Waive coverage	
Spouse/Eligible Domestic Partner Life Insurance	• Available in $10,000 increments up to $200,000. Evidence of Insurability (EOI) is required for coverage that exceeds $50,000; coverage cannot exceed 100% of employee coverage amount • Waive coverage	• Employee paid (based on employee's age)
Dependent Child Life Insurance	• $10,000 per child • Waive coverage	• Employee paid
Employee or Family Accidental Death and Dismemberment (AD&D) Insurance	• Available in increments of $10,000 up to $1 million • Waive coverage	• Employee paid
Business Travel Accident	• Five times annual salary up to $500,000	• Employer paid

[3] If you waive your health coverage because you have coverage elsewhere, please see "Special Enrollment Period" on page 30.

[4] Does not apply to employees whose hourly rate is $36.30 or less per hour as of August 31, 2019. Please note that rate tiers change at the time of Open Enrollment each year.

	Your Choices	Cost Sharing
Income Protection Benefits	**For Your Own Disability**	
First 12 Months Insurance (SDI)	• California State Disability Insurance (SDI)	• Automatic payroll deduction
Supplemental Short-Term Disability (STD) — up to Six Months	• Purchase coverage up to 60% of your base pay, up to weekly limits. (Note: STD benefit is offset by SDI calculated benefit amount, even if you don't apply for SDI.)	• Employee paid
Basic Long-Term Disability (LTD) — 50%	• Employer provided	• Employer paid
Supplemental Long-Term Disability — 66 2/3%	• Purchase coverage up to 66 2/3% of your base pay, up to weekly limits. (Note: LTD benefit is offset by SDI calculated benefit amount, even if you don't apply for SDI.)	• Employee paid
Retirement Benefits		
Retirement Savings Plan (RSP)	• The RSP allows you to invest a portion of your pay[6] for retirement For details about this plan, see the *Retirement Savings Plan* section at **www.healthysteps4u.org**.	• After one year of service, the hospitals automatically deposit into your Retirement Savings Plan account an amount equal to 5% of your eligible pay each pay period. If you contribute, the hospitals will match your contribution up to 4%.[6]
Retiree Medical		
Retiree Medical	• You may be eligible for retiree medical benefits if you are age 55 or older and meet the service requirements when you leave the hospitals.	• Please refer to the *Retiree Medical* section on **www.healthysteps4u.org** for more information.

[6] You may be eligible for an enhanced contribution and match. For more information, see the *Retirement Savings Plan* section at **www.healthysteps4u.org** for more details.

Benefit Options	Your Choices	Cost Sharing
Tax-Advantaged Savings Accounts and Health Reimbursement Account (HRA)		
Health Savings Account (HSA)	• Offered only with the Aetna Choice POS II with HSA medical plan. Employees can contribute to this account on a pre-tax basis and can use the funds to help pay for eligible health care expenses now and in the future. • Employees who do not satisfy all of the eligibility requirements for an HSA can instead contribute on a pre-tax basis to the Health Care Flexible Spending Account (FSA).	• The hospitals will contribute up to $500 for employee-only coverage or up to $1,000 for family coverage, based on your participation in the HealthySteps to Wellness program. • If you receive a hospital contribution to your HSA, you can contribute up to an additional $3,600 for employee-only coverage; $7,200 for family coverage in 2021. • IRS limits the annual employee and employer contribution to $3,600 per person; $7,200 for family coverage. These limits may change from year to year for those under age 55. • If you are age 55 or older as of the end of the calendar year in which contributions are made, you can make an additional $1,000 catch-up contribution.
Health Care Flexible Spending Account (FSA)	• Offered with the SHCA or Kaiser Permanente HMO medical plans, to employees in the Aetna Choice POS II with HSA who do not satisfy all HSA eligibility requirements to contribute to an HSA, or if you waive coverage. (Note: you cannot be enrolled in both a Health Care FSA and an HSA.)	• You may contribute up to $2,750 in 2021.

Benefit Options	Your Choices	Cost Sharing
	• You may make contributions to this account on a pre-tax basis. Use this account to pay for eligible health care expenses. Money in your account at the end of the plan year will be forfeited • You have until March 15 after the end of the plan year to file claims for expenses incurred in the prior plan year. If you leave the hospitals, you may request reimbursement only for expenses incurred during the plan year, up to the time of your termination. • You have up to 90 days from your termination date to submit claims for reimbursement. Money in your account after the 90-day period will be forfeited.	
Health Reimbursement Account (HRA)	• Offered only with employee participation in the HealthySteps to Wellness program to employees enrolled in the SHCA or Kaiser Permanente HMO, or to members of the Aetna Choice POS II with HSA who do not satisfy all HSA eligibility requirements. The HRA will be set up to allow you to receive your wellness incentive dollars. • You cannot make contributions to this account. Use this account to pay for eligible health care expenses. Money in your account at the end of the plan year will be forfeited.	• The hospitals will contribute up to $500 for employee-only coverage or up to $1,000 for family coverage, based on your participation in the HealthySteps to Wellness program.

Benefit Options	Your Choices	Cost Sharing
	• You have until March 31 after the end of the plan year to file claims for expenses incurred in the prior plan year. If you leave the hospitals, you may request reimbursement only for expenses incurred during the plan year, up to the time of your termination. • You have up to 90 days from your termination date to submit claims for reimbursement. Money in your account after the 90-day period will be forfeited.	
Dependent Care Flexible Spending Account (FSA)	• Allows you to pay certain expenses on a pre-tax basis. Money in your account at the end of the plan year will be forfeited. • You have until March 15 after the end of the plan year to file claims for expenses incurred in the prior plan year. • If you leave the hospitals, you may continue to submit reimbursement requests through March 31 of the year following your termination — up to your account balance — for eligible expenses incurred prior to your termination date	• You may contribute up to $5,000 each calendar year.
Employee Assistance Program (EAP)	• Provides a range of services: counseling, financial and legal guidance, workshops, online resources, peer support groups	• Employer paid

Survivor Protection

If you died, what would happen to your survivors? If your income is helping to support other people, they could face severe financial problems without you. Stanford Health Care as the plan sponsor, and Lucile Packard Children's Hospital Stanford as a participating employer, referred to collectively as "the hospitals," offer Life and Accidental Death and Dismemberment (AD&D) Insurance to help.

Your Survivor Benefits

The hospitals offer a variety of benefit options to protect your survivors in case you die or to protect you if your spouse/eligible domestic partner or dependent dies:

- Basic Employee Life Insurance for you;
- Supplemental Life Insurance for you;
- Life insurance for your spouse/eligible domestic partner;
- Life insurance for your child(ren) or child(ren) of your eligible domestic partner
- Supplemental Accidental Death and Dismemberment (AD&D) Insurance for you and your family; and
- Social Security program that pays survivor benefits to eligible dependents of covered workers. Both you and the hospitals pay for your Social Security coverage. For more information about Social Security survivor benefits, contact your local Social Security office.

Death benefits may also be available as part of the Long-Term Disability Plan.

Who Is Eligible

Survivor protection benefits are generally available to all Regular employees who work 40 hours per pay period.

Your Beneficiary

You are the beneficiary for your spouse/eligible domestic partner and child(ren)'s life insurance and AD&D insurance benefits. You may name anyone you wish to receive your life insurance benefits. If you do not name a beneficiary, the insurance company will pay your surviving relatives in the following order:

- Your surviving spouse/eligible domestic partner;
- Your surviving child(ren);
- Your surviving parents;
- Your surviving siblings; or
- Your executor or administrator of your estate.

Coverage If Both You and Your Spouse/Eligible Domestic Partner Work at the Hospitals

You and your spouse/eligible domestic partner may both be covered as employees or one of you may cover yourself as the employee and your spouse/eligible domestic partner as a dependent. However, neither of you can be covered as both an employee and a dependent. In addition, your dependent children may only be covered as dependents under one employee's plan.

For example, let's say that Robert and Tanya both work at one of the hospitals and are married with a teenage son. Their only option if they want to elect Supplemental Life coverage is for Robert to elect Supplemental Life coverage for himself and for Tanya to elect Supplemental Life coverage for herself. Either Robert or Tanya can elect Dependent Life coverage for their son, but not both of them.

Details on enrolling, naming beneficiaries and more can be found in the respective plan documents or through the HealthySteps benefits portal at **www.healthysteps4u.org**. You may also call the HealthySteps Benefits Service Center at 855-278-7157 with any questions.

Life Insurance Benefits

The hospitals provide you Basic Life Insurance protection for you equal to $50,000 or one times your base annual salary (rounded up to the nearest $1,000), whichever is lower. You do not pay for this benefit.

You have the option of purchasing Supplemental Life coverage for you equal to one, two, three, four, five or six times your base annual salary, rounded up to the nearest $1,000. The minimum amount of Supplemental Life Insurance you may purchase is one times your base annual salary. Your Basic and Supplemental Life Insurance combined may not exceed $3,000,000.

If you purchase Supplemental Life coverage for yourself, you may also purchase life insurance for your spouse/eligible domestic partner and child(ren).

Enrolling

Benefits-eligible employees are automatically covered for the Basic Life Insurance the hospitals provide.

You must enroll online for Supplemental Life coverage for you and for insurance for your spouse/eligible domestic partner and child(ren). You may enroll during annual open enrollment or within 31 days following a qualifying life event. If evidence of good health is required, the insurance company must approve your application before coverage begins.

More Information

For more information on Life Insurance, please refer to the plan documents and **www.healthysteps4u.org,** or contact HealthySteps Benefits Service Center at 855-278-7157.

Supplemental AD&D Insurance

The hospitals offer you the option to purchase Supplemental AD&D Insurance for yourself and your family thorugh after-tax payroll deductions. AD&D insurance provides a benefit if you or a covered family member dies or sustains a serious injury as a result of an accident.

The Supplemental AD&D benefit is paid in addition to your life insurance benefits and may be purchased in $10,000 increments. The minimum amount available is $10,000 and the maximum amount is $1,000,000. You may elect Supplemental AD&D Insurance even if you do not elect to purchase additional life insurance for yourself or spouse/eligible domestic partner.

Enrolling

You may elect Supplemental AD&D Insurance or change your coverage during the annual open enrollment period or within 31 days following a qualifying life event. Your insurance will be effective the first day of the month after you complete your online enrollment or change request form.

More Information

For more information on Supplemental AD&D Insurance, please refer to the plan documents and **www.HealthySteps4u.org,** or contact HealthySteps Benefits Service Center at 855-278-7157.

Other Options When Life Insurance Coverage Ends

If you are not disabled when your life insurance under the hospitals group plan ends, you have the following option:

- Convert and/or port all of your existing Basic Life, Supplemental Life and spouse/eligible domestic partner's life insurance to an individual policy or portable group term life insurance (however, if the terminating event is the cancellation of the policy, the maximum amount you may convert is $2,000).

To port or convert your coverage, you have 31 days from the date your coverage ends to:

- Contact the insurance company; and
- Complete and submit your application, along with the first premium payment, to the insurance company.

For more information, please refer to your certificate of coverage from The Hartford.

Income Protection

If you became ill or disabled and could not work, would you face financial difficulties? The Hospitals offer you income protection benefits, which provide a portion of your salary if you become disabled.

Who Is Eligible

Generally, you are eligible for the income protection plans offered by the hospitals if you are a Regular Employee scheduled to work at least 40 hours each pay period. Additionally, nearly all individuals who receive a paycheck are eligible to participate in the California State Disability Insurance (SDI) Plan.

The hospitals pay for your Basic Long-Term Disability (LTD) insurance and you pay for California State Disability Insurance (SDI) and Paid Family Leave (PFL) through payroll taxes. You also pay for Supplemental Short-Term Disability (STD) and Supplemental LTD insurance through post-tax payroll deductions, if elected. If you do not enroll for Supplemental STD or Supplemental LTD coverage when you are first eligible, you will have to submit Evidence of Insurability (EOI), or evidence of good health, to the insurance company when you enroll.

Contact your local SDI office for information about who is eligible to participate in the SDI Plan or visit the California Employee Development Department (EDD) website, **www.edd.ca.gov/disability**, for more details. Refer to the plan documents for more information.

Beneficiary Benefits

If you die while receiving benefits, any amount due to you will be paid to your beneficiary. If you did not designate a beneficiary or if the beneficiary has not survived you, the plan will pay the benefits to the executor or administrator of your estate. The plan may also pay the benefits to a surviving relative in the following order:

1. Your surviving spouse/eligible domestic partner;
2. Your surviving child(ren);
3. Your surviving parents;
4. Your surviving siblings; or

Your executor or administrator of your estate. More Information

For more information on your income protection benefits, please refer to the plan documents and **www.healthysteps4u.org**, or contact HealthySteps Benefits Service Center at 855-278-7157.

State Disability Benefits

The California State Disability Insurance (SDI) Plan pays approximately 60% to 70% (depending on income) of your covered weekly earnings up to a maximum weekly benefit of $1,357 in 2020. The maximum weekly benefit is set at the beginning of each year by the State and is subject to change.

SDI benefits begin after you have been continuously disabled for seven calendar days. You pay for SDI through payroll taxes on your covered weekly earnings. To be eligible for SDI benefits, you generally must have contributed to the SDI Plan within the last 18 months.

More Information

For more information about SDI benefits, visit the California Employee Development Department (EDD) website, **www.edd.ca.gov/disability**.

Supplemental Short-Term Disability (STD) Benefits

If you do not think the benefits under the California SDI Plan would provide sufficient income during a disability or illness, you may purchase supplemental benefits. The Supplemental STD Plan pays:

- 60% of your weekly base pay (no shift differentials) to a maximum weekly benefit of $1,846 , less any:
  - Disability benefits from any state-mandated disability plan such as the California SDI Plan or Social Security; and
  - Earnings from employment (except if you are receiving a partial disability benefit).

More Information

For more information on your Supplemental STD Benefits, please refer to the plan documents and **www.healthysteps4u.org**, or contact HealthySteps Benefits Service Center at 855-278-7157.

Long-Term Disability (LTD) Benefits

After you have received SDI/STD benefits for 182 days, you may be eligible for LTD benefits if you are still deemed disabled by the insurance company.

Summary of LTD Plans		
	Basic Plan	**Supplemental Plan**
Benefit as a Percent of Your Pre-Disability Monthly Earnings	50%	66 and 2/3%
Less	Income from other sources	
Minimum Benefit	$100/month	
Maximum Benefit	$8,000/month	

More Infomation

For more information on your LTD Benefits, please refer to the plan documents and **www.healthysteps4u.org**, or contact HealthySteps Benefits Service Center at 855-278-7157.

California Paid Family Leave

If you need to take time from work to care for an eligible family member, you may be entitled to California Paid Family Leave Benefits for up to eight weeks.

Paid Family Leave benefits are based on past quarterly earnings for up to eight weeks. There is a cap on the weekly benefit amount, which is subject to change. Refer to the plan documents for more detail. Paid Family Leave insurance does not provide approved time off, job protection or return rights. Your job may be protected if your leave falls under the Federal Family and Medical Leave Act and/or the California Family Rights Act. You must notify the hospitals of your reason for taking leave pursuant to the hospital's leave policy. To qualify for Paid Family Leave compensation, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least $300 from which deductions were withheld; and
- Complete your claim forms accurately, completely, truthfully and in a timely manner.

More Infomation

For more information, contact Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Human Resources Solutions Team at 650-721-5400 or the California Employment Development Department at:

1-877-BE-THERE (English)
1-877-379-3819 (Español)
1-800-563-2441 (TTY)
www.edd.ca.gov

Additional Benefits

Voluntary Benefits Program

The individual voluntary benefit offerings feature specialized vendors who deliver services should you choose to utilize them. See below to discover all of the offerings available to you. This information is also listed on the Voluntary Benefits website at **www.shclpchvoluntarybenefits.com.**

Auto and Home & Renters Insurance

Receive comparative quotes from some of the nation's leading auto, homeowners and renters insurance companies. Provided through Mercer Voluntary Benefits, the Auto and Home & Renters Insurance Program offers you a choice of programs through a web-based quoting model.

Insurers are matched side-by-side to pinpoint the most competitive rates and discounts to provide accurate, bindable real-time quotes. Insurance can be purchased at any time and paid for through after-tax payroll deductions or a number of alternative payment methods. Call Personalized Servicing with Mercer Voluntary Benefits at 800-689-9314 (Monday – Friday, 5:00 a.m. – 6:00 p.m. PT and Saturdays, 5:00 a.m. – 11:00 a.m. PT).

Identity Theft Protection

Unlike other crimes, identity theft can be difficult for you to detect early. In many instances, it can be years before victims realize their identities have been stolen. Receive comprehensive identity theft safeguards and restoration services through Allstate Identity Protection. You may elect, change or drop coverage at any time during the year.

Coverage includes:

- Identity Monitoring – detection of unauthorized account access, fund transfers and password resets.
- CreditArmor – annual credit report, monthly credit scores and tri-bureau credit monitoring.
- Internet and Dark Web Surveillance – detection of information misuse and compromised credentials in the Underground Internet.
- Digital Identity – interactive, easy-to-read report summarizing what a real-time deep Internet search finds out about you with tips to better secure personal information.
- WalletArmor – secure, online document repository that makes lost wallet replacement quick and easy.
- Solicitation Reduction – Allstate Identity Protection reduces the root cause of up to 20% of identity theft by decreasing junk mail, stopping pre-approved credit offers, and ending telemarketing calls.

If Allstate Identity Protection detects suspicious activity, a privacy advocate will act as a dedicated case manager on your behalf and resolve the issue from start to finish. For more information regarding Allstate Identity Protection, call 800-689-9314 (Monday – Friday, 6:00

a.m. – 3:00 p.m. PT) or visit **www.shclpchvoluntarybenefits.com** for LPCH plan participants. SHC plan participants will need to contact Allstate Identity Protection directly at 1-800-789-2720 or visit their website at **www.myaip.com**.

Pet Insurance

Nationwide Pet Insurance covers dogs, cats, birds and exotic pets with medical problems and conditions related to accidents, illnesses and injuries. You may visit any veterinarian, including specialists and emergency providers. Additional coverage is available for routine medical care such as vaccinations and spay/neuter procedures. You may elect, change or drop coverage at any time during the year. For more information regarding pet insurance, call 800-689-9314 (Monday – Friday, 6:00 a.m. – 3:00 p.m. PT) or visit **www.shclpchvoluntarybenefits.com**.

Purchasing Program

The Purchasing Program, driven by Purchasing Power, helps you buy brand-name computers, electronics and appliances—regardless of your credit—through the ease of after-tax payroll deductions. To be eligible for the program, you must be over 18 years of age, an active employee at the hospitals for six months, have a bank account or credit card and earn at least $16,000 annually. For more information regarding the program, call 800-689-9314 (Monday – Friday, 6:00 a.m. – 3:00 p.m. PT) or visit **www.shclpchvoluntarybenefits.com**.

Legal Plan

The Legal Plan gives you and your family access to legal advice and professional legal representation pertaining to a wide range of personal matters. You may elect, change or drop coverage during annual open enrollment.

The plan benefits include:

- Unlimited telephone advice and unlimited in-office consultations
- Legal representation
- Life Stages Identity Theft Defense

  This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

There are three services not covered 100% under the MetLife Legal Plan:

- Divorce participants are responsible for all attorney fees after the first 20 hours
- Probate participants are responsible for all attorney fees minus a 10% network discount

- Personal injury participants are responsible for all attorney fees minus a 25% discount on the reward.

Should you need advice for a personal legal matter that is not covered by the scope of the plan, you are permitted to solicit advice over the phone or in-office about the matter. This does not include employment-related matters. The plan attorney decides whether the matter is covered by the plan or not.

For more information regarding the plan, call 800-689-9314 (Monday – Friday, 6:00 a.m. – 3:00 p.m. PT) or visit **www.shclpchvoluntarybenefits.com** for LPCH plan participants. For SHC plan participants, please call MetLife Legal plans directly at 1-800-821-6400 or visit their website at **www.legalplans.com**.

Enrollment

If you are a new hire and meet the benefits eligibility requirements or a current employee transferring to a benefits-eligible position, you must enroll in your benefits online as follows:

Stanford Health Care	Lucile Packard Children's Hospital Stanford
To access the HealthySteps benefits portal: • Visit **www.healthysteps4u.org** and click "View or Change My Benefits (SHC)" from MyWorkday. • Enter your User ID and Password. – When you visit the portal for the first time, click "Are you a new user" to set up your User ID and Password. – When accessing the portal from a Stanford Health Care network, the registration process is handled for you via a secure sign-in process using your Stanford Health Care login and password.	• Visit AccessHR from any computer at **www.accesshr.lpch.org**. Enter your User ID and Password, click the "My Benefits" tile. – If you are accessing from your personal hospital work station, click the "Benefits" tile that states "Auto Sign In." OR – If you are accessing from a shared work station or a computer outside of the hospital network, click the "Benefits" tile that states "Shared Workstation."When accessing the HealthySteps benefits portal from AccessHR, the registration process is handled for you via a secure sign-in process using your Lucile Packard Children's Hospital Stanford login and password.

You must enroll within 31 days of your hire date or the date you became an eligible employee or you will be assigned a "default" coverage. This default coverage is effective the first day of the month after your hire date or the first of the month following the date you became an eligible employee.

If you waived your health coverage because you had coverage elsewhere and you lose that coverage, you may have the opportunity to enroll in the hospitals' health care option pursuant to a Special Enrollment Period. Please see "**Special Enrollment Period**" for more information.

If you waive benefit coverage through the hospitals, know that it is your responsibility to get health care coverage somewhere else. Be sure to review your health care options to determine which is best for you and your family.

During annual open enrollment each fall, you will be able to change your benefits elections under the medical, dental, Flexible Spending Accounts (FSAs) and group legal plans. If you do not make changes during annual open enrollment, you will receive the same coverage you had the previous year, but you will not be able to contribute to the FSAs. You must actively enroll in the FSAs during annual open enrollment each year in order to participate for the following year. You may enroll in and make contributions to a Health Savings Account (HSA), if eligible, at any time.

Other Benefits

When you become eligible, you are automatically enrolled in the Basic Life and Basic Long-Term Disability Insurance Plans.

For other benefits, you must enroll yourself and any eligible dependents, as well as authorize any applicable payroll deductions. Stanford Health Care employees enroll or make changes through the HealthySteps benefits portal via **www.healthysteps4u.org** and Lucile Packard Children's Hospital Stanford employees access the HealthySteps benefits portal through AccessHR at **www.accesshr.lpch.org**. See "

Enrollment" for enrollment instructions.

You can enroll within 31 days of your hire date or the date you become an eligible employee or are permitted to make a change in your enrollment:.

- If you do not wish to enroll in medical insurance, select the "Waive Coverage" option when you enroll through the HealthySteps benefits portal.
- To enroll your eligible dependents, the hospitals require documentation to verify the individuals you have enrolled meet the eligibility requirements of the plan. You must submit required documentation to the HealthySteps Benefits Service Center to verify your dependents' relationship to you. Documents must be provided within 45 days of the date you are first eligible for benefits, marry, start a new eligible domestic partnership or acquire a new dependent. See "**Supporting Documentation Needed**" for more information.

Default Coverage

When you are first hired or transfered into a benefits-eligible position, you must complete your enrollment process within 31 days of becoming benefits eligible or you will be assigned default coverage. You may change your default coverage only during annual open enrollment unless you experience a qualifying life event.

Default coverage is for you only and will be effective on the first day of the month after you became benefits eligible. Default coverage consists of the following benefits:

- Medical — Aetna Choice POS II (employee only); includes prescription drug, mental health and substance abuse benefits; does not include a Health Savings Account (HSA).
- VSP - bundled with medical coverage (employee only)
- Delta Dental Basic PPO (employee only).
- Delta Dental DHMO - employees enrolled in the DHMO plan in California and move out of state are required to switch to the Dental PPO plan. The DHMO plan is not available out of California. In the event you do not swith plans within 31 days of the move date, you will be defaulted to Employee only coverage under the Dental PPO plan. You are eligible to make changes to your plan during open enrollment or during a Qualifed Event.

Supporting Documentation Needed

When you are adding or removing a dependent from your benefits, you must provide supporting documentation proving your relationship with this dependent within 45 days from the date of the event. Please note, however, that changes to your benefit coverage must be made within 31 days of a qualifying life event. If the supporting documentation is not received within this timeframe, the dependent will be dropped from all coverage and you will be required to reimburse any benefits paid by the plans, plus any expenses incurred by the hospitals. Here is a list of the required supporting documentation:

Reason for Change	Required Documentation
Add a legal spouse/marriage	• Copy of your marriage certificate AND • Copy of the first page of your federal tax return filed within the last two years listing your spouse (please black out all financial information) OR • Proof of Joint Ownership issued within the last six months. Note: If marriage occurred within the last 12 months, you are not required to submit a secondary document.
Add an eligible domestic partner (non-tax dependent or tax dependent)	• Copy of your Domestic Partner Registration from any state or local government's Domestic Partnership registery AND Proof of Joint Ownership issued within the last six months OR • Proof of Joint Ownership issued within the last six months.

Reason for Change	Required Documentation
	• Note: If domestic partnership occurred within the last 12 months, you are not required to submit a secondary document.
Add your child who is under age 26	• Copy of the birth certificate naming you as parent • For children under three months of age ONLY: Copy of the non-government-issued birth certificate (including parents' names) Note: You are required to update the dependent's Social Security number when you receive it.
Add your stepchild who is under age 26	• Copy of the birth certificate naming your spouse as the parent AND a copy of your marriage certificate AND a copy of the first page of your federal tax return filed within the last two years listing your spouse (please black out all financial information) OR • Proof of Joint Ownership issued within the last six months in lieu of a federal tax return. Note: If the marriage occurred within the last 12 months, only the birth certificate and marriage certificate are required.
Add your eligible domestic partner's child who is under age 26	• Copy of the birth certificate naming your eligible domestic partner as the parent AND a copy of your notarized Affidavit of Domestic Partnership AND a copy of Proof of Joint Ownership issued within the last six months OR • Copy of the birth certificate naming your eligible domestic partner as the parent AND a copy of your Domestic Partner Registration AND a copy of Proof of Joint Ownership issued within the last six months.
Add your adopted child or a child who is under age 26 and for whom you have initiated adoption proceedings prior to age 18 and have legal guardianship	• Copy of the adoption certificate, which includes the child's date of birth OR • Copy of the adoption placement agreement or petition for adoption, which includes the child's date of birth.
Add a disabled dependent who is age 26 or older	• Please contact the HealthySteps Benefits Service Center
Death of a spouse or dependent	• Copy of the death certificate

EMPLOYEES ENROLLED IN THE SHCA MEDICAL PLAN:

If you have dependents who are attending college outside of the SHCA network area, you can enroll them in an out-of-area plan. They can then use the Open Access Aetna Select network of providers (known as "out-of-area" providers) and pay the same copays or coinsurance as they would for an in-network provider. However, claim amounts from out-of-area providers that apply to their deductible and out-of-pocket maximums will not apply to the family deductible and out-of-pocket maximum.

Once your dependents are enrolled, they will receive a new ID card at the physical address on file with SHCA Member Care Services.

Special Enrollment Period

If you decline enrollment for yourself or your dependents because either you or your dependent have health insurance coverage under another group health plan or other insurance, you may be able to enroll yourself or your dependent in one of the health care options offered through the hospitals in the future if you enroll within 31 days of a qualifying life event. For a list of qualifying life events, please see "Changing Your Benefits."

Cost of Coverage

Your share of the cost of your benefits depends on which plans you choose and which family members you cover. For some benefits, such as life and disability insurance, the cost may also depend on your age and/or covered salary.

Deductions for other benefits are taken over 24 pay periods. If there are three pay periods within a calendar month, deductions will only be taken from the first two paychecks.

- Payroll deductions for your health insurance are taken on a pre-tax basis. This election remains in effect until you revoke it. Special rules for covering eligible domestic partners are discussed below.

Paying for Eligible Domestic Partner Coverage

The IRS generally does not recognize eligible domestic partners (or their children) as legal dependents for income tax reporting. If you elect health coverage for your eligible domestic partner or his/her child(ren), your share of the cost for their coverage will be deducted from your pay on a post-tax basis.

Your payroll deductions for providing medical and dental coverage for your eligible domestic partner are the same as those charged for a legal spouse. However, federal law requires that the value of your domestic partner's benefits be treated as ordinary taxable income to you unless the eligible domestic partner qualifies as a tax dependent under the Internal Revenue Code. This is called imputed[8] (taxable) income. You will be taxed on this imputed income unless you certify that your eligible domestic partner is your tax dependent. You will also be taxed on the amount that the hospitals pay to provide medical and dental benefits to your partner's

child(ren) unless you are enrolling at least one child who is your dependent. You must certify that the child is your dependent.

In order to qualify as a tax dependent, an eligible domestic partner or your eligible domestic partner's child must:

- Receive over 50% of his or her support from you for the year, and
- Have your home as his/her principal residence for the entire year, and
- Be a member of your household.

If you are enrolling your eligible domestic partner and/or your eligible domestic partner's children and he/she/they also qualify as your tax dependents, please call the HealthySteps Benefits Service Center. If the tax status of your eligible domestic partner or eligible domestic partner's child(ren) changes during the year, you are responsible for reporting the change in eligibility status.

[8] Imputed income is the additional compensation employees receive as cash or as benefits that is considered taxable.

Changing Your Benefits

Each year, the hospitals give you the opportunity to change your medical/vision and dental plans, enroll in or change your Flexible Spending Account (FSA), add or delete family members from your coverage or enroll if you had previously waived coverage. You may not change your elections during the year unless you experience a qualifying life event (QLE) that results in a gain or loss of eligibility under the applicable benefit plans. These change "rules" are regulated by the federal government.

If you have a qualifying life event, you may make changes to your benefits coverage within 31 days and provide supporting documentation within 45 days of the event. The changes you can make must be consistent with your qualifying life event. For example, if you have a baby, you may add the new child, but you may not drop your spouse. If documentation is not provided within 45 days, the dependent will be terminated retroactively to the event date.

The following is a list of qualifying life events:

- Marriage or the establishment of an eligible domestic partnership;

SPECIAL RULES FOR ELIGIBLE DOMESTIC PARTNERSHIPS

Events that relate to an eligible domestic partnership, such as the establishment or dissolution of that partnership, are not qualifying life events that permit a change in your pre-tax contributions unless your eligible domestic partner is your tax dependent or the children of your eligible domestic partner are your tax dependents.

- Dissolution of marriage (including final divorce or annulment), legal separation or termination of an eligible domestic partnership (Note: If a court orders you to provide coverage, you must do so on your own — you cannot enroll your ex-spouse or former eligible domestic partner in your hospital-sponsored health care plan)
- The birth or adoption of a child or your court-ordered appointment of legal guardianship for a child
- The death of your spouse/eligible domestic partner or dependent child
- Your child or your eligible domestic partner's child reaching the plan's age limit or entering the military
- Your dependent child regaining eligibility
- You or your dependent becoming Medicare or Medicaid eligible
- A change in caregivers or a change in the cost for the services of a caregiver who is not a relative (applies to Dependent Care FSA only)
- A move out of your medical claims administrator's service area (applies to change of medical plan only)
- A change in the employment status of your spouse/eligible domestic partner or dependent that results in a gain or loss of health care coverage
- A change to or from a full-time or part-time benefits eligible employment status by you or your spouse/eligible domestic partner or dependent, if health plan eligibility is affected
- The retirement of your employee spouse/eligible domestic partner actively employed by the hospitals if you are covered as his or her dependent on a health care plan
- An unpaid leave of absence taken by you, your spouse/eligible domestic partner that significantly affects the cost of your health care coverage

In this section, we will examine general rules for making changes due to qualifying life events. For a look at the impact some common qualifying life events may have on your coverage choices, see the ***Life Events*** section.

If one of your dependents is no longer eligible for coverage, you must log on to the HealthySteps benefits portal and click "Life Events" under the Health & Welfare Benefits section to drop him/her from coverage:

- Stanford Health Care employees enroll or make changes through the HealthySteps benefits portal via **www.healthysteps4u.org**, and
- Lucile Packard Children's Hospital Stanford employees access the HealthySteps benefits portal through AccessHR at **www.accesshr.lpch.org**.

Failure to provide timely notification to the hospitals of your dependent's loss of eligibility will result in your dependent's claims being denied and loss of rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Health Coverage Changes

When One of These Events Occurs During the Calendar Year ...	You May Make the Following Changes to Your Health Plan Elections (subject to the general rules outlined above). Examples noted below
Acquire new dependents through marriage/eligible domestic partnership, birth, adoption (or placement for adoption) or legal guardianship	• Add dependent coverage. • Add new spouse/eligible domestic partner and any eligible children. • If you are enrolled, you can change your medical plan election. • If you are not enrolled, you can enroll yourself, your spouse/eligible domestic partner and any eligible children. • If you will be covered under your new spouse/eligible domestic partner's plan, you can stop the hospitals' coverage.
Change in a dependent's status, e.g. child reaches maximum age, death of a dependent, divorce/annulment/end of eligible domestic partnership; you may also make a change if you obtain a legal separation, although you are not required to make a change until divorce/annulment	• Stop coverage for spouse/eligible domestic partner or child who is no longer eligible. • If divorce or death causes you or your eligible children to lose other coverage, you and your eligible children may enroll in the hospitals' plans.[12]
Change in your or your dependent's employment status that affects eligibility for health coverage, such as termination or commencement of employment, the commencement or return from an approved unpaid leave of absence, a change to or from a benefits eligible employment status or a strike or lockout	• Drop dependent coverage. • Add spouse/eligible domestic partner and children to the hospitals' plans if they are losing other coverage.[13] • If you are losing other coverage and you are not enrolled in the hospitals' plans, you can enroll yourself, spouse/eligible domestic partner and children.[13] • If the event is the commencement of or return from a leave of absence (LOA), you may cancel coverage and re-enroll when you return to work (see "**Coverage During an Approved Leave of Absence (LOA)**" and your LOA information package).
Medicare or Medicaid eligibility	• You may cancel medical coverage for the individual who becomes eligible for Medicare or Medicaid. • You may enroll the individual who loses Medicare or Medicaid coverage.

When One of These Events Occurs During the Calendar Year ...	You May Make the Following Changes to Your Health Plan Elections (subject to the general rules outlined above). Examples noted below
Judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), that requires you (or your former spouse/eligible domestic partner) to provide health coverage for a child; the order may be the result of a divorce, legal separation, annulment or change in legal custody	• You may add your child to your coverage. • If you are not enrolled, you and your child may enroll in one of the hospitals' medical/vision and dental plans. • You may cancel coverage for the child if the order requires your former spouse or other individual to provide coverage for the child.
Change of residence or worksite	• You may change your medical/vision and/or dental plan if you move out of your current plan's service area.
Change in the hospitals' health coverage, e.g., the hospitals add or eliminate a plan option or significantly limit coverage under an option	• If you are already enrolled in a plan, you may change plans. • If you are not currently enrolled, you may enroll only if a new plan is being offered.
Significant increase or decrease in the cost of the hospitals' health coverage	• If cost increases, you may change to a less expensive plan. If you are not currently enrolled and cost decreases, you may enroll in the plan with the cost decrease. Note: Changes are not allowed for insignificant cost changes. Also, insignificant cost changes for the hospitals' coverage may result in an automatic change in your payroll deduction.
Health plan election change under spouse/eligible domestic partner's employer's plan, if the other employer's open enrollment period is different from the hospitals' annual open enrollment period	• If your dependent cancels or loses coverage under his/her employer's plan, you may: – Add the dependent to your plan OR – Enroll yourself and dependent in the hospitals' plan. • If your spouse/eligible domestic partner had previously declined his/her employer's coverage and now enrolls, you may cancel the hospitals' coverage. • If you enroll in your spouse/eligible domestic partner's employer plan, you may cancel the hospitals' coverage.
You or your dependent loses other coverage for any reason not mentioned above[13]	• You may enroll the dependent that is losing the other coverage.[13]

When One of These Events Occurs During the Calendar Year ...	You May Make the Following Changes to Your Health Plan Elections (subject to the general rules outlined above). Examples noted below
	• If you are not enrolled, you may enroll yourself and the dependent losing the other coverage.[13]

1 You and your dependent are entitled to a 30-day Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment Period to re-elect benefits. Special enrollment rights must mirror the enrollment rights typically available for similarly situated individuals at initial enrollment.

2 These special enrollment rights are available if you declined the hospitals' coverage when you were hired or at the last annual open enrollment period AND you (or your spouse/eligible domestic partner or your dependent) lose other coverage because you exhaust your rights to COBRA coverage, employer contributions to the other coverage stop or you are no longer eligible under that other coverage.

3 Under the Children's Health Insurance Program Reauthorization Act (CHIPRA), if you or your eligible dependents lose eligibility for coverage under a state Medicaid or CHIP program, or become eligible for state premium assistance under Medicaid or CHIP, you or your dependents can enroll in the hospitals' medical plan as long as you request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

Changes to benefits, including removing dependents who are no longer eligible for benefits, may be made online:

- Stanford Health Care employees enroll or make changes through the HealthySteps benefits portal via **www.healthysteps4u.org**, and
- Lucile Packard Children's Hospital Stanford employees access the HealthySteps benefits portal through AccessHR at **www.accesshr.lpch.org**.

Failure to notify the hospitals of your dependent's loss of eligibility will result in claims being denied and loss of COBRA rights.

Flexible Spending Account (FSA) Changes

For information about when you can make changes to FSAs, refer to the ***Tax-Advantaged Savings Accounts*** section.

Annual Open Enrollment Period

During the annual open enrollment period, you may:

- Enroll in or change medical/vision and dental plans
- Add/delete dependents for your medical/vision and dental plans
- Enroll or re-enroll in the Flexible Spending Accounts (FSAs)
- Add, change or drop life insurance coverage (some increases are subject to EOI)
- Add, change or drop disability coverage (any increases are subject to EOI)
- Add, change or drop coverage for the GroupLegal Plan

- Elect or re-elect your annual contribution to your Health Savings Account (HSA); if you miss your opportunity during annual open enrollment, you can enroll and/or make changes any time after the new year begins

Changes made during the annual open enrollment period are effective the following January 1. You have 45 days from when you make your annual open enrollment election to provide the required documentation to the HealthySteps Benefits Service Center.

Unless you make changes online, your health plan elections will automatically continue in the next calendar year. To enroll or make changes, you must log on to the HealthySteps benefits portal and enroll or make changes as follows:

- Stanford Health Care employees enroll or make changes through the HealthySteps benefits portal via **www.healthysteps4u.org**, and
- Lucile Packard Children's Hospital Stanford employees access the HealthySteps benefits portal through AccessHR at **www.accesshr.lpch.org**.

[14] Participation in the Health Care FSA and Dependent Care FSA does not automatically renew. The election you made for the current calendar will reset to zero on the first day of the new calendar year. You must re-enroll each year to continue participation in these tax-advantaged savings accounts. You may, however, change your HSA elections at any time during the year.

When Coverage Ends

This section defines when benefits coverage will end for you and your covered dependents. It also describes how to continue coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) and individual policy conversion options.

Your coverage as an active employee ends on the last day of the month in which the first one of the following events occurs:

- You stop working
- Your employment terminates
- Your pay ends
- You are no longer an eligible employee
- Exhaust Leave of Absence (LOA), per *Leaves of Absence policy*
- You stop making required contributions
- The plan terminates

Coverage for the Employee Assistance Program (EAP) will be available through the last day of the month following the date of active employment.

For Your Covered Dependents

Coverage for your dependents (see definition of "covered dependent" under "**Eligible Dependents — A Definition of Dependents**" for more information) under the hospitals' benefit plans (as applicable) ends on the earliest of the following:

- The date your coverage ends for any reason
- The date you elect to stop dependent coverage either during annual open enrollment or within 31 days of a qualifying life event
- The date on which your dependent ceases to be a dependent as defined by the plan for any reason, including age, marriage, divorce, legal separation or termination of an eligible domestic partnership arrangement
- The date the dependent enters active duty in the armed services of any state, country or international authority
- The date the hospitals terminate the dependent's coverage for nonpayment of the required contributions
- The date the hospitals terminate any of their benefit plans, to the extent the plan termination would affect your benefits

Options When Coverage Ends

When your coverage as an active employee ends, you may be able to continue certain insurance plans as follows:

- You, or your covered dependents, may be able to continue medical/vision or dental insurance, Employee Assistance Program (EAP) and Health Care FSA contributions under COBRA. See the ***Your Health Care Benefits*** section for information on COBRA.
- You, or your covered dependents, may be able to convert your medical insurance to an individual policy. See the *Your Health Care Benefits* section for information about converting your medical insurance to an individual policy.
- You may be able to continue your Basic Life and Supplemental Life Insurance under the insurance company's conversion and portability options. See the *Your Health Care Benefits* section for information about options when your life insurance coverage ends.
- You may be able to convert and become insured under a group disability conversion policy when, as a covered person, you terminate employment with a sponsor and are no longer insured under the policy. See the the *Your Health Care Benefits* section section for information regarding disability coverage.

Benefits Coverage During Layoff

Severance pay benefits for employees who sign an "At Will" agreement are described in that agreement.

Except for disability insurance, your benefit coverage continues until the last day of the month in which you work. You may continue your health benefits under COBRA, effective as of the first day you are laid off (see the ***Your Health Care Benefits*** section for information about COBRA). If you are temporarily laid off, your long-term disability (LTD) insurance coverage may be continued for 30 day(s) after the day in which the layoff commenced and your life insurance may be continued until the last day of the month following the month in which the layoff commenced. If the layoff becomes permanent, this continuation of life and LTD insurance will cease immediately. You may convert your life and long-term disability insurance to an individual policy, effective as of the first day you

are laid off. Short-term disability (STD) insurance ends the last day you work and cannot be converted to an individual policy.

Other Important Provisions

- *While you are on an approved leave of absence*, your benefits continue as long as you continue to pay the required premium. See "**Coverage During an Approved Leave of Absence (LOA)**" section below for information about continuing your benefits during an approved leave of absence.
- *Disability insurance* ends on the date a terminating event occurs (for examples of "terminating events," see "When Coverage Ends" on page 36). Benefits continue until you are no longer disabled or until you reach the maximum benefit period, whichever occurs first.
- *Coverage under the Health Care FSA* ends on the date of termination. You may request reimbursement only for expenses incurred during the plan year and while you were an active employee ,unless you elect COBRA coverage. If you leave the hospitals, you have up to 90 days from your termination date to submit claims for reimbursement.
- *Coverage under the Dependent Care FSA* ends on the date of termination. You may continue to submit reimbursement requests up to your account balance for eligible expenses incurred prior to your termination date.
- *If you leave regular employment on or after age 55* and meet certain service requirements, you may be eligible for retiree medical benefits. See the ***Retiree Medical*** section for information about retiree medical coverage.

Coverage During an Approved Leave of Absence (LOA)

Who pays for your coverage during an approved leave of absence (LOA)	
Medical/Vision, Dental, Life, AD&D, Disability	You pay a subsidized cost (the same as if you were still an active employee) during the first six months (consecutive or in combination of months) of: • Medical, pregnancy disability, family and military leaves; and • All paid personal and educational leaves. You pay the full cost during: • Unpaid personal leaves, educational leaves or any medical leave over six months (consecutive or in combination of months).
Dependent Care FSA	You have two options: 1. Take no action and your deductions will continue as long as you are receiving a paycheck. If you don't have sufficient pay to cover your deduction, your deduction will go in arrears and will be collected once you have sufficient pay again. 2. Within 30 days of the start of your leave of absence, you can stop your deductions through the HealthySteps benefits portal. Then, within 31 days of your return to work, you can resume your deductions through the HealthySteps benefits portal.

	• For Stanford Health Care employees, please contact the HealthySteps Benefits Service Center at 855-278-7157 to adjust your deduction amount so you can reach your annual goal. • For Lucile Packard Children's Hospital Stanford employees, contributions will recalculate when you return to work based on the number of pay periods remaining in the calendar year. Note: In either case, any claims you incur during your LOA are ineligible for reimbursement.
Health Care FSA	You have two options: 1. Take no action and your deductions will continue as long as you are receiving a paycheck. If you don't have sufficient pay to cover your deduction, your deduction will go in arrears and will be collected once you have sufficient pay again. 2. Within 30 days of the start of your leave of absence, you can stop your deductions through the HealthySteps benefits portal. Then, within 31 days of your return to work, you can resume your deductions through the HealthySteps benefits portal. Then, within 31 days of your return to work, you can resume your deductions through the HealthySteps benefits portal. • For Stanford Health Care employees, please contact the HealthySteps Benefits Service Center at 855-278-7157 to adjust your deduction amount so you can reach your annual goal. • For Lucile Packard Children's Hospital Stanford employees, contributions will recalculate when you return to work based on the number of pay periods remaining in the calendar year. Note: In either case, any claims you incur during your LOA and while you have paycheck deductions are eligible for reimbursement. See the ***Tax-Advantaged Savings Accounts*** section for information about submitting claims during an approved LOA.
Retirement Savings Plan (RSP)	All contributions to the RSP stop when pay/PTO ends and automatically resume when you return to work. You may be eligible to make up contributions to the RSP when you return to work following a military leave that qualifies under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Please contact Fidelity at 800-343-0860 for information regarding loan obligations while on an unpaid LOA.
Changing benefits during a LOA	
You may change your benefits under the same conditions as active employees who are allowed to make changes.	

If you have a planned LOA (e.g., pregnancy, scheduled surgery, etc.), benefits will continue as long as you continue to pay the required premium for coverage during your LOA.

If you discontinue your contributions or drop your coverage during your leave, please refer to "Resuming your benefits when you return to work" below for how to re-enroll.

Medical/vision or dental plans

You may enroll yourself, your spouse/eligible domestic partner and/or any eligible children within 31 days of the birth or adoption of a child. You must enroll, if you have not already enrolled, in order to cover dependents. If you are adding an eligible domestic partner, imputed income may apply.

If you are enrolled, you may change your medical plan option due to a qualifying life event. You may also drop your coverage (or dependent coverage) if you will be covered under your spouse's/eligible domestic partner's plan.

Supplemental Employee Life Insurance

You may enroll in the amount of one, two or three times your base annual salary ($50,000 minimum; $1,000,000 maximum) without providing Evidence of Insurability (EOI) within 31 days of the birth or adoption.

Coverage starts the first day of the month after you become eligible, or if EOI is required, coverage starts the first day of the month after approval by the insurance company, whichever is later.

Dependent Child Life Insurance

You may enroll your dependent children within 31 days of the birth or adoption of your child.

Coverage starts the first day of the month after you become eligible, or if Evidence of Insurability (EOI) is required, coverage starts the first day of the month after approval by the insurance company, whichever is later.

Optional AD&D Plan

If you are currently enrolled in employee-only coverage, you may change to family coverage or increase your current coverage amount within 31 days of the date of birth/adoption.

If you are currently not enrolled in the plan, you may enroll in employee-only coverage or family coverage within 31 days of the birth/adoption. Your beneficiary designations may be reviewed or changed at any time.

Supplemental STD & Supplemental LTD Plans

Supplemental STD

You may stop your Supplemental STD coverage at any time. You may enroll for Supplemental STD coverage under either of two circumstances:

- Within 31 days of becoming eligible; and
- During annual open enrollment.

Supplemental LTD

You may stop your Supplemental LTD coverage at any time. You may enroll for Supplemental LTD coverage under any of three circumstances:

- Within 31 days of becoming eligible;
- If you experience a qualifying life event; and
- During annual open enrollment.

Enroll for or change coverage by going online:

- Stanford Health Care employees enroll or make changes through the HealthySteps benefits portal via **www.healthysteps4u.org**, and
- Lucile Packard Children's Hospital Stanford employees access the HealthySteps benefits portal through AccessHR at **www.accesshr.lpch.org**.

If you elect to stop coverage, your change request form will be processed as soon as administratively possible.

For new Supplemental LTD coverage, you are required to provide Evidence of Insurability (EOI). Your coverage will be effective the first day of the month after the insurance company approved your application. If you are absent from work on the date your coverage begins, your coverage becomes effective when you return to work.

When benefits end

Benefits end on the earliest of:

- Leave ends and you do not return to work;
- Plan is terminated;
- You stop paying your share of the premium;
- You or your dependent is no longer eligible; and
- Six months, consecutive or in combination.

Options when benefits end

- See "**Options When Coverage Ends**."

Resuming your benefits when you return to work

You continue benefits during your leave by paying your share of the portion, if applicable, for up to six months (consecutive or in combination of months).

Insurance you discontinue, or which terminates during your leave, is effective again the first day of the month after you return to work if you re-enroll within 31 days of your return:

- When you return to work from a leave of absence where benefits terminated, you must make new benefit elections:
  - You and eligible dependents may re-enroll in the same plans, with the same level of coverage as before you left. You may add family members who became eligible during your leave.
  - Because a return from a LOA is a change in employment status, you will have a Special Enrollment Period (similar to the annual open enrollment period) to make changes to your benefits.
- You must re-enroll within your 31 day enrollment period. Your coverage will be effective the first of the month following your return to work.

You are required to provide Evidence of Insurability (EOI) for the life and disability plans. Coverage will be effective the first of the month following your return to work, subject to approval of EOI.

Refer to the LOA policy for more information about when your benefits resume when you return to work.

Changing your benefits when you return to work

- If your leave is longer than 30 days, you may change your benefits when you return to work under the same conditions as active employees who are allowed to make changes — for example, during annual open enrollment period and when a qualifying life event occurs.

Your Health Care Benefits

Stanford HEALTH CARE

Lucile Packard Children's Hospital Stanford

HealthySteps

Your Handbook and Health Booklets

The information provided in this Handbook and in the Health Booklets is intended to provide a Summary Plan Description (SPD) of the health care benefis for Stanford Health Care as the plan sponsor and Lucile Packard Children's Hospital Stanford as a participating employer, referred to as "the hospital" or collectively as "the hospitals." It is your responsibility to read the Handbook and the Health Booklets and to ask questions if you need more information. It is also your responsibility to visit **www.healthysteps4u.org** to download your plan's Health Booklet. If you do not have access to a computer, please contact the HealthySteps Benefits Service Center to have a paper copy mailed to you at no charge. The portal address and phone number are found in the ***Administrative Information*** section.

The summary provided in this Handbook and in the Health Booklets is intended to provide an accurate explanation of how your benefit plans work. It is not intended to serve as any form of contract or plan document. If there is a discrepancy between the descriptions in this Handbook and the insurance contracts and plan documents, the contracts and plan documents will always govern.

Your Health Plans

The hospitals' medical coverage is provided to eligible employees (and their eligible dependents) through Aetna or Kaiser Permanente. The plans give you the flexibility and support to actively manage both your health and your health care costs.

If you have questions or would like more information about your medical, prescription or mental health plan, call your carrier's member services number shown on your membership card and at the end of the *Administrative Information* section.

What's Offered

Types of Plans

You have three medical plan options for you and your eligible family members. Regardless of which plan you choose, you will receive free in-network preventive care, including annual physicals, well-woman exams, well-baby and well-child exams and immunizations.

ATTENTION KAISER PERMANENTE HMO PLAN MEMBERS

This section of the Handbook includes a high-level summary of the Kaiser Permanente HMO plan. All plan documenets can be found on HealthySteps.

Your medical plan choices are:

- Aetna Choice POS II with Health Savings Account (HSA), administered by Aetna
- Stanford Health Care Alliance (SHCA) plan, administered by Aetna
- Kaiser Permanente Health Maintenance Organization (HMO) plan

When you enroll in a medical plan, you will automatically be covered under the vision plan through VSP. The eligible dependents you enroll in the medical plan will also automatically have coverage under VSP.

You also may choose to participate in a dental plan. You have these dental plan options:

- Delta Dental Basic PPO — a managed fee-for-service plan
- Delta Dental Buy-Up PPO — a managed fee-for-service plan that offers greater coverage than the Delta Dental Basic PPO
- DeltaCare® USA DHMO— a Dental Health Maintenance Organization (DHMO)

Using Your Plan

Several weeks after you enroll in the Aetna Choice POS II with Health Savings Account (HSA) or Stanford Health Care Alliance (SHCA) medical plan, you will receive two membership cards. You may order more cards online or by calling Aetna. Membership cards contain the telephone number to call if you have questions about your plan.

If you enroll in the Kaiser Permanente HMO plan, you will receive a card for each member of your family.

When you visit a provider or facility, you will need to provide your membership card.

How the Plans Work

Aetna Choice POS II with Health Savings Account (HSA)
The Aetna Choice Point of Service (POS) II with Health Savings Account (HSA) allows participants to visit any doctor or facility; however, you will always have the lowest out-of-pocket costs when you seek care through the Tier 1 network; you will pay more when you use Tier 2 providers and facilities; and you will pay the most when you use Tier 3 out-of-network providers and facilities. You must pay an annual deductible each calendar year before eligible medical expenses are paid by the plan.

WHO ADMINISTERS THE MEDICAL PLANS?

The Aetna Choice POS II with HSA and Stanford Health Care Alliance (SHCA) plans are administered by Aetna. The HMO plan is administered by Kaiser Permanente.

When you sign up for the Aetna Choice POS II with HSA, you will also be eligible for an HSA to offset the cost of out-of-pocket health care expenses. An HSA is an employee-owned tax-advantaged account that can be used to pay for qualified health expenses such as deductibles, coinsurance and copayments.

Stanford Health Care Alliance (SHCA)

In the SHCA plan, you must use the physicians and facilities within the SHCA network. When you see your provider, there are no deductibles or claims to file. If you go to a doctor outside of the SHCA network, and are not referred by your primary care physician (PCP) and pre-authorized through SHCA, you pay the full cost for the care you receive, except in the case of an emergency, or if the care is for your dependent who qualifies for the out-of-area benefit (see text box on this page).

Your PCP may refer you to Aetna in-network facilities, and you will pay a plan deductible and coinsurance. For facility care outside of the SHCA/Aetna network, you pay the full cost for the care you receive except in the case of an emergency. For detailed information on in-network and out-of-network facilities, and to select a PCP, please call CareCounsel at 888-227-3334 or search the provider directory at https://stanfordhealthcarealliance.org.

SHCA participants are not eligible for a Health Savings Account. SHCA participants are eligible for the Health Reimbursement Account (HRA) and/or may open a Health Care Flexible Spending Account (FSA) to offset out-of-pocket costs.

DEPENDENTS WHO LIVE OUT OF AREA

If you have dependents who are attending college outside of the SHCA network area, they can use Aetna network providers (known as "out-of-area" providers) and pay the same applicable copays or coinsurance as they would for an in-network provider. However, claim amounts from "out-of-area" providers that apply to their deductible and out-of-pocket maximums will not apply to the family deductible and out-of-pocket maximum. Please call SHCA Member Care Services at 855-345-7422 or visit www.healthysteps4u.org for more details.

Kaiser Permanente HMO

Health Maintenance Organizations (HMOs) provide a broad range of medical services at a low cost. To receive benefits, you must use your Kaiser Permanente network physicians, facilities and hospitals, except in the case of an emergency. No benefits are payable for any non-emergency care you receive from a physician, facility or hospital outside the network.

When you sign up for the Kaiser Permanente HMO plan, you are not eligible for a Health Savings Account (HSA); however you are eligible for the Health Reimbursement Account (HRA) and/or may open a Health Care Flexible Spending Account (FSA) to offset out-of-pocket costs. Based upon your home/work zip code, access to care may be limited. Please contact Human Resources.

Medical Plan Coverage

Aetna Choice POS II with HSA

With the Aetna Choice POS II with HSA, you have the freedom to visit any licensed health care provider each time you need care. The choices you make affect the amounts you pay and the level of benefits you receive. In addition, certain benefit limitations may or may not apply. Generally:

- The Aetna Choice POS II with HSA has a three-tier provider network structure, which offers you even more providers and facilities from which to choose:
  - **Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network** — If you receive in-network care from providers in a Stanford Health Care, Stanford Children's Health and/or Stanford Health Care — ValleyCare Network facility, you will receive the highest level of coverage. As an added bonus, when you use the Stanford Health Care, Stanford Children's Health and/or Stanford Health Care — ValleyCare Network, inpatient hospital professional fees and outpatient surgery professional fees are covered at 100% after you've satisfied your deductible for the year and paid your copay. In-network preventive care services are covered at no cost to you.

    El Camino Hospital and Sequoia Hospital will also be covered at a Tier 1 network level for hospital facility charges and professional charges for maternity delivery and newborn services only.
  - **Tier 2: Aetna Choice POS II Network** — If you receive in-network care from providers who participate in the Aetna Choice POS II Network, you will receive the next highest level of benefits with negotiated rates and discounts, but slightly higher coinsurance than Tier One providers and facilities. In-network preventive care services are covered at no cost to you.
  - **Tier 3: Out-of-Network** — If you receive out-of-network care from providers who are not part of the Aetna Choice POS II Network, your benefits will be lower. Out-of-network preventive care services are typically not covered.

Find out which network a provider belongs to by calling the toll-free number listed on the back of the plan's membership card or visit **www.aetna.com/individuals-families/find-a-doctor.html**.

You must pay an annual deductible each calendar year before eligible medical expenses are covered. All non-preventive services are subject to your deductible including medical, prescription drug and behavioral health services. (This means that until you meet your deductible, you will pay 100% of the cost for non-preventive medical services.) Keep in mind that separate in-network and out-of-network annual deductibles apply.

After you satisfy the deductible, the plan pays the majority of the cost. You pay a percentage of eligible medical expenses, called coinsurance, until you reach your annual out-of-pocket maximum.[1] Your annual out-of-pocket maximum is the most you will pay each calendar year for eligible medical expenses. Once you reach the annual out-of-pocket maximum, the plan pays 100% of your eligible medical expenses through the end of the calendar year. Again, separate in-network and out-of-network annual out-of-pocket maximums apply.

The Aetna Choice POS II with HSA also lets you contribute to a tax-advantaged HSA to help pay for eligible medical expenses or save for future medical expenses.

If you are enrolled in this plan, any wellness incentive dollars earned by completing HealthySteps to Wellness activities will be contributed to your HSA. Wellness activities will help you earn money for eligible health care expenses and will be announced during annual open enrollment.

[1] The Aetna Choice POS II participants who use Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network hospital facilities will not have to pay coinsurance after the plan deductible for in-patient facility charges.

Schedule of Benefits

All health benefits shown on this Schedule of Benefits are subject to annual maximums, deductibles, copays, coinsurance and out-of-pocket maximums, if any.

Benefits are subject to all provisions of this plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the "What the Plan Covers" section in **Aetna's Health Booklet** for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Please refer to Aetna's Health Booklet for more details and a description of these services and prior authorization procedures.

Aetna Choice POS II with HSA

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Annual Deductible per Calendar Year:			
• Single Coverage	$1,400		$2,700
• Family Coverage	$2,800		$5,400
Note: Medical, pharmacy and behavioral health expenses are subject to the same deductible			
Coinsurance: (unless otherwise stated below)			
• Paid by Plan After Deductible	100%	80%	60%
Annual Out-of-Pocket Maximum:			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Single Coverage	$2,700		$5,400
• Family Coverage	$5,400		$10,800
Note: Medical, pharmacy and behavioral health expenses are subject to the same out-of-pocket maximum			
Acupuncture Treatment:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	12 visits	12 visits	12 visits
• Copay per Visit	$35	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
• Maximum Benefit per Visit	N/A	$30	$30
Ambulance Transportation:			
• Paid by Plan After In-Network Deductible	100%	100%	100% (UCR is waived for true emergency)
Chiropractic Services:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	N/A	30 visits	30 visits
• Paid by Plan After Deductible	N/A	80%	60%
Durable Medical Equipment:			
• Paid by Plan After Deductible	N/A	80%	60%
Emergency Services/Treatment:			
Urgent Care:			
• Paid by Plan After Deductible	100%	100%	100%
Emergency Room/Emergency Physicians In-Area:			
• Paid by Plan After In-Network Deductible	100%	80%	80%
Emergency Room/Emergency Physicians Out-of-Area:			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After In-Network Deductible	100%	80%	80%
Extended Care Facility Benefits Such as Skilled Nursing, Convalescent or Sub-Acute Facility:			
• Maximum Days per Calendar Year (combined Tier 2 and out-of-network)	N/A	100 days	100 days
• Paid by Plan After Deductible	N/A	80%	60%
Hearing Services: (if under age 22, covered under preventive care benefits; if age 22 or older, covered as shown below)			
Exams/Tests:			
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Hearing Aids:			
• Maximum Benefit Every 2 Years	N/A	1 pair of hearing aids	1 pair of hearing aids
• Paid by Plan After Deductible	N/A	80%	60%
Home Health Care Benefits:			
• Maximum Visits per Calendar Year (combined Tier 2 and out-of-network)	N/A	100 visits	100 visits
• Paid by Plan After Deductible	N/A	80%	60%
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four (4) hours of home health care services.			
Hospice Care Benefits:			
Hospice Services:			
• Paid by Plan After Deductible	100%	80%	60%
Bereavement Counseling:			
• Paid by Plan After Deductible	N/A	80%	60%
Hospital Services: (precertification required)			
Pre-Admission Testing:			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After Deductible	100%	80%	60%
Inpatient Services/Inpatient Physician Charges, Room and Board Subject to the Payment of Semi-Private Room Rate or Negotiated Room Rate:			
• Paid by Plan After Deductible	100%	80%	60%; $300 admission penalty without precertification (waived if emergency admission)
Outpatient Surgery Facility Charges:			
• Copay per Visit	$200	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Outpatient Surgery Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Outpatient Lab and X-ray Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Infertility Care:			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided; includes counseling and consultation, infertility studies and tests and assisted reproductive technologies (procedures and medication). Lifetime maximum of $10,000 for medical expenses and $5,000 for pharmacy expenses	80%; includes counseling and consultation, infertility studies and tests only	60%; includes counseling and consultation, infertility studies and tests only
Mental Health, Substance Abuse and Chemical Dependency Benefits: (provided through Aetna)			
Inpatient Services/Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Residential Treatment:			
• Paid by Plan After Deductible	100%	80%	60%; $300 admission penalty without precertification (waived if emergency admission)

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Partial Hospitalization Services/Physician Charges:			
• Paid by Plan After Deductible	100%	80%	60%
Outpatient Services/Physician Charges:			
• Copay per Visit	$20	N/A	N/A
• Paid by Plan After Deductible	100%	80%	60%
Physician Office Services:			
• Copay per Visit	$20 ($35 for specialist)	N/A	N/A
• Paid by Plan After Deductible	100%	80%	60%
Preventive/Routine Care Benefits: (see "Glossary of Terms" for definition of preventive treatment)			
Preventive/Routine Physical Exams at Appropriate Ages:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Immunizations:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Diagnostic Tests, Lab and X-rays at Appropriate Ages:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Mammograms and Breast Exams:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Pelvic Exams and Pap Test:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine PSA Test and Prostate Exams:			
• Maximum Exams per Calendar Year	1 exam	1 exam	1 exam
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Screenings/Services at Appropriate Ages and Gender:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Preventive/Routine Colonoscopy, Sigmoidoscopy and Similar Routine Surgical Procedures Done for Preventive Reasons:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Note: The first colonoscopy of the year is covered under the preventive/routine benefit regardless of diagnosis.			
Preventive/Routine Hearing Exams:			
• Paid by Plan After Deductible	100% (deductible waived, coverage to age 21 only)	100% (deductible waived, coverage to age 21 only)	60% (coverage to age 21 only)
Preventive/Routine Alcohol and Substance Abuse, Tobacco Use, Obesity, Diet and Nutrition Counseling:			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%
Temporomandibular Joint Disorder Benefits:			

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
• Paid by Plan After Deductible	N/A	80%	60%; $300 admission penalty without precertification (waived if emergency admission)
Therapy Services – Occupational/Physical/Speech:			
• Maximum Visits per Calendar Year (combined Tier 1, Tier 2 and out-of-network)	60 visits	60 visits	60 visits
• Copay per Visit	$35	N/A	N/A
• Paid by Plan After Deductible	100% (less copay)	80%	60%
Transgender Services			
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided	80%	60%
Wigs, Toupees or Hairpieces: (allowed for hair loss resulting from chemotherapy or radiation therapy, alopecia areata, endocrine diseases or accidental injury)			
• Maximum Benefit per 1 Wig, 1 Toupee or 1 Hairpiece (up to $500 maximum every 2 years combined in- and out-of-network)	N/A	Every 2 years	Every 2 years
• Paid by Plan After Deductible	N/A	80%	80%
Women's Contraceptive Injections and Devices, such as IUDs and Implants: (including the insertion and removal)			
• Paid by Plan After Deductible	100% (deductible waived)	100% (deductible waived)	60%

Covered Expense	Tier 1: Stanford Health Care, Stanford Children's Health and Stanford Health Care — ValleyCare Network	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
All Other Covered Expenses:			
• Paid by Plan After Deductible	100% (where applicable)	80%	60%

[2] Out-of-network means outside of the Tier 2 network. Usual, Customary and Reasonable (UCR) charges are the fees normally charged for medical services or supplies in a particular geographic location.

Notes: Refer to the "Provider Network" section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined maximum benefit for services that the covered person receives from all in-network and out-of-network providers and facilities.

Transplant Schedule of Benefits: Aetna Choice POS II with HSA	Tier 1: Stanford Health Care and Stanford Children's Health Network and Stanford Health Care — ValleyCare	Tier 2: Aetna Choice POS II Network	Tier 3: Out-of-Network[2]
Transplant Services at an Institute of Excellence (IOE) Transplant Facility: (benefits are provided only if service is received at an IOE)			
Transplant Services:			
• Paid by Plan After Deductible	100%	80%	N/A
Travel and Housing[3]:			
• Maximum Benefit per Transplant	$10,000 (combined maximum)		N/A
• Paid by Plan After Deductible	100%	80%	N/A

[3] Travel and housing at designated transplant facility for up to one year from date of transplant with prior authorization.

Note: If a transplant is performed at a Stanford Health Care or Lucile Packard Children's Hospital Stanford facility, you are not required to use an Institute of Excellence (IOE) transplant facility.

What the Plan Covers

Pre-Existing Conditions

The health plans offered by the hospitals treat health conditions you or a family member had prior to your coverage date the same as any other covered health condition.

Preventive Care

Preventive care services are recommended screenings for proactive wellness management. These services help identify health risks before they become greater health issues. By identifying risks early, you can avoid greater health complications as well as save on the costs of managing more complicated health issues.

The Aetna Choice POS II with HSA covers preventive care at 100% when you receive it from an in-network provider. The plan covers charges for routine preventive care, including immunizations of a dependent for the first two years of life. Routine preventive care means health care assessments, wellness visits and any related services.

While your doctor will determine the tests that are right for you based on your age, gender and family history, below is a list of items covered by your preventive care benefits. This list is not all inclusive and is subject to change according to the recommendations of the United States Preventive Services Task Force, Health Resources and Services Administration:

- Periodic well-baby and well-child visits, depending on age
- Immunizations (as appropriate by age):
  - Diphtheria, tetanus and acellular pertussis (DTAP)
  - Hepatitis A & B
  - HPV
  - Influenza
  - Measles-mumps-rubella (MMR)
  - Meningococcal (MCV4)
  - Varicella (chickenpox).
- Screenings (as appropriate by age):
  - Blood pressure
  - Cholesterol
  - Mammography screening
  - Osteoporosis screening
  - Pap smear and pelvic exam

- Prostate screening (PSA)
- Colorectal cancer screenings.

Urgent Care

Urgent care is defined as the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, but is not serious enough to warrant a visit to an emergency room. Examples include upper respiratory or urinary tract infections, sprains, strains, GI disorders, rashes and insect bites.

Often, urgent care centers are not open on a continuous basis, unlike a hospital emergency room that would be open at all times.

Emergency Care

Your first priority in a medical emergency is to get the care you need right away, without worrying about going to an in-network provider. In a true medical emergency, all three medical plans pay in-network benefits, even if the care is provided by an out-of-network provider. A medical emergency is a sudden illness or injury serious enough to threaten your life or cause permanent damage if it is not treated immediately. Emergency room copayments may apply.

Within 48 hours of seeking emergency medical care or as soon as it is medically possible, you or a family member must contact your medical plan to discuss your continuing treatment.

Home Health Care

Home health care services are provided for patients who are unable to leave their home, as determined by the utilization review organization. Covered persons must obtain prior authorization in advance before receiving services. Please refer to the “Home Health Care” section of **Aetna’s Health Booklet** for more details.

Covered services can include:

- Home visits instead of visits to the provider’s office that do not exceed the Usual, Customary and Reasonable charge to perform the same service in a provider’s office;
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period;
- Nutrition counseling provided by or under the supervision of a registered dietitian;
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist; and
- Medical supplies, drugs or medication prescribed by a physician and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital.

A home health care visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a therapist or a registered dietician.

Exclusions

In addition to the items listed in the "Home Health Care Limitations" section of Aetna's Health Booklet, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services
- Supportive environment materials such as handrails, ramps, air conditioners or telephones
- Services performed by family members or volunteer workers
- "Meals on Wheels" or similar food services
- Separate charges for records, reports or transportation
- Expenses for the normal necessities of living such as food, clothing and household supplies
- Legal and financial counseling services, unless otherwise covered under this plan

Transplant Benefits

The plan will pay for covered expenses incurred by a covered person at a designated transplant facility for an illness or injury, subject to any deductibles, plan participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual, Customary and Reasonable charge or the plan's negotiated rate.

It will be the covered person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual plan provisions. The approved transplant and medical criteria for such transplant must be medically necessary for the medical condition for which the transplant is recommended. Please see the Aetna Choice POS II with HSA plan documents for more information.

What the Plan Does Not Cover

Unless exceptions to the following exclusions are specifically made elsewhere in this section of the Handbook, no benefits are provided for the following services or supplies which are:

- For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a participating hospice agency and except as medically necessary.
- For rehabilitation services, except as specifically provided in the "Services for Treatment of Illness or Injury," "Home Health Care Benefits," "Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)" and "Hospice Program Benefits" sections.

- For or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, domiciliary care or residential care except as provided under hospice program benefits (see “Hospice Program Benefits” for exception).
- Performed in a hospital by house officers, residents, interns and others in training.
- Performed by a close relative or by a person who ordinarily resides in the covered participant's home.
- For any services relating to the diagnosis or treatment of any mental or emotional illness or disorder that is not a mental health condition.
- For or incident to services by non-preferred providers, except as may be provided for medically necessary emergency services.
- For any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine or any other language assistive devices, except as specifically listed under prosthetic appliances benefits.
- For routine physical examinations, except as specifically listed under preventive health benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment or insurance unless the examination is substituted for the annual health appraisal exam.
- For or incident to speech therapy, speech correction or speech pathology or speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition, injury or illness except as specifically listed under home health care benefits, speech therapy benefits and hospice program benefits.
- For drugs and medicines which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met.
- For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; exercise programs or nutritional counseling except as specifically provided for under diabetes care benefits. This exclusion shall not apply to medically necessary services which the plan is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions.
- For callus, corn paring or excision and toenail trimming except as may be provided through a participating hospice agency; over-the-counter shoe inserts or arch supports or any type of massage procedure on the foot.

- Which are experimental or investigational in nature, except for services for participants who have been accepted into an approved clinical trial for cancer as provided under clinical trial for cancer benefits.
- For learning disabilities, behavioral problems, social skills training/therapy or testing for intelligence or learning disabilities. This exclusion shall not apply to medically necessary services which the plan is required by law to cover for severe mental illnesses or serious emotional disturbances of a child.
- Hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation.
- For dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication, except as specifically provided under medical treatment of teeth, gums, jaw joints or jaw bones benefits and hospital benefits (facility services).
- For or incident to services and supplies for treatment of the teeth and gums (except for tumors and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays and topical fluoride treatment, except when used with radiation therapy to the oral cavity, fillings and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses, except as specifically provided under medical treatment of teeth, gums, jaw joints or jaw bones benefits and hospital benefits (facility services).
- Incident to organ transplant, except as explicitly listed under transplant benefits.
- For cosmetic surgery or any resulting complications, except that benefits are provided for medically necessary services to treat complications of cosmetic surgery (e.g., infections or hemorrhages), when reviewed and approved by the plan consultant. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
  - Lower eyelid blepharoplasty
  - Spider veins
  - Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing and abrasive procedures)
  - Hair removal by electrolysis or other means
  - Reimplantation of breast implants originally provided for cosmetic augmentation
  - Voice modification surgery

- For reconstructive surgery and procedures where there is another more appropriate covered surgical procedure or when the surgery or procedure offers only a minimal improvement in the appearance of the enrollee (e.g., spider veins). In addition, no benefits will be provided for the following surgeries or procedures unless for reconstructive surgery:
  - Surgery to excise, enlarge, reduce or change the appearance of any part of the body
  - Surgery to reform or reshape skin or bone
  - Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging or excessive on any part of the body
  - Hair transplantation
  - Upper eyelid blepharoplasty without documented significant visual impairment or symptomatology

  This limitation shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
- For penile implant devices and surgery, and any related services, except for any resulting complications.
- Not specifically listed as a benefit and medically necessary service.
- For patient convenience items such as telephone, television, guest trays and personal hygiene items.
- For which the participant is not legally obligated to pay or for services for which no charge is made.
- Incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.

  However, if Aetna provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by the plan for the treatment of such injury or disease.
- In connection with private duty nursing, except as provided under home health care benefits and home infusion/home injectable therapy benefits, except as provided through a participating hospice agency.
- For prescription and non-prescription food and nutritional supplements, except as provided under home infusion/home injectable therapy benefits, and PKU-related formulas and special food products benefit, except as provided through a participating hospice agency.

- For home testing devices and monitoring equipment, except as specifically provided under durable medical equipment benefits.
- For genetic testing, except as described under outpatient X-ray, pathology and laboratory benefits and pregnancy and maternity care benefits.
- For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under home health care benefits, home infusion/home injectable therapy benefits, hospice program benefits, diabetes care benefits, durable medical equipment benefits and prosthetic appliances benefits.
- For services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy benefits under the hospitals' health plan.
- For services provided by an individual or entity that is not licensed, certified or otherwise authorized by the state to provide health care services, or is not operating within the scope of such license, certification or state authorization, except as specifically stated herein.
- For massage therapy that is not physical therapy or a component of a multimodality rehabilitation treatment plan.
- For Christian Science practitioner benefits.
- For prescribed drugs and medicines for outpatient care, except as provided through a participating hospice agency when the participant is receiving hospice services and except as may be provided under the outpatient prescription drugs supplement or home infusion/home injectable therapy benefits in the "Covered Services" section.
- For services not authorized by the plan.

Medical Necessity Exclusion

The benefits of this plan are intended only for services that are medically necessary. Because a physician or other provider may prescribe, order, recommend or approve a service or supply does not, in itself, make it medically necessary even though it is not specifically listed as an exclusion or limitation. The plan reserves the right to review all claims to determine if a service or supply is medically necessary. The plan may use the services of doctor of medicine consultants, peer review committees of professional societies or hospitals and other consultants to evaluate claims. The plan may limit or exclude benefits for services which are not necessary.

Stanford Health Care Alliance (SHCA)

The Stanford Health Care Alliance is a health care plan that puts the best Stanford affiliated team in place — across Stanford Health Care (includes Stanford Hospital, Stanford Health Care — ValleyCare, Stanford Clinics, University Healthcare Alliance and Affinity), Stanford Children's Health (includes Lucile Packard Children's Hospital Stanford and Packard Children's Health Alliance) and Aetna's hospital and ancillary network — to provide you with world-class, integrated care that supports your best health.

The SHCA network of providers and facilities applies to enrolled employees and dependents who access services within the SHCA five core counties (Alameda, Contra Costa, San Francisco, San Mateo and Santa Clara).

- Brown & Toland physicians in San Francisco and northern peninsula cities are part of the network.
- In the Fremont/Newark region, Washington Township Medical Foundation physicians are included in the SHCA network.
- El Camino Hospital and Sequoia Hospital will also be covered at the network level for hospital facility charges and professional charges for maternity delivery and newborn services only.

Note: The SHCA network excludes Sutter providers and hospitals, except for Alta Bates.

DEPENDENTS WHO LIVE OUT OF AREA

If you have dependents who are attending college outside of the SHCA network area, they can use Aetna network providers (known as "out-of-area" providers) and pay the same applicable copays or coinsurance as they would for an in-network provider. However, claim amounts from "out-of-area" providers that apply to their deductible and out-of-pocket maximums will not apply to the family deductible and out-of-pocket maximum. Please call SHCA Member Care Services at 855-345-7422 or visit www.healthysteps4u.org for more details.

In the SHCA plan, you must use the physicians and facilities within the SHCA network. When you see your provider, there are no deductibles or claims to file. If you go to a doctor outside of the SHCA network, and are not referred by your PCP and pre-authorized through SHCA, you pay the full cost for the care you receive, except in the case of an emergency, or if the care is for your dependent who qualifies for the out-of-area benefit (see text box on this page).

Your PCP may refer you to Aetna's in-network facilities and you will pay a plan deductible and coinsurance.[4] For facility care outside of the SHCA/Aetna network, you pay the full cost for the care you receive. For detailed information on in-network and out-of-network facilities, and to select a PCP, please call CareCounsel at 888-227-3334 or search the provider directory at https://stanfordhealthcarealliance.org.

- Preventive care services like annual physical exams and certain types of screenings are provided at no cost to you.
- You are responsible for all medical expenses each year until you reach your annual deductible amount ($400/individual or $1,000/family).

[4] SHCA participants who use Stanford Health Care, Lucile Packard Children's Hospital Stanford and Stanford Health Care — ValleyCare Network hospital facilities will not have to pay a deductible or coinsurance.

Annual Deductible	Coinsurance	Out-of-Pocket Maximum
$400/person $1,000/family	Varies based on service	$1,800/individual $3,600/family

- Once you've reached your annual deductible, you will pay coinsurance or copays for covered expenses until you reach your out-of-pocket maximum for the year.
- When you reach your out-of-pocket maximum, you will pay nothing for the rest of the year for covered services.
- Prescription drug coverage and mental health and substance abuse treatment services are provided by Aetna.
- You pay a set copay for prescription drugs. Prescription drugs may only be filled at an Aetna-affiliated pharmacy.

When you enroll in the SHCA plan, you become eligible for a Health Reimbursement Account (HRA). Once you earn wellness incentive dollars by completing HealthySteps to Wellness activities, the hospitals will open an HRA and contribute to it on your behalf. Wellness activities will help you earn money for eligible health care expenses. Any funds remaining in this account at the end of the calendar year will be lost. Wellness activity incentives will be announced during annual open enrollment.

For more information about the Stanford Health Care Alliance, including a directory of in-network providers and facilities, visit **www.stanfordhealthcarealliance.org**.

Schedule of Benefits

All health benefits shown on this Schedule of Benefits are subject to annual maximums, deductibles, copays, coinsurance and out-of-pocket maximums, if any.

Benefits are subject to all provisions of this plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the "What the Plan Covers" and "Medical Plan Exclusions" sections in Aetna's Health Booklet for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Please refer to the "What the Plan Covers" section in **Aetna's Health Booklet** for more details, a description of these services and prior authorization procedures.

Stanford Health Care Alliance (SHCA)

Covered Expense	SHCA Network
Annual Deductible per Calendar Year:	
• Single Coverage	$400

Covered Expense	SHCA Network
• Family Coverage	$1,000
Plan Participation Rate: (unless otherwise stated below)	
• Paid by Plan After Satisfaction of Deductible	90%
Annual Out-of-Pocket Maximum:	
• Single Coverage	$1,800
• Family Coverage	$3,600
Acupuncture Treatment:	
• Copay per Visit	$35
• Maximum Visits per Calendar Year	12 visits
• Maximum Benefit per Visit	N/A
• Paid by Plan After Deductible	100% (deductible waived)
Ambulance Transportation:	
• Paid by Plan After Deductible	100% (deductible waived)
Chiropractic Services:	
• Copay per Visit	$35
• Maximum Visits per Calendar Year	30 visits
• Paid by Plan After Deductible	100% (deductible waived)
Durable Medical Equipment:	
• Paid by Plan After Deductible	90%
Emergency Services/Treatment:	
Urgent Care:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)
Emergency Room/Emergency Physicians:	
• Copay per Visit	$200
• Paid by Plan After In-Network Deductible	100% (deductible waived)
Extended Care Facility Benefits Such as Skilled Nursing, Convalescent or Sub-Acute Facility:	
• Maximum Days per Calendar Year	100 days
• Paid by Plan After Deductible	90%
Hearing Services:	
Exams/Tests:	
• Copay per Visit	$35

Covered Expense	SHCA Network
• Paid by Plan After Deductible	100% (deductible waived)
Hearing Aids:	
• Maximum Benefit Every 2 Years	1 pair of hearing aids
• Paid by Plan After Deductible	90%
Home Health Care Benefits:	
• Maximum Visits per Calendar Year	100 visits
• Paid by Plan After Deductible	90%
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or up to four hours of home health care services.	
Hospice Care Benefits:	
Hospice Services:	
• Paid by Plan After Deductible	90%
Bereavement Counseling:	
• Paid by Plan After Deductible	90%
Hospital Services:	
Pre-Admission Testing:	
• Paid by Plan After Deductible	90%
Inpatient Services/Inpatient Room and Board Subject to the Payment of Semi-Private Room Rate or Negotiated Room Rate:	
• Paid by Plan After Deductible	90%
Inpatient Services/Inpatient Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Inpatient Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Surgery Facility Charges:	
• Paid by Plan After Deductible	90%
Outpatient Surgery Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Copay per Visit	$200
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Surgery Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Basic and Complex Outpatient Lab and X-ray Charges:	
• Paid by Plan After Deductible	90%

Covered Expense	SHCA Network
Basic Outpatient Lab and X-ray Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford, Stanford Health Care – ValleyCare or SHCA Physician's Office:	
• Copay per Visit	$25
• Paid by Plan After Deductible	100% (deductible waived)
Complex Outpatient Lab and X-ray Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford, Stanford Health Care – Valley Care or SHCA Physician's Office:	
• Copay per Visit	$100
• Paid by Plan After Deductible	100% (deductible waived)
Infertility Care:	
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided; includes counseling and consultation, infertility studies and tests and assisted reproductive technologies (procedures and medication). Lifetime maximum of $10,000 for medical expenses and $5,000 for pharmacy expenses
Mental Health, Substance Abuse and Chemical Dependency Benefits:	
Inpatient Services/Physician Charges:	
• Paid by Plan After Deductible	100% (deductible waived)
Inpatient, Partial Hospitalization, Outpatient and Outpatient Observation Facility Charges:	
• Paid by Plan After Deductible	90%
Residential Treatment:	
• Paid by Plan After Deductible	90%
Inpatient, Partial Hospitalization, Residential Treatment, Outpatient and Outpatient Observation Facility Charges Incurred at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
• Paid by Plan After Deductible	100% (deductible waived)
Outpatient Services/Physician Charges:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)

Covered Expense	SHCA Network
Physician Office Visit:	
Primary Care Physician Office Visit:	
• Copay per Visit	$20
• Paid by Plan After Deductible	100% (deductible waived)
Specialist Office Visit:	
• Copay per Visit	$35
• Paid by Plan After Deductible	100% (deductible waived)
Allergy Testing:	
• Copay per Visit	$20 for PCP or $35 for specialist
• Paid by Plan After Deductible	100% (deductible waived)
Allergy Injections:	
If Billed without an Office Visit:	
• Copay per Visit	N/A
• Paid by Plan After Deductible	100% (deductible waived)
If Billed with an Office Visit:	
• Copay per Visit	$20 for PCP or $35 for specialist
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Care Benefits: (see "Glossary of Terms" for definition of preventive treatment)	
Preventive/Routine Physical Exams at Appropriate Ages:	
• Paid by Plan After Deductible	100% (deductible waived)
Immunizations:	
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Diagnostic Tests, Lab and X-rays at Appropriate Ages:	
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Mammograms and Breast Exams:	
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Pelvic Exams and Pap Test:	
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine PSA Test and Prostate Exams:	

Covered Expense	SHCA Network
• Maximum Exams per Calendar Year	1 exam
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Screenings/Services at Appropriate Ages and Gender:	
• Paid by Plan After Deductible	100% (deductible waived)
Preventive/Routine Colonoscopy, Sigmoidoscopy and Similar Routine Surgical Procedures Done for Preventive Reasons:	
• Paid by Plan After Deductible	100% (deductible waived)
Note: The first colonoscopy of the year is covered under the preventive/routine benefit regardless of diagnosis.	
Preventive/Routine Hearing Exams:	
• Paid by Plan After Deductible	100% (deductible waived)
Transgender Services:	
• Paid by Plan After Deductible	Payable in accordance with the type of expense incurred and the place where the service is provided
Temporomandibular Joint Disorder Benefits:	
• Paid by Plan After Deductible	90%
Therapy Services – Occupational/Physical/Speech:	
• Maximum Visits per Calendar Year	60 visits
• Copay per Visit	$35
• Paid by Plan After Deductible	100% (deductible waived)
Wigs, Toupees or Hairpieces:	
• Maximum Benefit per Wig, Toupee or Hairpiece	$500
• Maximum Benefit per Treatment Every 2 Years	1 wig, toupee or hairpiece
• Paid by Plan After Deductible	90%
Women's Contraceptive Injections and Devices, such as IUDs and Implants: (including the insertion and removal)	
• Paid by Plan After Deductible	100% (deductible waived)
All Other Covered Expenses:	
• Paid by Plan After Deductible	90%

Transplant Schedule of Benefits: SHCA
Transplant Services at an Institute of Excellence (IOE) Transplant Facility:
Transplant Services:

Transplant Schedule of Benefits: SHCA	
• Paid by Plan After Deductible	90%
Travel and Housing:	
• Maximum Benefit per Transplant	$10,000
Transplant Services at Stanford Health Care, Lucile Packard Children's Hospital Stanford or Stanford Health Care – ValleyCare:	
Transplant Services:	
• Paid by Plan After Deductible	100% (deductible waived)
Travel and Housing at Designated Transplant Facility for up to One Year from Date of Transplant with prior authorization.	

What the Plan Covers

Pre-Existing Conditions

The hospitals treat health conditions you or a family member had prior to your coverage date the same as any other covered health condition.

Preventive Care

Preventive care services are recommended screenings for proactive wellness management. These services help identify health risks before they become greater health issues. By identifying risks early, you can avoid greater health complications as well as save on the costs of managing more complicated health issues.

The SHCA Plan covers preventive care at 100% when you receive it from an in-network provider.

The plan covers charges for routine preventive care, including immunizations of a dependent for the first two years of life. Routine preventive care means health care assessments, wellness visits and any related services.

While your doctor will determine the tests that are right for you based on your age, gender and family history, below is a list of items covered by your preventive care benefits. This list is not all inclusive and is subject to change according to the recommendations of the United States Preventive Services Task Force, Health Resources and Services Administration.

- Periodic well-baby and well-child visits, depending on age
- Immunizations (as appropriate by age):
  - Diphtheria, tetanus and acellular pertussis (DTAP)
  - Hepatitis A & B
  - HPV

  - Influenza
  - Measles-mumps-rubella (MMR)
  - Meningococcal (MCV4)
  - Varicella (chickenpox).
- Screenings (as appropriate by age):
  - Blood pressure
  - Cholesterol
  - Mammography screening
  - Osteoporosis screening
  - Pap smear and pelvic exam
  - Prostate screening (PSA)
  - Colorectal cancer screenings.

Urgent Care

Urgent care is defined as the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Examples include upper respiratory or urinary tract infections, sprains, strains, GI disorders, rashes and insect bites.

Often, urgent care centers are not open on a continuous basis, unlike a hospital emergency room that would be open at all times.

Emergency Care

Your first priority in a medical emergency is to get the care you need right away, without worrying about going to an in-network provider. In a true medical emergency, all three medical plans pay in-network benefits even if the care is received by an out-of-network provider. A medical emergency is a sudden illness or injury serious enough to threaten your life or cause permanent damage if it is not treated immediately. Emergency room copayments may apply.

Within 48 hours of seeking emergency medical care, or as soon as it is medically possible, you or a family member must contact your medical plan to discuss your continuing treatment.

Home Health Care

Home health care services are provided for patients who are unable to leave their home, as determined by the utilization review organization. Covered persons must obtain prior

authorization in advance before receiving services. Please refer to the "Home Health Care" section of Aetna's Health Booklet for more details.

Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual, Customary and Reasonable charge to perform the same service in a provider's office
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period
- Nutrition counseling provided by or under the supervision of a registered dietitian
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist
- Medical supplies, drugs or medication prescribed by a physician and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital.

A home health care visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a therapist or a registered dietician.

Exclusions

In addition to the items listed in the "Home Health Care Limitations" section of **Aetna's Health Booklet**, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services
- Supportive environment materials such as handrails, ramps, air conditioners or telephones
- Services performed by family members or volunteer workers
- "Meals on Wheels" or similar food services
- Separate charges for records, reports or transportation
- Expenses for the normal necessities of living such as food, clothing and household supplies
- Legal and financial counseling services, unless otherwise covered under this plan

Transplant Benefits

The plan will pay for covered expenses incurred by a covered person at a designated transplant facility for an illness or injury, subject to any deductibles, plan participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual, Customary and Reasonable charge or the plan's negotiated rate.

It will be the covered person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual plan provisions. The approved transplant and medical criteria for such transplant must be medically necessary for the medical condition for which the transplant is recommended. Please see the "Transplant Benefits" section of **Aetna's Health Booklet** for more information.

What the Plan Does Not Cover

Exclusions, including complications from excluded items, are not considered covered benefits under this plan and will not be considered for payment as determined by the plan unless medically necessary.

The plan does not pay for expenses incurred for the following unless otherwise stated below:

- Acts of war: Injury or illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, war or acts of war, whether declared or undeclared
- Alternative/complementary treatment: Includes treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the plan
- Appointments missed: An appointment the covered person did not attend
- Aquatic therapy unless provided by a qualified physical therapist, doctor of medicine, occupational therapist or chiropractor
- Assistance with activities of daily living
- Assistant surgeon services, unless determined medically necessary by the plan
- Augmentation communication devices
- Auto excess: Illness or bodily injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage
- Before enrollment and after termination: Services, supplies or treatment rendered before coverage begins under this plan or after coverage ends
- Biofeedback services
- Blood donor expenses
- Blood pressure cuffs/monitors
- Cardiac rehabilitation beyond Phase II including self-regulated physical activity that the covered person performs to maintain health that is not considered to be a treatment program

- Chelation therapy, except in the treatment of conditions considered medically necessary, medically appropriate and not experimental or investigational for the medical condition for which the treatment is recognized
- Claims received later than 12 months from the date of service
- Claims not specifically listed as a benefit
- Contraceptive products unless covered elsewhere in this document
- Cosmetic treatment, cosmetic surgery or any portion thereof, unless the procedure is otherwise listed as a covered benefit
- Court-ordered: Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation or custody or visitation evaluation, unless such treatment or therapy is normally covered by this plan; the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court
- Criminal activity: Illness or injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place
- Custodial care as defined in the "**Glossary of Terms**" section of this Handbook
- Dental services: The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to hospital charges including professional charges for X-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an accident. Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances
- Dental implants including preparation for implants
- Duplicate services and charges or inappropriate billing including the preparation of medical reports and itemized bills
- Education: Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics
- Environmental devices: Environmental items such as but not limited to air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers or vacuum devices
- Examinations: Examinations for employment, insurance, licensing or litigation purposes

- Excess charges: Charges or the portion thereof which are in excess of the Usual, Customary and Reasonable charge, the negotiated rate or fee schedule
- Experimental, investigational or unproven: Services, supplies, medicines, treatment, facilities or equipment which the plan determines are experimental, investigational or unproven, including administrative services associated with experimental, investigational or unproven treatment. This does not include qualifying clinical trials as described in the "What The Plan Covers" section of **Aetna's Health Booklet**
- Extended care: Any extended care facility services which exceed the appropriate level of skill required for treatment as determined by the plan
- Financial counseling
- Fitness programs: General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building
- Foot care (podiatry): Routine foot care
- Foreign services received outside the United States when the sole purpose of travel is to obtain medical services and/or supplies
- Genetic counseling other than that based on medical necessity unless covered elsewhere in this Handbook
- Genetic testing unless covered elsewhere in this Handbook
- Growth hormones
- Hearing services: Implantable hearing devices unless covered elsewhere in this Handbook
- Home births and associated costs
- Home modifications: Modifications to your home or property such as but not limited to escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps
- Infant formula not administered through a tube as the sole source of nutrition for the covered person
- Lamaze classes or other child birth classes
- Learning disability: Non-medical treatment including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a learning disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to plan provisions

- Liposuction, regardless of purpose
- Maintenance therapy if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services
- Mammoplasty or breast augmentation unless covered elsewhere in this Handbook
- Marriage counseling
- Massage therapy unless provided by a qualified physical therapist, doctor of medicine, occupational therapist or chiropractor
- Maximum benefit: Charges in excess of the maximum benefit allowed by the plan
- Military: A military-related illness or injury to a covered person on active military duty, unless payment is legally required
- Nocturnal Enuresis Alarm (bed wetting)
- Non-custom-molded shoe inserts
- Non-professional care: Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license
- Not medically necessary: Services, supplies, treatment, facilities or equipment which the plan determines is not medically necessary. Services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition or maintain the current health status of the covered person. See also maintenance therapy, above
- Nursery and newborn expenses for grandchildren of a covered employee or spouse
- Nutrition counseling unless covered elsewhere in this Handbook
- Nutritional supplements, vitamins and electrolytes except as listed under the covered benefits
- Over-the-counter medication, products, supplies or devices unless covered elsewhere in this Handbook
- Palliative foot care
- Panniculectomy/abdominoplasty unless determined by the plan to be medically necessary

- Personal comfort: Services or supplies for personal comfort or convenience such as but not limited to private rooms, televisions, telephones and guest trays
- Pharmacy consultations: Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects and the like
- Private duty nursing services
- Reconstructive surgery when performed only to achieve a normal or nearly normal appearance and not to correct an underlying medical condition or impairment, as determined by the plan, unless covered elsewhere in this Handbook
- Return to work/school: Telephone or internet consultations or completion of claim forms or forms necessary for the return to work or school
- Reversal of sterilization: Procedures or treatments to reverse prior voluntary sterilization
- Room and board fees when surgery is performed other than at a hospital or surgical center
- Self-inflicted injuries unless due to a medical condition (physical or mental) or domestic violence
- Services at no charge or cost: Services which the covered person would not be obligated to pay in the absence of this plan or which are available to the covered person at no cost, or which the plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law
- Services that should legally be provided by a school
- Services provided by a close relative
- Sex therapy
- Sexual function: Non-surgical and surgical procedures and prescription drugs (unless covered under the “Prescription Benefits” section of this Handbook) in connection with treatment for male or female impotence
- Standby surgeon charges
- Subrogation: Charges for illness or injuries suffered by a covered person due to the action or inaction of any third party if the covered person fails to provide information as specified in the “Expenses for Which a Third Party May Be Responsible (Subrogation)” section

- Surrogate parenting and gestational carrier services: Any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges incurred by a covered person acting as a surrogate parent
- Taxes: Sales taxes, shipping and handling unless covered elsewhere in this Handbook
- Transportation: Transportation services which are solely for the convenience of the covered person, the covered person's close relative or the covered person's physician
- Travel: Travel costs, whether or not recommended or prescribed by a physician, unless authorized in advance by the plan
- Vision care unless covered elsewhere in this Handbook
- Vitamins, minerals and supplements, even if prescribed by a physician, except for vitamin B-12 injections and IV iron therapy that are prescribed by a physician for medically necessary purposes
- Vocational services: Vocational and educational services rendered primarily for training or education purposes; work hardening, work conditioning and industrial rehabilitation services rendered for injury prevention education or return-to-work programs
- Weekend admissions to hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the plan, unless the admission is deemed an emergency or for care related to pregnancy that is expected to result in childbirth
- Weight control: Treatment, services or surgery for weight control, whether or not prescribed by a physician or associated with an illness, except as specifically stated for preventive counseling. This does not include specific services for morbid obesity as listed in the "What The Plan Covers" section of **Aetna's Health Booklet**
- Wigs, toupees, hairpieces, hair implants, transplants, hair weaving or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this Handbook
- Workers' compensation: An illness or injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the covered person was or could have been entitled to benefits under any workers' compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force

The plan does not apply exclusions based upon the source of the injury to treatment listed in the "Covered Medical Benefits" section when the plan has information that the injury is due to a medical condition (physical or mental) or domestic violence.

The plan does not limit a covered person's right to choose his or her own medical care. If a medical expense is not a covered benefit or is subject to a limitation or exclusion, a covered

person still has the right and privilege to receive such medical service or supply at the covered person's own personal expense.

Kaiser Permanente HMO

After you enroll in the Kaiser Permanente HMO plan, you may access the Kaiser Permanente HMO Plan Evidence of Coverage (EOC) Booklet through their website at **my.kp.org/stanfordmed**.

You may also contact the HealthySteps Benefits Service Center for a paper copy of the EOC Booklet to be mailed to you at no charge, or you can visit **www.healthysteps4u.org**. It has complete information about what is covered, including any limitations or exclusions that might apply. Together, the EOC and this Handbook are your Summary Plan Description (SPD) for your Kaiser Permanente HMO plan. Keep them handy so you can refer to them when you have a question.

Additionally, Kaiser Permanente encourages members to choose a plan physician to coordinate your health care needs. To learn how to choose a plan physician, call the Kaiser Permanente member services number listed at the end of the ***Administrative Information*** section.

When you enroll in the Kaiser Permanente HMO plan, you become eligible for a Health Reimbursement Account (HRA). Once you earn wellness incentive dollars by completing HealthySteps to Wellness activities, the hospitals will open an HRA and contribute to it on your behalf. Wellness activities will help you earn money for eligible health care expenses. Any funds remaining in this account at the end of the calendar year will be lost. Wellness activity incentives will be announced during annual open enrollment.

Schedule of Benefits

Please see your **Kaiser Permanente HMO Plan Evidence of Coverage Booklet** for more information about the Schedule of Benefits.

Prescription Drug Benefits

Aetna Choice POS II with HSA

Your prescription drug benefits are administered by CVS/Caremark. You do not need to enroll to participate in the CVS/Caremark prescription benefit; enrollment is automatic when you enroll in the Aetna Choice POS II with HSA.

CVS/Caremark

If you are enrolled in the Aetna Choice POS II with HSA, you can fill short-term prescriptions at retail pharmacies and long-term prescriptions through the CVS/Caremark mail-order program.

The amount you pay per prescription depends on whether the drug is generic, formulary or non-formulary and whether you use a participating or non-participating pharmacy. You receive the highest benefit level when you use the mail-order service.

Prescription Drug Copays and Coinsurance

Medication Type	Aetna Choice POS II with HSA	
	In-Network	Out-of-Network
Retail Generic		
• Preventive	$0 (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Retail Formulary Brand		
• Preventive	$0 (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Retail Non-Formulary Brand		
• Preventive	$50 copay (no deductible)	60% after deductible
• Non-Preventive	80% after deductible	60% after deductible
Mail-Order Generic		
• Preventive	$0 (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered
Mail-Order Formulary Brand		
• Preventive	$0 (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered
Mail-Order Non-Formulary Brand		
• Preventive	$100 copay (no deductible)	Not covered
• Non-Preventive	80% after deductible	Not covered

Finding a Participating Pharmacy

Locate participating pharmacies online at **www.caremark.com** or by calling CVS/Caremark at 844-214-2607. If you are a new member to the CVS/Caremark Pharmacy Plan, you will receive a new member packet.

Using the Mail-Order Pharmacy Benefit

If you are taking medication on a regular or long-term basis (90 days or longer) to treat an ongoing health condition, you are encouraged to use the mail-order pharmacy. When you use the mail-order pharmacy, you save money because you receive a 90-day supply of medication for the cost of two copayments (compared to three copayments if purchased through a participating retail pharmacy). You also have the option to pick up your 90-day mail order prescription in a CVS pharmacy.

How to Get Started with the Mail-Order Benefit

To use your mail-order benefit:

- Ask your doctor to write two prescriptions — one for an initial 30-day supply that you can fill at your local pharmacy, and one for a 90-day supply, with appropriate refills up to one year.
- Complete the member profile form that you received with your CVS/Caremark new member packet (you only need to complete the profile the first time you use the mail-order service). Be sure to include your member ID number, appropriate copayment and your prescription in the mailer envelope. You can also obtain a profile form online at **www.caremark.com** or by calling CVS/Caremark at 844-214-2607.
- Mail your prescription and member profile form to CVS/Caremark (the address is on the form).

Your first mail order prescription will be delivered to you within five days after the order is processed. Mail-order shipping is free.

Refilling Your Mail-Order Prescriptions

You must re-order your prescriptions by phone, mail or on the website every 90 days to continue receiving the medication. Subsequent mail orders take approximately seven days from the date you place the order until you receive the medication. You should order your next prescription 30 days before your current supply runs out to allow sufficient time for your request to be filled and shipped.

You may order refills:

- Online — go to the member website at **www.caremark.com**
- By phone — call 844-214-2607. Have your member ID number, your refill slip with the prescription number and your credit card ready
- By mail — use the refill and order forms provided with your medication. The address is on the form

Paying for Your Mail-Order Medication

You may pay for your mail-order prescriptions by check, money order or credit card. If you send the wrong copayment amount and there is a balance due, an invoice will be included with your prescription order. If you overpay, your account will be credited.

How to Use the Retail Pharmacy Benefit

When you need to have a prescription filled on a short-term basis (typically for up to a 30-day supply), present your CVS/Caremark member ID card to any CVS/Caremark participating pharmacy. The pharmacy's computerized system will confirm your eligibility for benefits. If the prescription is covered, the pharmacist will fill your prescription and charge you the applicable copayment. You do not have to fill out a claim form when you fill your prescription at a participating pharmacy.

If you are in the Aetna Choice POS II with HSA and you fill your prescription at a non-participating pharmacy, you will have to pay for the prescription up front and send a claim form to CVS/Caremark for reimbursement.

CVS/Caremark Website
www.caremark.com

CVS/Caremark maintains a personalized and secure website that provides you with instant access to your complete pharmacy benefit information, available whenever you need it. Access is quick and easy. Just go to the above website, click the "Register Now" link in the "Member Sign In" section and follow the online instructions to register and create your personal user name and password. You can access the following information on this website:

- **Your Pharmacy Benefits** — Overview of your pharmacy benefits and coverage, including formulary lookup and pharmacy locator tools
- **Prescription Price Check** — Helpful information about costs and savings opportunities for prescription medications
- **Your Prescription History** — Your personal record of prescription claims history with CVS/Caremark
- **Online Prescription Ordering** — Mail-order prescriptions online and prescription refills every 90 days with free delivery to your home address. Also lets you check the status of your order and request forms for new and transferred prescriptions
- **Drug and Health Information** — Information on potential drug interactions, side effects, symptoms, risk factors, drug comparisons and treatment options
- **Online Customer Service** — Online access to a customer service team 24 hours a day, seven days a week

Questions About CVS/Caremark Benefits
CVS/Caremark has a nationwide, toll-free telephone number you can call 24 hours a day, 365 days a year with questions about your prescription drug benefits. Call 844-214-2607 to:

- Ask questions about eligibility
- Find out if a particular prescription drug is covered under your plan
- Find out the status of a mail-order claim

Preventive Care Medications

If you are enrolled in the Aetna Choice POS II with HSA, CVS/Caremark covers a broad range of generic and formulary brand preventive prescription drugs at 100%, at no out-of-pocket cost to you. Non-formulary brand preventive drugs are $50 for a 30-day supply with no deductible. The types of preventive drugs covered at 100% include medication for high blood pressure, cholesterol, bone density, anticoagulants, vaccines, antiviral treatment, prenatal vitamins, diabetes, breast cancer prevention and asthma. For the most current list of preventive prescription drugs covered at 100%, visit the HealthySteps website at **www.healthysteps4u.org**.

Generic Drugs

After a brand-name drug patent expires, other drug manufacturers may begin selling the drug under its chemical or "generic" name. Generally, generic drugs cost less because they do not require the same level of sales, marketing research and development expenses associated with brand-name drugs.

Formulary Drugs

CVS/Caremark maintains a drug "formulary," which is a comprehensive list of commonly prescribed brand-name and generic drugs selected by CVS/Caremark for safety, clinical effectiveness and cost. You may view the formulary online at **www.info.caremark.com/druglist**. The website allows you to enter the name of your medication and learn whether or not it is on the formulary. If the medication is not on the formulary, the website will list alternative drugs that are available.

Your prescription cost will be higher if your physician does not prescribe a formulary drug. Sometimes your physician may prescribe a medication for which a brand-name or generic alternative drug is available. In such cases, your physician may specify that the prescription be dispensed as written (DAW). The pharmacist may then ask your physician whether an alternative drug may be appropriate for you. If so, your prescription will be filled with the alternative drug and a confirmation will be sent to you and your physician explaining the change. Note that your physician always makes the final decision on your medication and you can always choose to keep the original prescriptions. Pharmacies will only dispense the medication authorized by your physician.

Specialty Injectable Drugs — CVS/specialty

Specialty injectable drugs are drugs that must be injected (rather than swallowed or applied topically) to be effective. These are high-cost biotech drugs that are used to treat chronic diseases such as:

- Growth hormone disorders
- Hemophilia, von Willebrand disease and related bleeding disorders
- Hepatitis C
- Immune deficiencies

- Infertility
- Multiple sclerosis
- Osteo and rheumatoid arthritis

Drugs such as insulin, vitamin B-12, epinephrine and glucagon are not considered specialty injectables and will be covered under the retail or mail-order plan. Any prescription drug excluded from coverage is also excluded as an injectable.

Injectable drugs that can be self-administered (injected subcutaneously), administered intravenously (directly into a vein) or intramuscularly (directly into a muscle) are dispensed under the prescription drug plan and must be purchased at the CVS/specialty mail-order pharmacy or through a contract CVS/specialty retail pharmacy only. These drugs can also be covered under your medical plan benefits if administered by a physician in the physician's office. Please note that specialty medications are limited to a 30-day supply — they are not available in 90-day supplies.

Please call CVS/specialty at 800-237-2767 with any questions or clarifications regarding a specific injectable drug's category, coverage or benefit.

Prior Authorization

Certain drugs require "prior authorization" from CVS/Caremark before they can be covered. Prior authorization is the process by which requests for these drugs are reviewed against objective clinical criteria to determine whether coverage will be provided. Some products, such as those that are used for cosmetic purposes, are specifically excluded from coverage. If the medication you are trying to fill has a prior authorization requirement under the plan, the pharmacist will inform you of this. To request a prior authorization, your physician provides information to CVS/Caremark's prior authorization unit. To do this, they must call in the required information to a special toll-free phone number or send the information by fax. The phone number and fax can be obtained by calling CVS/Caremark's toll-free customer service number at 844-214-2607. Response to a physician's prior authorization request can take from one to two business days. Both the patient and physician will be notified in writing when the review process is completed. If your medication is approved for coverage, an automatic authorization will be entered in the system to allow your pharmacist to fill your prescription for your regular plan copayment. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Your doctor can ask for reconsideration of a prior authorization denial by submitting further information to the prior authorization unit. If reconsideration for the coverage is denied, you may file an appeal with CVS/Caremark for further consideration of coverage.

The following are some of the drugs that require prior authorization under the prescription drug plan, although this list is not all-inclusive:

- Tretinoin such as Retin-A, if patient is over age 45

- Enbrel
- Lamisil
- Provigil
- Prescription drugs that exceed plan level limits. See "**Quantity Level Limits**" following this section for more information

This list can change without prior notice. Please call CVS/Caremark if you have any questions.

Quantity Level Limits

In most cases, when you fill a prescription you will receive the prescribed amount, up to a 30-day supply from the retail pharmacy, or a 90-day supply from the mail-order pharmacy. Certain drugs are limited, however, to a set quantity, regardless of what your physician prescribes. If the quantity requested is greater than plan level limits, the following are some of the drugs that require prior authorization, although this list is not all-inclusive:

- Injectable and non-injectable impotence medications (such as Viagra, Muse, Cialis, Caverject and Edex)
- Imitrex nasal spray

This list can change without prior notice. Please call CVS/Caremark if you have questions about coverage and/or quantity limits for a specific prescription drug.

Step Therapy

There are certain prescription drugs subject to step therapy. Step therapy is a program especially for people who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. This program applies edits to drugs in specific therapeutic classes at the point of service to guide patients into using more cost-effective, first-line alternatives when medically appropriate. Coverage for second-line therapies is determined at the patient level based on the presence or absence of first-line drugs in the patient's claims history. This allows you and your family to receive the treatment you need while making prescription drugs more affordable for you and also helps our organization provide quality prescription drug benefits. The program moves you along a well-planned path or series of steps. Your doctor is consulted, approving and writing your prescriptions based on the step therapy drugs covered by our plan. The list of drugs subject to step therapy can change without prior notice.

What Drugs Are in the Step Therapy Program?

- Generic drugs are usually in the first step. Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by the plan are effective for treating many medical conditions. Generics have the same chemical makeup and the same effect in the body as the original brand-name drug. They usually have a different name, color and/or shape. The companies that make generic drugs do not spend a great deal of money on research and advertising. That means the savings are passed on to

you in the form of a lower copayment. This first step lets you begin or continue treatment with prescription drugs that have the lowest copayment.

- Brand-name drugs are usually in the second step. If your path requires more medications, then the program moves you along to this step. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

How Does Step Therapy Work?

- When you submit a prescription that is not for a first-step drug, your pharmacist will tell you that the plan uses step therapy. If you would rather not pay the full price for the drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. Call CVS/Caremark to get some examples of safe, effective first-step drugs to discuss with your doctor.

- More expensive brand-name drugs are covered in a later step. That is, if you have already tried the first-step drugs provided by your program, or your doctor decides you need a different drug for medical reasons, then your doctor can call CVS/Caremark to request a prior authorization. A CVS/Caremark representative will check your plan's guidelines to see if a second-step drug can be covered. If it can, you could pay a higher copayment than for a first-step drug. If it cannot be covered, you may need to pay the full price for the drug.

Drugs Not Covered

The following drugs are specifically not covered under the prescription drug plan:

- Agents used to suppress appetite and control fat absorption (including Xenica and Meridia)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Drugs not specifically listed as a benefit
- Durable medical equipment (including respiratory therapy supplies, peak-flow meters, non-insulin syringes and ostomy supplies)
- Growth hormones
- Hair growth agents (including Propecia and Vaniqa)
- Injectables except insulin (including Aranesp, Epogen/Procrit, Botox, Prolastin, Forteo, Amevive, Remicade and Xolair, all allergens)
- Injectable cosmetics (including Botox cosmetic)
- Implants (including Norplant)
- IUDs
- Lancet devices

- Legend homeopathic drugs
- Photo-aged skin products (including Renova and Avage)
- Prescription vitamins, except prenatal agents used in pregnancy and therapeutic agents used for specific deficiencies and conditions
- Serums, toxoids and vaccines
- Yohimbine (for impotence)

To determine what medications are covered under the pharmacy plan, the CVS/Caremark member website can be utilized to run a "Price/Coverage Check." This tool processes test claims and, if covered, will return the current price based on the pharmacy plan benefits that are in place at the time of the check.

In addition, if there are lower cost alternatives (lower cost brand-name or generics) those products will be offered and priced on the results screen. To use this tool, visit **www.caremark.com**.

SHCA

Your prescription drug benefits are administered by Aetna. You do not need to enroll to participate in the Aetna prescription benefit; enrollment is automatic when you enroll in the SHCA. Prescription drugs may only be filled at an Aetna-affiliated pharmacy.

Aetna

If you are enrolled in the SHCA, you can fill short-term prescriptions at retail pharmacies and long-term prescriptions through the Aetna mail-order program.

The amount you pay per prescription depends on whether the drug is generic, formulary or non-formulary and whether you use a participating or non-participating pharmacy. You receive the highest benefit level when you use the mail-order service.

Prescription Drug Copays

Medication Type (Preventive and Non-Preventive)	**SHCA**
Retail Generic	$10 copay
Retail Formulary Brand	$25 copay
Retail Non-Formulary Brand	$50 copay
Mail Order Generic	$20 copay
Mail Order Formulary Brand	$50 copay
Mail Order Non-Formulary Brand	$100 copay

Finding a Participating Pharmacy

Locate participating pharmacies online at **www.aetna.com**. If you are a new member to the Aetna Pharmacy Plan, you will receive a new member packet.

Using the Mail-Order Pharmacy Benefit

If you are taking medication on a regular or long-term basis (90 days or longer) to treat an ongoing health condition, you are encouraged to use the mail-order pharmacy. When you use the mail-order pharmacy, you save money because you receive a 90-day supply of medication for the cost of two copayments (compared to three copayments if purchased through a participating retail pharmacy).

How to Get Started with the Mail-Order Benefit

To use your mail-order benefit:

- Ask your doctor to write two prescriptions — one for an initial 30-day supply that you can fill at your local pharmacy, and one for a 90-day supply, with appropriate refills up to one year.
- Complete the member profile form that you received with your Aetna new member packet (you only need to complete the profile the first time you use the mail-order service). Be sure to include your member ID number, appropriate copayment and your prescription in the mailer envelope. You can also obtain a profile form online at **www.aetna.com** or by calling Aetna at 888-277-4041.
- Mail your prescription and member profile form to Aetna (the address is on the form).

Your first mail order will be delivered to you within 21 days. Mail-order shipping is free.

Refilling Your Mail-Order Prescriptions

You must re-order your prescriptions by phone, mail or on the website every 90 days to continue receiving the medication. Subsequent mail orders take approximately seven days from the date you place the order until you receive the medication. You should order your next prescription 30 days before your current supply runs out to allow sufficient time for your request to be filled and shipped.

You may order refills:

- Online — go to the member website at **www.aetna.com**
- By phone — call 888-277-4041. Have your member ID number, your refill slip with the prescription number and your credit card ready
- By mail — use the refill and order forms provided with your medication. The address is on the form

Paying for Your Mail-Order Medication

You may pay for your mail-order prescriptions by check, money order or credit card. If you send the wrong copayment amount and there is a balance due, an invoice will be included with your prescription order. If you overpay, your account will be credited.

How to Use the Retail Pharmacy Benefit

When you need to have a prescription filled on a short-term basis (typically for up to a 30-day supply), present your Aetna member ID card to any Aetna-participating pharmacy. The pharmacy's computerized system will confirm your eligibility for benefits. If the prescription is covered, the pharmacist will fill your prescription and charge you the applicable copayment. You do not have to fill out a claim form when you fill your prescription at a participating pharmacy.

If you are in the SHCA and you fill your prescription at a non-participating pharmacy, you will pay the full cost for the prescription. Claims from a non-participating pharmacy are not covered by the plan.

Aetna Website

www.aetna.com

Aetna maintains a personalized and secure website that provides you with instant access to your complete pharmacy benefit information, available whenever you need it. Access is quick and easy. Just go to the website, click the link for members and follow the online instructions to register and create your personal user name and password. You can access the following information on this website:

- **Your Pharmacy Benefits** — Overview of your pharmacy benefits and coverage, including formulary lookup and pharmacy locator tools
- **Prescription Price Check** — Helpful information about costs and savings opportunities for prescription medications
- **Your Prescription History** — Your personal record of prescription claims history with Aetna
- **Online Prescription Ordering** — Mail-order prescriptions online and prescription refills every 90 days with free delivery to your home address. Also lets you check the status of your order and request forms for new and transferred prescriptions
- **Drug and Health Information** — Information on potential drug interactions, side effects, symptoms, risk factors, drug comparisons and treatment options
- **Online Customer Service** — Online access to a customer service team 24 hours a day, seven days a week

Questions About Aetna Benefits

Aetna has a nationwide, toll-free telephone number you can call 24 hours a day, 365 days a year with questions about your prescription drug benefits. Call 888-277-4041 to:

- Ask questions about eligibility
- Find out if a particular prescription drug is covered under your plan
- Find out the status of a mail-order claim

Generic Drugs

After a brand-name drug patent expires, other drug manufacturers may begin selling the drug under its chemical or "generic" name. Generally, generic drugs cost less because they do not require the same level of sales, marketing research and development expenses associated with brand-name drugs.

Formulary Drugs

Aetna maintains a drug "formulary," which is a comprehensive list of commonly prescribed brand-name and generic drugs selected by Aetna for safety, clinical effectiveness and cost. The formulary list will be included in your new member ID card packet.

The website allows you to enter the name of your medication and learn whether or not it is on the formulary. If the medication is not on the formulary, the website will list alternative drugs that are available.

Your prescription cost will be higher if your physician does not prescribe a formulary drug. Sometimes your physician may prescribe a medication for which a brand-name or generic alternative drug is available. In such cases, your physician may specify that the prescription be dispensed as written (DAW). The pharmacist may then ask your physician whether an alternative drug may be appropriate for you. If so, your prescription will be filled with the alternative drug and a confirmation will be sent to you and your physician explaining the change. Note that your physician always makes the final decision on your medication and you can always choose to keep the original prescriptions. Pharmacies will only dispense the medication authorized by your physician.

Specialty Injectable Drugs — Aetna Specialty Pharmacy

Specialty injectable drugs are drugs that must be injected (rather than swallowed or applied topically) to be effective. These are high-cost biotech drugs that are used to treat chronic diseases such as:

- Growth hormone disorders
- Hemophilia, von Willebrand disease, and related bleeding disorders
- Hepatitis C
- Immune deficiencies
- Infertility
- Multiple sclerosis

- Osteo and rheumatoid arthritis.

Drugs such as insulin, vitamin B-12, epinephrine and glucagon are not considered specialty injectables and will be covered under the retail or mail-order plan. Any prescription drug excluded from coverage is also excluded as an injectable.

Injectable drugs that can be self-administered (injected subcutaneously), administered intravenously (directly into a vein), or intramuscularly (directly into a muscle) are dispensed under the prescription drug plan and must be purchased at the Aetna Specialty Pharmacy mail-order pharmacy or through a contract Aetna Specialty Pharmacy retail pharmacy only. These drugs can also be covered under your medical plan benefits if administered by a physician in the physician's office. Please note that specialty medications are limited to a 30-day supply — they are not available in 90-day supplies.

Please call Aetna Specialty Pharmacy at 888-277-4041 with any questions or clarifications regarding a specific injectable drug's category, coverage or benefit.

Prior Authorization

Certain drugs require "prior authorization" from Aetna before they can be covered. Prior authorization is the process by which requests for these drugs are reviewed against objective clinical criteria to determine whether coverage will be provided. Some products, such as those that are used for cosmetic purposes, are specifically excluded from coverage. If the medication you are trying to fill has a prior authorization requirement under the plan, the pharmacist will inform you of this.

To request a prior authorization, your physician provides information to Aetna's prior authorization unit. To do this, they must call in the required information to a special toll-free phone number or send the information by fax. The phone number and fax can be obtained by calling Aetna's toll-free Customer Service number at 888-277-4041. Response to a physician's prior authorization request can take from one to two business days. Both the patient and physician will be notified in writing when the review process is completed. If your medication is approved for coverage, an automatic authorization will be entered in the system to allow your pharmacist to fill your prescription for your regular plan copayment. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Your doctor can ask for reconsideration of a prior authorization denial by submitting further information to the prior authorization unit. If reconsideration for the coverage is denied, you may file an appeal with Aetna for further consideration of coverage.

The following drugs require prior authorization under the prescription drug plan, although this list is not all-inclusive:

- Tretinoin such as Retin-A, if patient is over age 36
- Enbrel
- Lamisil

- Provigil
- Prescription drugs that exceed plan level limits. See “Quantity Level Limits” in the below section for more information

This list can change without prior notice. Please call Aetna if you have any questions.

Quantity Level Limits

In most cases, when you fill a prescription you will receive the prescribed amount, up to a 30-day supply from the retail pharmacy, or a 90-day supply from the mail-order pharmacy. Certain drugs are limited, however, to a set quantity, regardless of what your physician prescribes. If quantity requested is greater than plan level limits, the following drugs require prior authorization, although this list is not all-inclusive:

- Injectable and non-injectable impotence medications (such as Viagra, Muse, Cialis, Caverject and Edex)
- Imitrex nasal spray
- Stadol nasal spray

This list can change without prior notice. Please call Aetna if you have questions about coverage and/or quantity limits for a specific prescription drug.

Step Therapy

There are certain prescription drugs subject to step therapy. Step therapy is a program especially for people who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. This program applies edits to drugs in specific therapeutic classes at the point of service to guide patients into using more cost-effective, first-line alternatives when medically appropriate. Coverage for second-line therapies is determined at the patient level based on the presence or absence of first-line drugs in the patient’s claims history. This allows you and your family to receive the treatment you need while making prescription drugs more affordable for you and also helps our organization provide quality prescription drug benefits. The program moves you along a well-planned path or series of steps. Your doctor is consulted, approving and writing your prescriptions based on the step therapy drugs covered by our plan. The list of drugs subject to step therapy can change without prior notice.

What Drugs Are in the Step Therapy Program?

- Generic drugs are usually in the first step. Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by the plan are effective for treating many medical conditions. Generics have the same chemical makeup and the same effect in the body as the original brand-name drug. They usually have a different name, color and/or shape. The companies that make generic drugs do not spend a great deal of money on research and advertising. That means the savings are passed on to you in the form of a lower copayment. This first step lets you begin or continue treatment with prescription drugs that have the lowest copayment.

- Brand-name drugs are usually in the second step. If your path requires more medications, then the program moves you along to this step. Brand-name drugs are usually more expensive than generics, so most have a higher copayment.

How Does Step Therapy Work?

- When you submit a prescription that is not for a first-step drug, your pharmacist will tell you that the plan uses step therapy. If you would rather not pay the full price for the drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. Call Aetna to get some examples of safe, effective first-step drugs to discuss with your doctor.

- More expensive brand-name drugs are covered in a later step. That is, if you have already tried the first-step drugs provided by your program, or your doctor decides you need a different drug for medical reasons, then your doctor can call Aetna to request a prior authorization. An Aetna representative will check your plan's guidelines to see if a second-step drug can be covered. If it can, you could pay a higher copayment than for a first-step drug. If it cannot be covered, you may need to pay the full price for the drug.

Drugs Not Covered

The following drugs are specifically not covered under the prescription drug plan:

- Agents used to suppress appetite and control fat absorption (including Xenica and Meridia)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Drugs not specifically listed as a benefit
- Durable medical equipment (including respiratory therapy supplies, peak-flow meters, non-insulin syringes and ostomy supplies)
- Growth hormones
- Hair growth agents (including Propecia and Vaniqa)
- Injectables except insulin (including Aranesp, Epogen/Procrit, Botox, Prolastin, Forteo, Amevive, Remicade and Xolair, all allergens)
- Injectable cosmetics (including Botox cosmetic)
- Implants (including Norplant)
- IUDs
- Lancet devices
- Legend homeopathic drugs
- Photo-aged skin products (including Renova and Avage)

- Prescription vitamins, except prenatal agents used in pregnancy and therapeutic agents used for specific deficiencies and conditions
- Serums, toxoids and vaccines
- Yohimbine (for impotence)

To determine what medications are covered under the pharmacy plan, the Aetna member website can be utilized to run a "Price/Coverage Check." This tool processes test claims and, if covered, will return the current price based on the pharmacy plan benefits that are in place at the time of the check.

In addition, if there are lower cost alternatives (lower cost brand name or generics) those products will be offered and priced on the results screen. To use this tool, visit **www.aetnanavigator.com**.

Kaiser Permanente HMO

If you are enrolled in the Kaiser Permanente HMO plan, your prescription drug coverage will be through Kaiser Permanente. Kaiser Permanente HMO plan participants should refer to their **Evidence of Coverage Booklet** for more information about their prescription drug coverage.

HealthySteps to Wellness

To help you improve and maintain your health and well-being — personally, financially and in the workplace — we offer HealthySteps to Wellness, a program available to employees enrolled in the hospitals' medical plans. Through the program, you have access to a variety of resources and tools to help you take a step in the direction of better health.

For more information about HealthySteps to Wellness, visit **www.wellness.healthysteps4u.org**.

Employee Assistance Program (EAP)

In addition to mental health and substance abuse benefits provided in your medical plan, the hospitals offer confidential and free counseling services to help you and members of your household with work-related, marital, family and personal issues. Receive up to 10 visits per problem per calendar year. A licensed professional is available to help you with 24/7 issues such as stress, depression, substance abuse, grief/loss, interpersonal relationships and transitions in the workplace, as well as financial and legal matters. To obtain more information or to make an appointment, call Beacon Health Options at the number provided at the end of the ***Administrative Information*** section.

Dental Plan

Your Dental Plan Choices

The hospitals offer dental coverage through Delta Dental. You may choose from these options, which all offer preventive and diagnostic services:

- Delta Dental Basic PPO
- Delta Dental Buy-Up PPO
- DeltaCare® USA

After you enroll in a Delta Dental plan, you may access the Delta Dental Plan Evidence of Coverage (EOC) and Disclosure Booklet online. It fully describes your benefits under this plan and is an official part of this Handbook. Together, the applicable EOC and this Handbook are your Summary Plan Description (SPD) for your Delta Dental plan. Keep them handy so you can refer to them when you have a question.

You may also contact the HealthySteps Benefits Service Center at 855-278-7157 for a paper copy of the EOC Booklet to be mailed to you at no charge, or you can visit **www.healthysteps4u.org**.

Vision Plan

What's Offered

When you enroll in one of the medical plans offered by the hospitals, you and the dependents you enroll in your medical plan automatically receive vision coverage administered by VSP®. VSP has an extensive nationwide network of providers who deliver quality eye care and eyewear. When you are ready to obtain vision care services, locate a VSP-participating provider by calling VSP at 800-877-7195 or by visiting VSP's website at **www.vsp.com**.

You may access the VSP Vision Plan Evidence of Coverage (EOC) and Disclosure Booklet online. It fully describes your benefits under this plan and is an official part of this Handbook. Together, the EOC and this Handbook are your Summary Plan Description (SPD) for your VSP plan. Keep them handy so you can refer to them when you have a question.

You may also contact the HealthySteps Benefits Service Center at 855-278-7157 for a paper copy of the EOC Booklet to be mailed to you at no charge, or you can visit **www.healthysteps4u.org**.

Filing and Appealing Medical Claims

Filing Medical Claims

This section applies to the Aetna Choice POS II with HSA and SHCA plans. For the Kaiser Permanente HMO plan, please refer to the Kaiser Permanente HMO Plan **Evidence of Coverage Booklet** for details.

Type of Claims and Definitions

- **Pre-service claim** needing prior authorization as required by the plan – This is a claim for a benefit where the covered person is required to get approval from the plan before obtaining the medical care such as in the case of prior authorization of health care items or service that the plan requires. If a covered person or provider calls the plan just to find out if a claim will be covered, that is not a pre-service claim, unless the plan and/or Aetna's Health Booklet specifically requires the person to call for prior authorization. Giving prior authorization does not guarantee that the plan will ultimately pay the claim.

- **Post-service claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent care claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the plan.

Urgent or Emergency Claims

Note that these plans do not require prior authorization for urgent or emergency care claims; however, covered persons may be required to notify the plan following stabilization. Please refer to the "Claims, Appeals and External Review" section in the applicable Aetna Health Booklet for more details. A condition is considered to be an urgent or emergency care situation when a sudden and serious condition such that a prudent layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care was rendered. Examples of an urgent or emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity or a severe allergic reaction.

Personal Representative

Personal representative means a person (or provider) who can contact the plan on the covered person's behalf to help with claims, appeals or other benefit issues. Minor dependents must have the signature of a parent or legal guardian in order to appoint a third party as a personal representative.

If a covered person chooses to use a personal representative, the covered person must submit a written letter to the plan stating the following: the name of the personal representative, the date and duration of the appointment and any other pertinent information. In addition, the covered person must agree to grant their personal representative access to their Protected Health Information (PHI). This letter must be signed by the covered person to be considered official.

Procedures for Submitting Claims

Most providers will accept assignment and coordinate payment directly with the plan on the covered person's behalf. If the provider will not accept assignment or coordinate payment

directly with the plan, then the covered person will need to send the claim to the plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health membership card.

Covered persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the plan, the covered person will need to pay the claim up front and then submit the claim to the plan for reimbursement. The plan will reimburse covered persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the covered person paid the claim or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered person/patient ID number, name, sex, date of birth, Social Security number, address and relationship to employee;
- Authorized signature from the covered person;
- Diagnosis;
- Date of service;
- Place of service;
- Procedures, services or supplies (narrative description);
- Charges for each listed service;
- Number of days or units;
- Patient account number (if applicable);
- Total billed charges;
- Provider billing name, address and telephone number;
- Provider Taxpayer Identification Number (TIN);
- Signature of provider;
- Billing provider;
- Any information on other insurance (if applicable);
- Whether the patient's condition is related to employment, auto accident or other accident (if applicable); and
- Assignment of benefits (if applicable).

Timely Filing

Covered persons are responsible for ensuring that complete claims are submitted to the third party administrator as soon as possible after services are received, but no later than 24 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

Adverse Benefit Determination (Denied Claims)

Sending in Your Appeal

Appeals should be sent within 60 calendar days following the date you received the plan's decision regarding the first level appeal.

This plan contracts with various companies to administer different parts of this plan. Covered persons who want to appeal a decision or a claim determination made by one of these companies should send appeals directly to the company that made the decision being appealed.

In this instance, send medical appeals to:

For the Aetna Choice POS II with HSA and SHCA plans:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512

Time Periods for Making Decision on Appeals

After reviewing a claim that has been appealed, the plan will notify the covered person of its decision within the following timeframes:

- Urgent/expedited claim — Within 36 hours after the appeal is received
- Pre-service claim — Within a reasonable period of time appropriate to the medical circumstances but no later than 15 calendar days after the plan receives the request for review
- Post-service claim — Within a reasonable period of time but no later than 30 calendar days after the plan receives the request for review
- Concurrent care claims — Before treatment ends or is reduced

Covered persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the plan will

provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Right to External Review
If you have utilized all of your internal appeal options, including a mandatory and voluntary appeal and you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- Exclusions for experimental or investigational services or unproven services; or
- Otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Aetna or your employer fails to respond to your appeal within the timelines stated above.

You may request an independent review of the adverse benefit determination. Neither you nor Aetna or your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If your appeal is eligible and you wish to pursue an external review, you will be provided with a form and return address in the response to your final appeal.

Your written request should include: (1) Your specific request for an external review; (2) the employee's name, address and member ID number; (3) Your designated representative's name and address, if applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time your request is received.

All requests for an independent review must be made within 123 calendar days of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the plan. The Independent Review Organization (IRO) has been contracted by Aetna and has no material affiliation or interest with Aetna or your employer. Aetna will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of Aetna's receipt of a request for independent review, the request will be forwarded to the IRO together with:

- All relevant medical records;
- All other documents relied upon by Aetna and/or your employer in making a decision on the case; and
- All other information or evidence that you or your physician has already submitted to Aetna or your employer.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Aetna will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Aetna and/or your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

Filing a Claim or Appeal for Prescription Benefits

Filing a Pharmacy Claim or Appeal — Aetna

In some instances, you will be required to pay for your prescription and then submit a claim to Aetna. Should you have any questions regarding your pharmacy benefits and making a claim, contact Aetna at any time by calling 888-277-4041.

If you need to file an appeal, please contact Aetna at the address listed below:

Aetna
Attn: National Account CRT
P. O. Box 14463
Lexington, KY 40512

Filing a Pharmacy Claim or Appeal — CVS/Caremark

In some instances, you will be required to pay for your prescription and then submit a claim to CVS/Caremark. Should you have any questions regarding your pharmacy benefits and making a claim, contact CVS/Caremark at any time by calling 844-214-2607.

If you need to file an appeal, please contact CVS/Caremark at the address listed below:

CVS/Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Coordination of Benefits

How Coordination of Benefits Works

Coordination of Benefits (COB) applies whenever a covered person has health coverage under more than one plan as defined below. The purpose of coordinating benefits is to help covered persons pay for covered expenses but not to result in total benefits that are greater than the covered expenses incurred.

The order of benefit determination rules determine which plan will pay first (primary plan). The primary plan pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays for covered expenses after the primary plan has processed the claim, and will reduce the benefits it pays so that the total payment between the primary plan and secondary plan does not exceed the covered expenses incurred. If the covered benefit under this plan is less than or equal to the primary plan's payment, then no payment is made by this plan.

The plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured
- Hospital indemnity benefits in excess of $200 per day
- Specified disease policies
- Foreign health care coverage
- Medical care components of group long-term care contracts such as skilled nursing care
- Medical benefits under group or individual motor vehicle policies. See "**Order of Benefit Determination Rules**" for details
- Medical benefits under homeowner's insurance policies
- Medicare or other governmental benefits as permitted by law. See "**Order of Benefit Determination Rules**." This does not include Medicaid

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

Order of Benefit Determination Rules

The first of the following rules that apply to a covered person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this plan shall always be considered secondary regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.
- Where an individual is covered under one plan as a dependent and another plan as an employee, member or subscriber, the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This plan will deem any employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.
- The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent (see "**COBRA Continuation of Coverage**"). Also see "**If You Are Covered by Medicare**" for exceptions.
- When an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

If one or more plans cover the same person as a dependent child:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
  - The parents are married;
  - The parents are not separated (whether or not they have been married);
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage; or

  - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

- If 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 starting after the plan is given notice of the court decree.

- If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

  - The plan of the custodial parent;

  - The plan of the spouse of the custodial parent;

  - The plan of the non-custodial parent; and then

  - The plan of the spouse of the non-custodial parent.

- Active or inactive employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule, as referenced above, can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in "If You Are Covered by Medicare" on page 105.)

- Longer or shorter length of coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If the above rules do not determine the primary plan, the covered expenses can be shared equally between the plans. This plan will not pay more than it would have paid had it been primary.

If You Are Covered by Medicare

If you or your covered spouse or dependent is also receiving benefits under Medicare, including Medicare prescription drug coverage, federal law may require this plan to be primary over Medicare. When this plan is not primary, the plan will coordinate benefits with Medicare.

Order of Benefit Determination Rules for Medicare

This plan complies with the Medicare secondary payer regulations. Examples of these regulations are as follows:

- This plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and you or your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through your spouse's former employer. In this case, this plan will be primary for you and your covered spouse, Medicare pays second and the retiree plan would pay last.
  - For a covered person with end-stage renal disease (ESRD), this plan usually has primary responsibility for the claims of a covered person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or your spouse has Medicare coverage due to age, plus you or your spouse also has COBRA continuation coverage through the plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus you also have COBRA continuation coverage through the plan. Medicare normally pays first; however, an exception is that COBRA may pay first for covered persons with ESRD until the end of the 30-month period; or
  - You or your covered spouse have retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability before being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis.)
- Medicare is the secondary payer when no-fault insurance, workers' compensation or liability insurance is available as primary payer.

Expenses for Which a Third Party May Be Responsible (Subrogation)

This plan is designed to cover you and your dependent(s) with health benefits. This plan is not intended to serve as a supplement to, or replacement for, any payments or benefits you or your dependent(s) have or may recover when charges are incurred as the result of an accident,

illness, injury or other medical condition caused by an act or omission of any other party. Benefits under this plan are reduced or excluded subject to the terms and conditions of this subrogation, reimbursement and offset provision anytime there is another party who is liable or responsible (legally or voluntarily) to make payments in relation to the accident, illness or injury.

For purposes of this section, "other party" is defined to include, but is not limited to, the following:

- The party or parties that caused the accident, illness, injury or other medical condition.
- The insurer or other indemnifier of the party or parties who caused the accident, illness, injury or other medical condition.
- The covered person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers or homeowner's insurance.
- A workers' compensation or school insurer.
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the accident, illness, injury or other medical condition.

For purposes of this section, recovery is defined to include, but is not limited to, any amount paid or payable by another party through a settlement, judgment, mediation, arbitration or other means in connection with an accident, injury or illness.

If the covered person and/or his or her dependent(s) have the legal right to seek a recovery from such other party, benefits will only be payable if you and your dependents agree to the following:

- That the plan is subrogated to all rights the covered person may have, and you and your dependents acknowledge that the plan will have a first priority lien and right of recovery, on any recovery received from any other party as a result of an accident, illness, injury or other medical condition caused by an act or omission of the other party. Any covered person accepting benefits from the plan assigns from any such recovery an amount equal to the benefits paid by the plan. A covered person further agrees that notice of this assignment presented to the covered person's attorney and/or insurance company or other party responsible for payment of the damages is binding on the party receiving such notice.
- That the covered person, or their legal representative, shall notify the plan of any claim or potential claim the covered person and/or their dependent(s) have against any other party within 30 days of the act which gives rise to such claim. That, if requested, the covered person or his or her dependent(s) or legal representative shall supply the plan with any information that is reasonably necessary to protect the plan's subrogation interests.

- If an act or omission of another party causing an accident, illness or injury results in payments being made under the plan, that neither the covered person nor their dependent(s) do anything that would prejudice the plan's rights to recover payments.

- That, if requested, the covered person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else is necessary to protect the plan's rights. Such documents may require the covered person to direct their attorney (and other representatives) in writing to retain separately from any recovery that the attorney or representative receive on the covered person's behalf an amount of money sufficient to reimburse the plan as required by such agreement and to pay such money to the plan. Failure or refusal to execute such documents or agreements or to furnish information does not preclude the plan from exercising its right to subrogation or obtaining full reimbursement. In the event the covered person does not sign or refuses to sign such an agreement, the plan has no obligation to make any payment for any treatment required as a result of the act or omission of any other party, such agreement is expressly incorporated in this plan and will be provided to the covered person at any time upon request.

- The plan is also granted a right of reimbursement from the proceeds of any recovery obtained or that may be obtained by the covered person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the plan's subrogation and lien rights described above. A covered person shall promptly convey to the plan any amounts received from any recovery for the reasonable value of the medical benefits advanced by the plan or provided by the plan to the covered person.

- In the event that the covered person fails to cooperate with the plan or fails to comply with the terms of this provision, the plan may offset or otherwise reduce present or future benefits otherwise payable to the covered person or their spouse or dependent under the terms of the plan. Moreover, in the event that a covered person fails to cooperate with the plan, the covered person shall be responsible for any and all costs incurred by the plan in enforcing its rights, including, but not limited to, attorney's fees.

- That the plan has a right to recover, through subrogation, reimbursement, offset or through any other available means, the following:

  - Any amount from the first dollar, that the covered person or any other person or organization on behalf of the covered person is entitled to receive as a result of the accident, illness, injury or other medical condition, to the full extent of benefits paid or provided by the plan; and

  - Any overpayments made directly to providers on behalf of the covered person for the accident, illness, injury or other medical condition.

- That the plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the plan, and will not be reduced due to the covered person's own negligence or due to the covered person not being made whole.

- That the covered person shall be solely responsible for all expenses of recovery from any other party, including but not limited to all attorney's fees and costs, which amounts

will not reduce the amount of reimbursement payable to the plan under the operation of any common fund doctrines.

- That the plan will not pay any fees or costs associated with any claim or lawsuit without the plan's express written consent in advance.
- That the covered person or their legal representative or legal guardian, shall be considered a constructive trustee with respect to any recovery received or that may be received from any other party in consideration of an accident, illness, injury or other medical condition for which they have received benefits. Any such funds will be held in trust until the plan's lien is satisfied.
- The plan's rights apply to the covered person, to the spouse and dependent(s) of a covered person, COBRA beneficiaries and any other person who may recover on behalf of a participant, including the covered person's estate.
- That the plan reserves the right to independently pursue and recover paid benefits.
- The plan's subrogation, reimbursement and offset provisions apply to a recovery obtained by the covered person in connection with an accident, injury or illness without regard to the description, name or label applied to the recovery.

COBRA Continuation of Coverage

Important. Read this entire provision to understand a covered person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides a general notice of a covered person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. The COBRA administrator, VITA Administration Company, will provide additional information to you or your dependents as required. This summary generally explains:

- COBRA continuation coverage
- When it may become available to you and your family
- What you and your dependents need to do to protect the right to receive it

Introduction

Federal law gives certain persons, known as qualified beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The qualified beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a qualified beneficiary has the same rights and obligations under the plan as an active participant.

A qualified beneficiary may elect to continue coverage under this plan if such person's coverage would terminate because of a life event known as a COBRA qualifying life event, outlined below. When a COBRA qualifying life event causes (or will cause) a loss of coverage, then the plan must offer COBRA continuation coverage.

Generally, you, your covered spouse and your dependent children may be qualified beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election. However, note that COBRA coverage is generally the secondary payer of health care claims for a qualified beneficiary already enrolled in Medicare.

Qualifying Life Events

The length of COBRA continuation coverage that is offered varies based on who the qualified beneficiary is and what qualifying life event is experienced as outlined below.

An employee will become a qualified beneficiary if coverage under the plan is lost because either one of the following qualifying life events happens:

Qualifying Life Event	Length of Continuation
Your employment ends for any reason other than your gross misconduct	Up to 18 months
Your hours of employment are reduced	Up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See "**Right to Extend the Length of Continuation Coverage**" for more information.)

The spouse of an employee will become a qualified beneficiary if coverage is lost under the plan because any of the following qualifying life events happen:

Qualifying Life Event	Length of Continuation
The employee dies	Up to 36 months
The employee's hours of employment are reduced	Up to 18 months
The employee's employment ends for any reason other than his or her gross misconduct	Up to 18 months
The employee becomes entitled to Medicare benefits (under Part A, Part B, or both). A COBRA event occurs only if the plan requires the employee to lose coverage due to Medicare Entitlement. There is no COBRA event for the dependent(s) if the employee voluntarily drops from the plan due to Medicare Entitlement.	Up to 36 months
The employee and spouse become divorced or legally separated	Up to 36 months

The dependent children of an employee become qualified beneficiaries if coverage is lost under the plan because any of the following qualifying life events happen:

Qualifying Life Event	Length of Continuation
The parent/employee dies	Up to 36 months
The parent/employee's employment ends for any reason other than his or her gross misconduct	Up to 18 months
The parent/employee's hours of employment are reduced below the minimum needed to remain enrolled by the plan	Up to 18 months
The parent/employee becomes entitled to Medicare benefits (Part A, Part B or both)	Up to 36 months
The parents become divorced or legally separated	Up to 36 months
The child stops being eligible for coverage under the plan as a dependent	Up to 36 months

Notification and Responsibilities

The Notice(s) a Covered Person Must Provide Under This Handbook

To be eligible to receive COBRA continuation coverage, covered employees and their dependents have certain obligations with respect to certain COBRA qualifying life events (including divorce or legal separation of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either your employer or the COBRA administrator.

A qualified beneficiary's written notice must include all of the following information (a form to notify the COBRA administrator is available upon request):

- The qualified beneficiary's name, their current address and complete phone number
- Name of the employer that the employee was with
- Description of the COBRA qualifying life event (i.e., the life event experienced)
- The date that the qualifying life event occurred or will occur

Send all COBRA notices or other COBRA information required to be provided by this Handbook by email **help@vitamail.com**, or in writing to:

VITA Administration Company
900 N. Shoreline Blvd.
Mountain View, CA 94043-1933
650-810-1480

For purposes of the deadlines described in this Handbook, the notice must be postmarked by the deadline. In order to protect your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA administrator.

COBRA Survivor Benefit for Children

If you die while an active employee, your employer will subsidize the cost for the first 12 months of COBRA coverage for your eligilble children. For the first 12 months of COBRA coverage, your children's share of the cost is the same as if you were still an active eligible employee. At the end of the 12 months, your eligible children pay the regular COBRA premium for the balance of their COBRA continuation period. Your children must be eligible for COBRA coverage to receive this survivor benefit.

Electing COBRA Coverage

Employer Obligations to Provide Notice of the Qualifying Life Event

Your employer will give notice to the COBRA administrator when coverage terminates due to qualifying life events that are the employee's termination of employment or reduction in hours, death of the employee or the employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B or both). Your employer will notify the COBRA administrator within 30 calendar days when these events occur.

Employee Obligations to Provide Notice of the Qualifying Life Event

The covered person must give notice to the Plan Administrator in the case of other qualifying life events that are divorce or legal separation of the employee and a spouse, a dependent child ceasing to be eligible for coverage under the plan or a second qualifying life event. The covered employee or qualified beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The covered person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the qualifying life event;
- The date on which there is a loss of coverage (or would lose coverage); or
- The date on which the qualified beneficiary is informed of this notice requirement by receiving this Handbook or the General COBRA Notice.

The Plan Administrator will notify the COBRA administrator within 30 calendar days from the date that notice of the qualifying life event has been provided.

The COBRA administrator will, in turn, provide an election notice to each qualified beneficiary within 14 calendar days of receiving notice of a qualifying life event from the employer, covered employee or the qualified beneficiary.

Making an Election to Continue Group Health Coverage

Each qualified beneficiary has the independent right to elect COBRA continuation coverage. A qualified beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this plan. A qualified beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date plan coverage terminates due to a qualifying life event; or
- The date the Plan Administrator provides the qualified beneficiary with an election notice.

A qualified beneficiary must notify the COBRA administrator of their election in writing (including online election) to continue group health coverage and must make the required payments when due in order to remain covered. If the qualified beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the last day of the month following the qualifying life event.

Continued Coverage for Eligible Domestic Partners

Eligible domestic partners do not qualify as qualified beneficiaries under federal COBRA law. Therefore, under federal law, eligible domestic partners do not have the right to elect COBRA independently and separately from the eligible employee.

However, this plan allows eligible domestic partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible employees, subject to the same terms and conditions as outlined for qualified beneficiaries under the COBRA law, when a qualifying life event occurs.

Payment of Claims and Date Coverage Begins

No claims will be paid under this plan for services the qualified beneficiary receives on or after the date coverage is lost due to a COBRA qualifying life event. If, however, the qualified beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the qualified beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will start to be reprocessed by the health insurance carrier once the COBRA administrator receives the completed COBRA election form and required payment. Note that the reinstatement process starts when the COBRA administrator receives your completed COBRA election form and required payment. It can take up to 10 business days for the health insurance carrier to complete the process of retroactive reinstatement of coverage.

If a qualified beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the qualifying life event but instead will be effective on the date the waiver is revoked.

Payment for Continuation of Coverage

Qualified beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If your employer offers annual open enrollment opportunities for active employees, each qualified beneficiary will have the same options under COBRA (for example, the right to add

coverage for dependents or switch between health plan options). The cost of continuation coverage will be adjusted accordingly.

The initial payment is due no later than 45 calendar days after the qualified beneficiary elects COBRA as evidenced by the postmark date on the envelope or the online election date. This first payment must cover the cost of continuation coverage from the time coverage under the plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for subsequent payments is typically the first day of the month for any particular period of coverage, however the qualified beneficiary will receive specific payment information including due dates and payment grace periods, when the qualified beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any qualified beneficiary receives any benefits under the plan during a month for which the payment was not made on time, then the qualified beneficiary will be required to reimburse the plan for the benefits received.

If the COBRA administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA administrator will notify the qualified beneficiary of the discrepancy and the qualified beneficiary will be required to send a corrected check within the original payment grace period. If a corrected check is not postmarked within the original payment grace period, then the occurrence will be treated as non-payment and the qualified beneficiary(s) will be termed from the plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

Length of Continuation Coverage

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Handbook:

- For employees and dependents — 18 months from the date of loss of coverage following the qualifying life event if due to the employee's termination of employment or reduction of work hours. (If the employee becomes entitled to Medicare and within 18 months experiences a termination of employment or reduction in work hours resulting in a loss of coverage, your covered dependents may elect to continue coverage for the period ending 36 months after the date you became entitled to Medicare.)
- For dependents only — 36 months from the date of loss of coverage following the qualifying life event if coverage is lost due to one of the following events:
  - Employee's death
  - Employee's divorce or legal separation
  - Former employee becomes enrolled in Medicare (if applicable)

- A dependent child no longer being a dependent as defined in the plan

Right to Extend the Length of Continuation Coverage

While on COBRA continuation coverage, certain qualified beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA administrator is given as soon as possible but no later than the required timeframes stated below.

Social Security disability determination (for employees and dependents) — A qualified beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the qualified beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the qualified beneficiary has non-disabled family members who are also qualifying beneficiaries, those non-disabled family members are also entitled to the disability extension.

The qualified beneficiary must give the COBRA administrator a copy of the Social Security Administration letter of disability determination within 60 days of the disability determination and before the end of the initial 18-month COBRA continuation period.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA. (See “COBRA Premium Subsidy for Disabled Employees” on page 116 for more information.)

If the Social Security Administration determines the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the plan of that fact within 30 days after the Social Security Administration’s determination.

Second qualifying life events (dependents only): If your family experiences another qualifying life event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family who are qualified beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA administrator. This additional coverage may be available to the spouse or dependent children who are qualified beneficiaries if the employee or former employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent. This extension is available only if the qualified beneficiaries were covered under the plan prior to the original qualifying life event. A dependent acquired during COBRA continuation (other than newborns and newly-adopted children) is not eligible to continue coverage as the result of a subsequent qualifying life event. These events will only lead to the extension when the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying life event not occurred.

You or your dependents must provide the notice of a second qualifying life event to the COBRA administrator within a 60-day period that begins to run on the latest of:

- The date of the second qualifying life event;
- The date the qualified beneficiary loses (or would lose) coverage due to the second qualifying life event; or
- The date on which the qualified beneficiary is informed of the requirement to notify the COBRA administrator of the second qualifying life event by receiving this Handbook or the General COBRA Notice.

COBRA Premium Subsidy for Disabled Employees

If COBRA coverage is extended for 29 months because you are disabled, your employer will subsidize the cost of the first 24 months of COBRA coverage (at the same rate as active employees). To be eligible for this subsidy you must be approved for a waiver of premium under the life insurance plan. The subsidy will be equal to the amount that your employer would pay if you were still an active employee. Employee will be responsible for the amount of the employee premium plus the 2% vendor administrative fee.

The subsidy will end on the last day of the month in which one of the following events occurs:

- You cease to be eligible for COBRA coverage due to disability or for waiver of premium under the life insurance plan;
- You fail to pay timely your share of the COBRA premium; or
- In the event an employee passes before their subsidy ends, the subsidy for eligible dependents will continue but not to exceed 18 months total.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any employees. (Note that if the employer terminates the group health plan that the qualified beneficiary is under, but still maintains another group health plan for other similarly-situated employees, the qualified beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)
- The required contribution for the qualified beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the qualified beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan.

- The qualified beneficiary is found not to be disabled during the disability extension. The plan will terminate the qualified beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the qualified beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

Alternative to COBRA Coverage

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers “one-stop-shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments) right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA continuation coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next annual open enrollment period will be and what you need to know about qualifying life events and special enrollment periods, visit **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you**.

Tax-Advantaged Savings Accounts

Stanford HEALTH CARE
Lucile Packard Children's Hospital Stanford
HealthySteps

Getting the Most for Your Money

Stanford Health Care as the plan sponsor and Lucile Packard Children's Hospital Stanford as a participating employer are referred to as "the hospital" or collectively as "the hospitals," offer you ways to save money on certain expected dependent day care and/or health care out-of-pocket expenses you may have planned during the year.

Your Tax-Advantaged Savings Account and Health Reimbursement Account Options

Dependent Care Flexible Spending Account (FSA) Administered by HealthEquity	
Advantage	By contributing tax-free dollars to this tax-advantaged savings account, you lower your taxable income. You may also use these tax-free contributions to reimburse yourself for qualified dependent day care expenses.
Who Can Contribute	You, as the employee.
Who Is Eligible	All employees.
Method of Payment	Submit a reimbursement claim form and supporting documentation by mail, fax, or online. You can find the reimbursement instructions and claim form at **www.learn.healthequity.com/shclpch**.
Maximum and Minimum Calendar-Plan-Year Contribution Amounts	Maximum: $5,000 (including contributions to another employer's plan) if you are single or married filing jointly, or $2,500 if you are married and filing separately.
Eligible Expenses	To identify eligible expenses, please refer to the IRS website: **www.irs.gov/pub/irs-pdf/p503.pdf**.
Making Changes	Generally, you may enroll only during the annual open enrollment period. However, if certain qualifying life events occur during the year, you may enroll, stop or change your contributions within 31 days of the event. The change must be consistent with the event. For details on qualifying life events as defined by the IRS, refer to the plan document.
Use It or Lose It	The IRS "use it or lose it" rule applies. Money in your account at the end of the plan year will be forfeited. Money left in one account cannot be transferred to the other account nor can it be carried forward to the next year. The plan year is January 1 through December 31 of that same year. You have until March 15 after the end of the plan year to file claims for expenses incurred in the prior plan year.
You Must Re-Enroll Every Year	To continue your participation, you must re-enroll during the annual open enrollment period, even if you are a current participant.

Dependent Care Flexible Spending Account (FSA) Administered by HealthEquity	
What Happens If You Leave the Hospitals?	You may continue to submit reimbursement requests through March 15 of the year following your termination – up to your account balance — for eligible expenses incurred prior to your termination date.
What Happens If You Stop Contributions Following a Qualifying Life Event?	You may continue to submit reimbursement requests through March 15 of the year following when you stopped contributing — up to your account balance — for eligible expenses incurred prior to when you stopped contributing.
What Happens If You Take a Leave of Absence?	You have two options: 1. Take no action and your deductions will continue as long as you are receiving a paycheck. If you do not have sufficient pay to cover your deduction, your deduction will go in arrears and will be collected once you have sufficient pay again. 2. Within 30 days of the start of your leave of absence, you can stop your deductions through the HealthySteps benefits portal. Then, within 31 days of your return to work, you can resume your deductions through the HealthySteps benefits portal. For Stanford Health Care employees, please contact the HealthySteps Benefits Service Center at 855-278-7157 to adjust your deduction amount so you can reach your annual goal. For Lucile Packard Children's Hospital Stanford employees, contributions will recalculate when you return to work based on the number of pay periods remaining in the calendar year. In either case, any claims you incur during your leave of absence are ineligible for reimbursement.

Health Care Flexible Spending Account (FSA) Administered by HealthEquity	
Advantage	By contributing tax-free dollars to one of these two tax-advantaged savings accounts, you lower your taxable income. You may also use these tax-free contributions to reimburse yourself for qualified health care expenses, including copays, prescription medications and deductibles.
Who Can Contribute	You, as the employee.
Who Is Eligible	Employees who work 40 hours per pay period and who are enrolled in the Stanford Health Care Alliance (SHCA) plan, Kaiser Permanente HMO plan or who have waived coverage. Employees enrolled in the Aetna Choice POS II with Health Savings Account (HSA) are not eligible to participate in the Health Care FSA, unless you are not eligible to contribute to an HSA based on IRS guidelines. In that case, you will be able to enroll in the Health Care FSA.
Method of Payment	Use the Health Care FSA debit card, submit paper claims via mail, fax, or online. For paper claims, you can find the reimbursement instructions and claim form at **www.learn.healthequity.com/shclpch**.
Maximum and Minimum Calendar-Plan-Year Contribution Amounts	Maximum: $2,700 (this limit may change from year to year).
Eligible Expenses	To identify eligible expenses, please refer to the IRS website: **www.irs.gov/pub/irs-pdf/p502.pdf**.
Making Changes	Generally, you may enroll only during the annual open enrollment period. However, if certain qualifying life events occur during the year, you may enroll, stop or change your contributions within 31 days of the event. The change must be consistent with the event. For details on qualifying life events as defined by the IRS, see “Qualifying Life Events” in the Health Coverage Changes section or refer to the plan document.
Use It or Lose It	The IRS “use it or lose it” rule applies. Money in your account at the end of the plan year will be forfeited. Money left in one account cannot be transferred to the other account nor can it be carried forward to the next year. The plan year is January 1 through December 31 of that same year. You have until March 15 after the end of the plan year to file claims for expenses incurred in the prior plan year.
You Must Re-enroll Every Year	To continue your participation, you must re-enroll during the annual open enrollment period, even if you are a current participant.

Health Care Flexible Spending Account (FSA) Administered by HealthEquity	
What Happens If You Leave the Hospitals?	You may request reimbursement only for expenses incurred during the plan year, up to the time of your termination. You have up to 90 days from your termination date to submit claims for reimbursement. Money in your account after the 90-day period will be forfeited.
What Happens If You Stop Contributions Following a Qualifying Life Event?	You have up to 90 days from the date you stopped your deductions to submit claims for reimbursement — up to your account balance — for eligible expenses incurred prior to when you stopped contributing.
What Happens If You Take a Leave of Absence?	You have two options: 1. Take no action and your deductions will continue as long as you are receiving a paycheck. If you do not have sufficient pay to cover your deduction, your deduction will go in arrears and will be collected once you have sufficient pay again. 2. Within 30 days of the start of your leave of absence, you can stop your deductions through the HealthySteps benefits portal. Then, within 31 days of your return to work, you can resume your deductions through the HealthySteps benefits portal. For Stanford Health Care employees, please contact the HealthySteps Benefits Service Center at 855-278-7157 to adjust your deduction amount so you can reach your annual goal. For Lucile Packard Children's Hospital Stanford employees, contributions will recalculate when you return to work based on the number of pay periods remaining in the calendar year. If you do not resume your deductions within 31 days of your return to work, you have up to 90 days from the date you stopped your deductions to submit claims for reimbursement. Money left in your account after the 90-day period will be forfeited. In either case, any claims you incur during your leave of absence and while you have paycheck deductions are eligible for reimbursement.

Health Savings Account (HSA) Administered by HealthEquity	
Advantage	By contributing tax-free dollars to one of these two tax-advantaged savings accounts, you lower your taxable income. You may also use these tax-free contributions to reimburse yourself for qualified health care expenses, including copays, prescription medications and deductibles.
Who Can Contribute	You and the Hospitals.

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<tr><th colspan="4">Health Savings Account (HSA)
Administered by HealthEquity</th></tr>
<tr><td>Who Is Eligible</td><td colspan="3">Employees who work 40 hours per pay period and are enrolled in the Aetna Choice POS II with HSA.</td></tr>
<tr><td>Who Is Not Eligible</td><td colspan="3">• Employees who are enrolled in the Stanford Health Care Alliance (SHCA) or Kaiser Permanente HMO plans.
• Employees covered by any medical plan which is not a high-deductible health plan as defined by the Internal Revenue Code.
• Employees covered by Medicare Part A and/or B.
• Employees who participate in a Health Care FSA through the hospitals or their spouse/eligible domestic partner's employer.
• Employees who are claimed as a dependent on another person's tax return.
• If you are eligible for national health coverage in your home country (e.g., Canada), you are not eligible to contribute to an HSA.</td></tr>
<tr><td>Method of Payment</td><td colspan="3">Use the HSA debit card, submit paper claims via mail, fax, or online. For paper claims, you can find the reimbursement instructions and claim form at www.learn.healthequity.com/shclpch.</td></tr>
<tr><td>Maximum and Minimum Calendar-Plan-Year Contribution Amounts</td><td colspan="3">Maximum contributions are limited by the amount contributed by the hospitals and are based on IRS limits, which are subject to change each year.
<table>
<tr><th></th><th>Employee-only coverage</th><th>Family coverage</th></tr>
<tr><td>Hospitals contribution (for participants in the HealthySteps to Wellness program)</td><td>Up to $500[1]</td><td>Up to $1,000[1]</td></tr>
<tr><td>Employee contribution[2]</td><td>Up to $3,050</td><td>Up to $6,100</td></tr>
<tr><td>2021 IRS annual limit (subject to change each year)</td><td>$3,600</td><td>$7,200</td></tr>
</table>
1 Amount is subject to change each year.
2 Employees age 55 or older as of the end of the calendar year in which the contribution is made can make an additional $1,000 catch-up contribution.</td></tr>
<tr><td>Eligible Expenses</td><td colspan="3">To identify eligible expenses, please refer to the IRS website: www.irs.gov/pub/irs-pdf/p502.pdf. HSA funds cannot be used for an eligible domestic partner who fails to meet the definition of a dependent under Internal Revenue Code Section 152(d).</td></tr>
</table>

Health Savings Account (HSA) Administered by HealthEquity	
Making Changes	You may change your HSA contribution elections at any time during the year.
"Use It or Lose It" Rule Does NOT Apply	Any funds remaining in your HSA will be rolled over from year to year — and will be yours even if you no longer participate in the Aetna Choice POS II with HSA. You will be responsible for paying any administrative fees.
You Must Re-enroll in the HSA Every Year	To continue your participation in the HSA, you must remain enrolled in the Aetna Choice POS II with HSA plan and make a new contribution election to the HSA every year during annual open enrollment. Your contribution election does not carry over to the new plan year and you can make changes to your contribution amount any time during the year.
What Happens If You Leave the Hospitals?	You can roll over the balance to another HSA or you can use this balance to pay for eligible health care expenses. You will be responsible for paying any administrative fees. You may not continue to contribute to an HSA through the hospitals after termination.
What Happens If You Take a Leave of Absence?	If you have an HSA balance, you may continue to use the funds while you are on leave.
Not an ERISA Plan	The Health Savings Account is not an ERISA plan. Information about its features is provided in this section for your convenience. If you have any questions about how the HSA works, please contact HealthEquity at 877-395-6548 or go online to **www.learn.healthequity.com/shclpch** to learn more.

For further information regarding HSA laws, go to **www.irs.gov/pub/irs-pdf/p969.pdf**.

Health ReimbursementAccount (HRA) Administered by HealthEquity	
Advantage	If you complete HealthySteps to Wellness activities, the hospitals will contribute to a reimbursement account. You may use the funds to pay for eligible expenses, including copays, prescription medications and deductibles.
Who Can Contribute	The Hospitals.

Health ReimbursementAccount (HRA) Administered by HealthEquity	
Who Is Eligible	The HRA is an employer-sponsored account for those employees who participate in the HealthySteps to Wellness program and earn wellness incentive dollars. Once those incentive dollars are earned, those dollars will be deposited into an HRA that will be set up for them by the hospitals. Eligible employees are those enrolled in the Stanford Health Care Alliance (SHCA) plan, Kaiser Permanente HMO plan and those enrolled in the Aetna Choice POS II with HSA who are not eligible for the HSA. For details on the HealthySteps to Wellness program, go to **www.wellness.healthysteps4u.org**.
Method of Payment	Submit claims to be reimbursed for eligible expenses. You can find the reimbursement instructions and claim form at **www.learn.healthequity.com/shclpch**.

Health ReimbursementAccount (HRA) Administered by HealthEquity	
Maximum and Minimum Calendar-Plan-Year Contribution Amounts	The hospitals will make contributions into the employee's account based on the wellness activities that have been completed during the year. The hospitals will contribute to this account on a quarterly basis[1] as employees earn Wellness dollars. You must be enrolled in a hospital medical plan and be an active employee on the date the funds are deposited in order to receive the contribution. Otherwise, the funds will be forfeited.
Eligible Expenses	To identify eligible expenses, please refer to the IRS website: **http://www.irs.gov/pub/irs-pdf/p502.pdf**.
Making Changes	This is an employer-contribution only plan, so this does not apply.
Use It or Lose It	Money in your account at the end of the plan year will be forfeited. Money cannot be transferred to another account nor can it be carried forward to the next year. The plan year is January 1 through December 31 of that same year. You have until March 15 after the end of the plan year to file claims for expenses incurred in the prior plan year.
Enrollment	You are automatically enrolled, if you are eligible.
What Happens If You Leave the Hospitals?	You may request reimbursement only for expenses incurred during the plan year, up to the time of your termination. You have up to 90 days from your termination date to submit claims for reimbursement. Money in your account after the 90-day period will be forfeited.
What Happens If You Take a Leave of Absence?	You may continue to submit reimbursement requests — up to your account balance — for eligible expenses incurred during the calendar year. If you return to work, your participation continues. If you do not return to work, see "**What Happens If You Leave the Hospitals?**" above.

[1] The frequency is subject to change.

Enrolling in a Tax-Advantaged Savings Account and Health Reimbursement Account

IMPORTANT NOTE!

Your participation in a Tax-Advantaged Savings Account does not automatically renew each year. You must re-enroll during each annual open enrollment period to continue your participation the following calendar year.

For the Dependent Day Care FSA and Health Care FSA

You must elect participation during annual open enrollment or within 31 days of the date you are hired or the date you become eligible for these benefits. To enroll, follow the instructions below:

Stanford Health Care	Lucile Packard Children's Hospital Stanford
To access the HealthySteps benefits portal: • Visit **www.healthysteps4u.org** and click on "View or Change My Benefits (SHC)" from the homepage. • Enter your User ID and Password. – When you visit the portal for the first time, click on "Are you a new user" to set up your User ID and Password. – When accessing the portal from a Stanford Health Care network, the registration process is handled for you via a secure sign-in process using your Stanford Health Care login and password.	• Visit AccessHR from any computer at **www.accesshr.lpch.org.** • Enter your User ID and Password. – Click on the "My Benefits" tile. – Click on the "Benefits" tile that states "Auto Sign In" if you are accessing from your personal hospital work station. OR – Click on the "Benefits" tile that states "Shared Workstation" if you are accessing from a shared work station or a computer outside of the hospital network. When accessing the HealthySteps benefits portal from AccessHR, the registration process is handled for you via a secure sign-in process using your Lucile Packard Children's Hospital Stanford login and password.

If you have a question or need assistance, contact the HealthySteps Benefits Service Center at 855-278-7157 (Monday – Friday, 5:00 a.m. – 5:00 p.m. PT).

Generally, you must enroll when you are first eligible or wait until the next annual open enrollment period. However, if certain events occur during the year, which impact your need for Tax-Advantaged Savings Accounts, you may enroll within 31 days of one of these events. See "**Making Changes to Dependent Day Care FSA and Health Care FSA Elections**" for a list of the permissible events.

For the Health Savings Account (HSA)

You can enroll in an HSA at any time. After you enroll in the Aetna Choice POS II with HSA in the HealthySteps benefits portal, you will be prompted to open an HSA and confirm that you meet specific criteria by:

- Certifying that you are eligible (see the **Health Savings Account (HSA) chart**),
- Reading the HSA Custodial Agreement (located in the Media Library on **www.healthequity.com**, then clicking "Learn," then "Health Savings Account (HSA)," then "Documents & Forms"), and
- Following the prompts to agree or disagree with this statement:

  "I accept the Terms and Conditions as outlined."

The HSA Custodial Agreement is located in the Media Library on **www.healthequity.com**. Click "Learn," then "Health Savings Account (HSA)," then "Documents & Forms." In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.

If you agree, your eligibility information will be sent to HealthEquity for ID verification and account setup. If you do not pass the ID verification, you will be notified by HealthEquity regarding required documentation. For more information, call 877-395-6548 or visit **www.learn.healthequity.com/shclpch**.

For the Health Reimbursement Account (HRA)
If you are eligible, you are automatically enrolled in the HRA.

Appeals for Dependent Care FSA, Health Care FSA and Health Reimbursement Account (HRA) Claims

See the ***Administrative Information*** section for general information about how to appeal a denied claim for Dependent Day Care FSA, Health Care FSA or HRA expenses. Although the Dependent Day Care FSA is not subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), the appeal procedures outlined in the ***Administrative Information*** section apply. Eligible expenses are reimbursed up to:

- The amount in your Dependent Day Care FSA at the time the expense is submitted
- The annual amount you elected to contribute to your Health Care FSA, less the amount of any year-to-date reimbursements
- The amount in your HRA

HealthEquity will not process reimbursement requests that do not have all of the following required documentation:

- Proof of payment;
- Your name and Social Security number;
- The name of the individual for whom the expense was incurred;
- The name of the person/organization providing the service;
- The tax identification number and signature of the provider (for dependent day care reimbursement requests);
- The date the care or service was provided;
- The amount charged; and

- Special documentation that may be required for the FSA.

You have until March 15 to file claims for expenses incurred during the previous plan year.

Submit all claims immediately so that if there is a problem with your documentation, you will have some time to secure the correct documentation and resubmit it prior to the March 15 deadline. If your claim is denied for insufficient documentation on March 15, you will not have an option to resubmit your claim with additional documentation at a later date and you will forfeit any amount left in your Dependent Day Care FSA, Health Care FSA and HRA.

Dependent Day Care FSA, Health Care FSA and HRA expenses incurred in the next year, or while you are not an eligible participant, may not be applied to any remaining balance from the previous year.

Retiree Medical

Your Handbook and Health Booklets

The information provided in this Handbook is intended to provide a Summary Plan Description (SPD) of the Stanford Health Care and Lucile Packard Children's Hospital Stanford retiree medical benefit.

The summary provided in this Handbook is intended to provide an accurate explanation of how your benefit plans work. It is not intended to serve as any form of contract or plan document. If there is a discrepancy between the descriptions in this Handbook and the insurance contracts and plan documents, the contracts and plan documents will always govern.

Retiree Medical Insurance

Eligible employees who leave the hospitals on or after age 55 may continue their medical insurance under one of the hospitals' retiree medical plans.

Retiree Medical Insurance Eligibility

When you leave the hospitals, you may be eligible for retiree medical benefits if:

- You are at least age 55 when your active employment status with the hospitals ends, and
- You have at least 10 years of continuous service after age 45 (Retiree Groups A and B) or at least 15 years of continuous service after age 40 (Retiree Groups C and D).

If you are not eligible for retiree medical coverage, you may be eligible to continue the medical coverage in which you are enrolled at retirement under the provisions of COBRA.

NOTE

If you or your dependents are not eligible for retiree medical coverage:

See the *Your Health Care Benefits* section for active employees for information about COBRA rights after coverage as an active employee ends.

Your dental and vision coverage ends the last day of the month in which your employment terminates. You may continue your dental coverage at the full cost under the provisions of COBRA. The Vision Service Plan is not available as a separate election through COBRA as it is part of medical coverage through COBRA.

In some cases, you may be eligible for retiree medical coverage but you may not be able to cover your dependents. In that case, your dependents may be eligible to continue their health coverage under COBRA.

Retiree Groups

Your "Retiree Group" determines which retiree medical plan you are eligible for and your share of the cost for your retiree medical coverage. See the "**How to Determine Your Retiree Group**" charts to determine your Retiree Group.

Continuous Service

Years of continuous service are all the consecutive years you worked as a regular, benefits-eligible employee with the hospitals without a break in service. Years of continuous service includes the time you work with a Predecessor Employer (as defined below), without a break in service (i.e., your employment with the hospitals begins on the next business day) from the Predecessor Employer to the hospitals. You do not receive credit for time you work as a:

- Relief employee (however, time worked as a relief or temporary employee will not cause a break in service to occur); or
- Temporary agency or contract employee.

Predecessor Employer

A Predecessor Employer is UCSF Stanford Health Care, UCSF, Stanford University, Stanford Health Services (SHS) and Lucile Packard Children's Hospital Stanford.

Breaks in Service

Voluntary Terminations

A break in continuous service occurs when you leave the hospitals. If you return to work with the same hospital within one year, you will get credit for your prior eligible service. If you return to work with the same hospital after one year, you will not receive credit for your prior eligible service. You may or may not receive credit for other breaks in service, as described here:

- If you were a Lucile Packard Children's Hospital Stanford employee and you are directly hired by Stanford Health Care (i.e., in the pay period immediately following the pay period in which you ceased employment with Lucile Packard Children's Hospital Stanford), you will receive credit for your continuous service with Lucile Packard Children's Hospital Stanford. This also applies if you were a Stanford Health Care employee and you are directly hired by Lucile Packard Children's Hospital Stanford.
- If you were a Stanford University employee and you leave your employment with the University and are later hired by the hospitals, but not immediately after your termination from Stanford University (i.e., your employment with the hospitals begins on the next business day), your years of service at Stanford University before the break will not count.
- Effective January 1, 2013:
    - If you were a Lucile Packard Children's Hospital Stanford employee and you leave your employment with Lucile Packard Children's Hospital Stanford and are later hired by Stanford Health Care, but not immediately after your termination from Lucile Packard Children's Hospital Stanford or not within the pay period immediately following the pay period in which employment ceased with Lucile Packard Children's Hospital Stanford, your years of service at Lucile Packard Children's Hospital Stanford before the break will not count. If, however, you receive benefits under a collective bargaining agreement with the SEIU-UHW and you commence work at Stanford Health Care within one year of your employment terminating from Lucile Packard Children's Hospital Stanford, you

will get credit for your prior eligible service at Lucile Packard Children's Hospital Stanford.

- If you were a Stanford Health Care employee and you leave your employment with Stanford Health Care and are later hired by Lucile Packard Children's Hospital Stanford, but not immediately after your termination from Stanford Health Care or not within the pay period immediately following the pay period in which employment ceased with Stanford Health Care, your years of service at Stanford Health Care before the break will not count. If, however, you receive benefits under a collective bargaining agreement with the SEIU-UHW and you commence work at Lucile Packard Children's Hospital Stanford within one year of your employment terminating from Stanford Health Care, you will get credit for your prior eligible service at Stanford Health Care.

Layoffs

If you are rehired within one year of a layoff:

- Your service prior to the layoff is restored;
- The period of time that you were laid off is not counted towards your service; and
- If you are rehired while you are still receiving severance pay from the hospitals, the period of time that you continue to receive severance pay after your rehire date will not count towards your service unless you repay the severance pay benefits for the overlapping period.

Leave of Absence

You do not incur a break in service during an approved leave of absence. However, leave of absence time in excess of six months (seven months for a combination pregnancy and family leave) does not count toward your continuous service requirement for retiree medical eligibility.

If You Become Disabled Six Months Prior to Age 55

Your service will be bridged for up to six months if your disability is approved by Social Security.

To be eligible for retiree medical benefits you must:

- **Be age 55 or older when your active employment status with the hospitals ends, AND**
- **Have at least 10 years of continuous service after age 45 (Retiree Groups A and B) or at least 15 years of continuous service after age 40 (Retiree Groups C and D).**

How to Determine Your Retiree Group

If You Meet This Criteria:		Your Retiree Group is:
Stanford Health Services (SHS) employees who were retired on December 31, 1992		**Group A**
SHS employees who, on December 31, 1992, met one of the following three criteria (based solely on SHS service, without regard to any service with UCSF, UCSF Stanford Health Care, Stanford University and Lucile Packard Children's Hospital Stanford):		**Group A**
Age	**Years of Continuous Service**	
65 or over	5	
55 or over	10	
Any age	25	
Individuals who, on October 31,1997, were employees of Stanford Health Services, Lucile Packard Children's Hospital Stanford or UCSF and on November 1,1997 (a) became UCSF Stanford Health Care employees[1] and (b) met one of the following 3 criteria:		**Group B**
Age	**Years of Continuous Service**	
50 or over	5	
40 or over	10	
Any Age	15	
Individuals who on October 31,1997, were employees of Stanford Health Services, Lucile Packard Children's Hospital Stanford or UCSF and on November 1,1997 (a) became UCSF Stanford Health Care employees[1] and (b) did not meet the criteria for Groups A and B.		**Group C**
All other individuals hired by UCSF Stanford Health Care or Stanford Health Care on or after November 1, 1997, or by Lucile Packard Children's Hospital Stanford on or after January 1, 2013.		**Group D**

[1] Including former UCSF and Stanford University employees whose jobs were transferred to UCSF Stanford Health Care after November 1, 1997 but prior to October 31, 1998. Their retiree category is determined based on their age and service as of November 1, 1997.

Acquisitions

Employees of the clinics acquired by UCSF Stanford Health Care in 1998 were assigned to Retiree Groups B, C or D based on their age and continuous service at the time of the acquisition. Employees of clinics or hospitals acquired in the future will be assigned to Retiree Groups B, C or D based on the terms of the acquisition.

Which Plans Are You Eligible for?

The medical plans for which you are eligible depend on your Retiree Group, as described in the chart below. For more information about the under age 65 plans (Aetna Choice POS II Plan, SHCA and Kaiser Permanente HMO), see the ***Your Health Care Benefits*** section and/or the

applicable evidence of coverage documents. For more information about the over age 65 plans (AARP Medicare Coordination Plan and Kaiser Senior Advantage), see the summary plan descriptions and/or evidence of coverage documents.

Group A

Current Situation	Coverage Choices	
If you and all your dependents are under age 65, you may enroll in:	• Aetna Choice POS II Plan[1] • Stanford Health Care Alliance (SHCA) Plan • Kaiser Permanente HMO Plan	
If you and all of your dependents are age 65 or older, you may enroll in:	• Medicare Coordination Plan • Kaiser Permanente Senior Advantage Plan • Stanford Health Care Advantage – Gold Plan • Stanford Health Care Advantage – Platinum Plan	
If you are a split family with one individual over 65 and one or more individuals under 65, you may enroll in the following plan combinations:	**Over 65**	**Under 65**
	• Medicare Coordination Plan • Stanford Health Care Advantage – Gold Plan • Stanford Health Care Advantage – Platinum Plan	• Stanford Health Care Alliance (SHCA) Plan • Aetna Choice POS II Plan[1]
	• Kaiser Permanente Senior Advantage Plan	• Kaiser Permanente HMO Plan

Group B, C or D

Current Situation	Coverage Choices	
If you and all your dependents are under age 65, you may enroll in:	• Aetna Choice POS II Plan[1] • Stanford Health Care Alliance (SHCA) Plan • Kaiser Permanente HMO Plan	
If you and all of your dependents are age 65 or older* on or before January 1, 2020, you may enroll in:	• AARP Medicare Supplemental Plans: C, F, G, K or N • Stanford Health Care Advantage – Gold Plan • Stanford Health Care Advantage – Platinum Plan • Kaiser Permanente Senior Advantage Plan	
If you and all of your dependents are age 65 or older* on or after January 2, 2020, you may enroll in:	• AARP Medicare Supplemental Plans: G, K or N • Kaiser Permanente Senior Advantage Plan • Stanford Health Care Advantage – Gold Plan • Stanford Health Care Advantage – Platinum Plan	
	Over 65	**Under 65**
	• AARP Medicare Supplemental Plans: C, F G, K, or N • Stanford Health Care Advantage – Gold Plan	• Stanford Health Care Alliance (SHCA) Plan • Aetna Choice POS II Plan[1]

Current Situation	Coverage Choices	
If you are a split family with one individual over 65 and one or more individuals under 65* on or before January 1, 2020, you may enroll in the following plan combinations:	• Stanford Health Care Advantage – Platinum Plan • Kaiser Permanente Senior Advantage Plan	• Kaiser Permanente HMO Plan
If you are a split family with one individual over 65 and one or more individuals under 65* on or after January 2, 2020, you may enroll in the following plan combinations:	**Over 65** • AARP Medicare Supplemental Plans: G, K, or N • Stanford Health Care Advantage – Gold Plan • Stanford Health Care Advantage – Platinum Plan • Kaiser Permanente Senior Advantage Plan	**Under 65** • Stanford Health Care Alliance (SHCA) Plan • Aetna Choice POS II Plan[1] • Kaiser Permanente HMO Plan

[1] If you enroll in the Aetna Choice POS II Plan, you may be eligible to set up a Health Savings Account (HSA) at the Stanford Federal Credit Union or any bank that provides HSA services. The HSA may allow you to contribute pretax dollars to an account to pay for expenses such as prescription drugs, office visit coinsurances and a wide range of medical expenses not payable under the Aetna Choice POS II Plan.

TIP

When you become eligible for Medicare (generally at age 65), you must enroll in and obtain Medicare Parts A and B to receive retiree medical benefits from the hospitals. If you enroll in Medicare Part D, you can only participate in the AARP United Health Care Plan. If you do not enroll in Part D when you're first eligible, and you don't have other creditable prescription drug coverage or qualify for Medicare's Extra Help program, you'll likely pay a late enrollment penalty.

Cost Sharing

If you aren't sure which retiree group you are in (A, B, C or D), see "**How to Determine Your Retiree Group**."

Retiree Group A

The hospitals pay 100% of the cost of retiree medical coverage for you and your spouse.

Retiree Group B

If you retire on or after January 1, 2017, you will have 30 days to decide between the following two cost sharing options:

For all Retiree Groups, the amount, if any, the hospitals pay to cover your eligible domestic partner or his/her children is a taxable benefit. This amount will be reported to the IRS and will be treated as income for tax purposes.

Option 1 — Enroll in a Stanford Health Care/Lucile Packard Children's Hospital Stanford Retiree Medical Plan with part of the premiums paid by the hospitals.

The hospitals pay a share of the cost of retiree medical coverage for you and your spouse up to a 1994/1995 plan year maximum contribution determined in accordance with the applicable table below, and you pay 20% of that cost plus any costs that exceed the hospitals' contribution.

You and the hospital each pay a portion. The hospitals' maximum monthly contribution $317 for the retiree and $293 for the retiree's spouse.

Refer to the "Retiree Medical Coverage Contribution Methodology" charts for details on how the contributions are determined.

Option 2 — Elect a one-time contribution to a Health Reimbursement Account (HRA) instead of having the hospitals pay part of the premiums.

If you elect this option, the hospitals will set up an HRA in your name for you to use. You can use the account to pay for IRS qualified health care expenses, including medical premiums either through a hospital plan or other coverage of your choice. The amount in your HRA depends on your age and years of service at retirement. When you retire, you will receive a personalized packet with an estimate of the potential HRA contribution that the hospitals would make for you.

If you elect Option 2:

- Only you will receive an HRA — one will not be provided to your eligible dependents
- You will be moved to Retiree Group D — the value of your HRA benefit and the cost of retiree medical coverage will be the same as Retiree Group D (See "Retiree Group D" on page 138 for more details.)
- While you pay the full cost of your retiree medical coverage, you can use the Retiree HRA to help offset these costs.

Important: Determining which option is best for you requires some careful thought. Once you submit your decision form, your option choice is irrevocable, meaning it cannot be changed at any time. Your personalized packet will include items to consider as you make this important one-time decision. If the hospitals don't receive your decision form within the 30-day window, you will default to Option 1.

Retiree Group C

If you retire on or after January 1, 2017, you will have 30 days to decide between the following two cost sharing options:

Option 1 — Enroll in a Stanford Health Care/Lucile Packard Children's Hospital Stanford Retiree Medical Plan with part of the premiums paid by the hospitals.

Effective January 1, 2009 for Non-Represented retirees and spouses, retirees and spouses represented by CRONA, and effective August 27, 2009 for retirees and spouses represented by the SEIU-UHW, the hospitals will pay a share of the cost of retiree medical coverage for you and your spouse up to a maximum contribution determined in accordance with the applicable table below, and you pay 20% of that cost plus any costs that exceed the hospitals' contribution.

Option 2 — Elect a one-time contribution to a Health Reimbursement Account (HRA) instead of having the hospitals pay part of the premiums.

If you elect this option, the hospitals will set up a HRA in your name for you to use. You can use the account to pay for IRS qualified health care expenses, including medical premiums either through a hospital plan or other coverage of your choice. The amount in your HRA depends on your age and years of service at retirement. When you retire, you will receive a personalized packet with an estimate of the potential HRA contribution that the hospitals would make for you.

If you elect Option 2:

- Only you will receive an HRA — one will not be provided to your eligible dependents
- You will be moved to Retiree Group D — the value of your HRA benefit and the cost of retiree medical coverage will be the same as Retiree Group D (See "Retiree Group D" on page 138 for more details.)
- While you pay the full cost of your retiree medical coverage, you can use the Retiree HRA to help offset these costs.

Important: Determining which option is best for you requires some careful thought. Once you submit your decision form, your option choice is irrevocable, meaning it cannot be changed at any time. Your personalized packet will include items to consider as you make this important one-time decision. If the hospitals don't receive your decision form within the 30-day window, you will default to Option 1.

Retiree Group D

Retiree Health Reimbursement Account (HRA)

If you are a member of Retiree D group, you are eligible for a tax-free HRA if you were hired on or after November 1, 1997, and you are at least 55 with at least 15 years of continuous service when you retire. While you pay the full cost of your retiree medical coverage, you can use the Retiree HRA to help offset some of these costs.

The value of your benefit is based on your number of continuous years of service with the hospitals and your age at retirement. The money in your account may be used to help pay for IRS qualified medical expenses and premiums in retirement – tax free, as determined by the IRS. The hospitals will determine your benefit amount at the time of your retirement, based on the table on the next page. The Retiree HRA will be set up automatically and does not require

you to complete an enrollment form; however, you must notify the hospital of your retirement. Your Retiree HRA is generally available two months following the date of your retirement.

Your Benefit Amount

Note: Any years of service as a relief employee do not count toward your years of continuous service for eligibility or the benefit amount you receive.

Your years of continuous service when you retire	Your age when you retire							
	55 – 61	62 – 64	65	66	67	68	69	70+
15	$7,500	$10,500	$18,000	$19,500	$21,000	$22,500	$24,000	$25,500
16	$8,625	$11,625	$19,125	$20,625	$22,125	$23,625	$25,125	$26,625
17	$9,750	$12,750	$20,250	$21,750	$23,250	$24,750	$26,250	$27,750
18	$10,875	$13,875	$21,375	$22,875	$24,375	$25,875	$27,375	$28,875
19	$12,000	$15,000	$22,500	$24,000	$25,500	$27,000	$28,500	$30,000
20	$13,125	$16,125	$23,625	$25,125	$26,625	$28,125	$29,625	$31,125
21	$14,625	$17,625	$25,125	$26,625	$28,125	$29,625	$31,125	$32,625
22	$16,125	$19,125	$26,625	$28,125	$29,625	$31,125	$32,625	$34,125
23	$17,625	$20,625	$28,125	$29,625	$31,125	$32,625	$34,125	$35,625
24	$19,125	$22,125	$29,625	$31,125	$32,625	$34,125	$35,625	$37,125
25	$20,625	$23,625	$31,125	$32,625	$34,125	$35,625	$37,125	$38,625
26	$22,125	$25,125	$32,625	$34,125	$35,625	$37,125	$38,625	$40,125
27	$23,625	$26,625	$34,125	$35,625	$37,125	$38,625	$40,125	$41,625
28	$25,125	$28,125	$35,625	$37,125	$38,625	$40,125	$41,625	$43,125
29	$26,625	$29,625	$37,125	$38,625	$40,125	$41,625	$43,125	$44,625
30	$28,125	$31,125	$38,625	$40,125	$41,625	$43,125	$44,625	$46,125

Enrolling in Retiree Medical Insurance

When you leave the hospitals at or after age 55 you may be eligible for retiree medical benefits.

Initial Enrollment

Retirees who are eligible for retiree medical benefits are required to sign an enrollment form 31 days prior to leaving the hospitals.

By signing the form, you agree to pay your share of the premium, if any, and to obtain Medicare Parts A and B coverage as soon as you are eligible. The form also allows you to waive coverage.

If you elect retiree medical coverage and you are under age 65 and are not Medicare-eligible, you and the eligible dependents you enroll may remain in the same plan you had as an active

employee or you may enroll in a different plan, so long as you elect to do so within 30 days of your retirement. You may change plans during annual open enrollment or if you experience a qualifying life event, such as moving out of your medical plan's service area. See ***Using Your Handbook and Benefits Program*** for more details. Covered individuals who are eligible for Medicare are enrolled in one of the post-65 benefit plan options listed in the "**When Family Members Become Eligible for Medicare**."

If you waive coverage, you must provide proof of continuous coverage if you want to re-enroll at the next annual open enrollment. You may also enroll during the year if you lose group coverage and enroll within 31 days of the loss. Please review your enrollment materials carefully to be sure you understand the applicable rules.

Assess Your Retiree Medical Needs Early

As you approach retirement and each year thereafter, consider these points:

- If you and your spouse/eligible domestic partner both work at the hospitals and are eligible under different categories, you should contact the Benefits Service Center at 855-278-7157 five years prior to your expected retirement to determine the appropriate classification.
- Where will you live? To be covered under the Kaiser Permanente HMO plan, you must live in their service area. The service area for Kaiser Senior Advantage can be different from the service area for Kaiser Permanente HMO.
- Will you continue to have medical coverage elsewhere as an active employee or as the dependent of an active employee? Review the coordination of benefit rules in the ***Your Health Care Benefits*** section for active employees and consider whether you need retiree medical coverage while you have "active" plan coverage.
- Does your spouse/eligible domestic partner have retiree medical with his/her employer? Review the coordination of benefit rules in the *Your Health Care Benefits* section for active employees and consider whether your spouse/eligible domestic partner needs retiree medical coverage.
- Who will you cover under the hospital plan? You can enroll your spouse/eligible domestic partner and children only if they were continuously covered under a hospital medical plan for the five years immediately prior to your retirement (one year for Category "A" retirees).

When Retiree Medical Coverage Begins

Your retiree medical coverage from the hospitals begins the first day of the month after your active employment status ends. You must submit the enrollment form 31 days prior to leaving the hospitals.

Eligible Dependents

You may enroll the spouse/eligible domestic partner and children who were continuously covered under your medical plan for the five years immediately prior to your retirement (one year for Category "A" retirees).

Generally, eligible dependents are your:

- Legally married spouse/eligible domestic partner
- Children under age 26
- Unmarried children of any age who are incapable of self-support as a result of a physical or mental disability which began before age 19 and who are principally dependent on you or your spouse/eligible domestic partner.

See the ***Using Your Handbook and Benefits Program*** section for active employees for a complete definition of eligible dependents. Eligible dependents who have not been covered for five[1] years, may purchase COBRA coverage immediately after you retire. See the ***Your Health Care Benefits*** section for active employees for more information about when dependents must make their COBRA or conversion election.

[1] Only a spouse/eligible domestic partner and children who meet the definition of dependent outlined in the ***Using Your Handbook and Benefits Program*** section for active employees may be enrolled for medical coverage.

If You Have Other Coverage

When you leave the hospitals, you may plan to work for another employer who offers medical benefits or you may have coverage under your spouse's/eligible domestic partner's employer plan.

REMEMBER

If you waive coverage and are not *continuously* covered elsewhere, you forfeit future rights to enroll in a Retiree Medical plan offered by the hospitals.

Plans that cover you as an active employee or as the dependent of an active employee pay before the retiree medical plan pays. Therefore, you may prefer to waive retiree medical coverage until you need it. You may enroll in the hospitals' retiree medical plan within 31 days of losing your other employer-sponsored coverage or during any annual open enrollment period. If you wish to enroll during an annual open enrollment period, you must provide proof of continuous enrollment in another health plan; the proof must include the coverage period from the date you first waived participation in the plan through the date your coverage under this plan will be effective.

If Both You and Your Spouse/Eligible Domestic Partner Worked for the Hospitals

If your spouse/eligible domestic partner is eligible for the hospitals' medical benefits as an active employee or retiree, you can:

- Both enroll — Each of you can select coverage on your own as either a retiree or employee. If you you so choose, this will allow each of you to elect a one-time contribution into your own individual Health Reimbursement Account (HRA). If you are covering children[1], you can determine which of you has the better rates and/or is in the best position to cover them. This also allows each of you to choose to elect a one-time contribution into your own individual Health Reimbursement Accounts (HRA), or

- Enroll one of you as the employee/retiree, and the other as a dependent — Choose no coverage for one of you, and enroll the other person and any children[1] as dependents of the retiree/employee, or

- Both enroll in the better plan — If you and your spouse/eligible domestic partner both work for the hospitals and are in different retiree groups, the employee with more comprehensive coverage may enroll his or her spouse/eligible domestic partner. The spouse/eligible domestic partner must have been continuously covered (as either an employee or a dependent) under an active plan for the five years immediately prior to the retirement of the employee with better coverage. Note: If you or your spouse/eligible domestic partner choose this option, the employee who is covered as a dependent cannot later enroll in coverage under his/her Retiree Group.

[1] Only a spouse/eligible domestic partner and children who meet the definition of dependent outlined in the ***Using Your Handbook and Benefits Program*** section for active employees may be enrolled for medical coverage.

When You Become Eligible for Medicare

When you or your spouse/eligible domestic partner reach age 65, your retiree medical benefits change because, generally, that is when Medicare eligibility begins. Before your 65th birthday, you or your spouse/eligible domestic partner will receive a reminder that:

- You must enroll in Medicare Parts A and B to continue to receive retiree medical benefits through the hospital;
- Your benefits are changing; and
- Your plan enrollment options and premium contribution, if any, are changing.

The hospitals will send you a packet a couple of months before you turn 65 with your medical plan options along with an enrollment form. If you are in the Kaiser Permanente HMO Plan, Kaiser Permanente will also send you enrollment material about the Senior Advantage Plan. If you are in the Aetna Choice POS II Plan or SHCA, the hospitals will request that UnitedHealthcare send you an AARP packet (applies to Group B, C and D retirees).

TIP

If you are eligible for Medicare prior to age 65, for example if you have been receiving Social Security disability income benefits for 24 months, you must enroll in Medicare Parts A and B and notify the Benefits Service Center at 855-278-7157. Failure to obtain Medicare Parts A and B when you first become eligible could result in the loss of the hospitals' retiree medical coverage.

Everyone must return the hospitals' enrollment form 31 days before you (or your spouse/eligible domestic partner) reach age 65. You must also return the Kaiser Permanente Senior Advantage or the AARP forms directly to the hospitals if you are enrolling in one of their plans.

Covered family members not yet eligible for Medicare remain in the same plan, as shown in the following charts.

When Family Members Become Eligible for Medicare

Group A		
Current Plan	**New Plan for Family Members Who Are...**	
	Covered by Medicare	**Not Covered by Medicare**
Aetna Choice POS II Plan	Medicare Coordination Plan	Aetna Choice POS II Plan
SHCA	Medicare Coordination Plan	Stanford Health Care Alliance (SHCA)
Kaiser Permanente HMO	Kaiser Permanente Senior Advantage	Kaiser Permanente HMO
Coverage Waived	Medicare Coordination Plan	Aetna Choice POS II Plan
Coverage Waived	Kaiser Permanente Senior Advantage	Kaiser Permanente HMO

Group B, C or D		
Current Plan	**New Plan for Family Members Who Are...**	
	Covered by Medicare	**Not Covered by Medicare**
Aetna Choice POS II Plan	AARP Medicare Supplement and Prescription Drug Plan	Aetna Choice POS II Plan
SHCA	AARP Medicare Supplement and Prescription Drug Plan	Stanford Health Care Alliance (SHCA)
Kaiser Permanente HMO	Kaiser Permanente Senior Advantage	Kaiser Permanente HMO
Coverage Waived	AARP Medicare Supplement and Prescription Drug Plan	Aetna Choice POS II or SHCA
Coverage Waived	Kaiser Permanente Senior Advantage	Kaiser Permanente HMO

Enrolling in Medicare

When you become eligible for Medicare (generally at age 65), you must enroll in both Medicare Parts A and B to receive the hospitals' retiree medical benefits. Part A covers hospital expenses and enrollment is generally automatic if you are receiving a Social Security retirement pension check. Part B covers physician expenses and you must actively enroll in and pay for Part B coverage.

Group A retirees are offered the Medicare Coordination Plan only if they do not have Medicare Part D coverage. Your coverage under the hospitals' Medicare Coordination Plan will be cancelled if you enroll in Medicare Part D. The Medicare Coordination Plan includes the prescription drug Medicare Part D coverage.

Medicare considers you a late enrollee if you do not enroll in Medicare when you reach age 65 or when you cease to be covered by an active employee plan, whichever is later. Late enrollees are subject to a Part B premium surcharge and may only enroll in Medicare from January 1 to March 31 each year, with coverage effective July 1.

You may delay enrolling in Medicare, without a premium surcharge, if you are covered under an employer's plan as an active employee or the dependent of an active employee. In that case, consider waiving the hospitals' retiree medical coverage until you lose your active coverage and have enrolled in Medicare.

Please note that if you are covering an eligible domestic partner (or if you are being covered as an eligible domestic partner on another employer's plan), federal law requires that an eligible domestic partner must enroll in Medicare at the earlier of age 65, or when first eligible to do so, regardless of whether the eligible domestic partner is covered as a dependent while his or her partner is receiving health care benefits as an active employee.

Contact your local Social Security office for information about enrolling in Medicare.

Annual Open Enrollment Versus Medicare's Enrollment Period

Once each year, the hospitals offer its eligible retirees an opportunity to:

- Change plans
- Add or cancel coverage for dependents who were eligible when you retired
- Enroll if you previously declined coverage[1]
- Waive coverage[1]

[1] If you waive coverage and are not continuously covered elsewhere, you forfeit future rights to the hospitals' retiree medical benefits.

Once each year, Medicare gives retirees an opportunity to join or leave a Medicare Advantage Plan. The hospitals' annual open enrollment period may not coincide with Medicare's enrollment period. For information regarding Medicare options and enrollment periods, call 800-MEDICARE (800-633-4227).

When Coverage Ends

As an eligible retiree, the hospitals' retiree medical coverage is available to you for your lifetime unless you stop paying your share of the premium or until the hospitals decide to no longer offer retiree medical coverage, whichever occurs first.

Your eligible spouse/eligible domestic partner and children may continue coverage for the remainder of their lifetime until the earliest of the following events occurs:

- You or they stop making any required contribution
- They become covered under the hospitals' medical plan as an employee
- They are no longer eligible. For your spouse/eligible domestic partner, this means you divorce, obtain a legal separation (optional) or end your domestic partnership. For children, this means they reach the maximum age or you fail to provide proof of their continued eligibility if they are to be covered beyond the maximum coverage age (example: if they are disabled)
- You request to end their coverage
- The hospitals decide to no longer offer retiree medical coverage.

Please note that while the hospitals offer retiree medical benefits with the intention of doing so indefinitely, the hospitals reserve the right to amend or terminate the benefits at any time.

Options When Coverage Ends

COBRA

Under certain circumstances, your covered dependents may be able to continue their medical benefits under COBRA. See the ***Your Health Care Benefits*** section for active employees for information about COBRA coverage.

How to Obtain More Information About Retiree Medical Benefits

Call or visit:

- Your local Medicare office or **www.medicare.gov** to learn how and when to enroll in Medicare Part B
- Your medical plan to obtain information about their Medicare plan benefits
- The Benefits Service Center at 855-278-7157:
  - Find out which Retiree Group you have been assigned in the event you are eligible for retiree medical insurance when you leave the hospitals
  - Information provided to retirees during the annual open enrollment period is available at **healthysteps4u.org/retiree**
- Care Counsel Advocates who can help you navigate the health care system at **www.healthysteps4u.org**
- HealthEquity, the HRA administrator, at **www.healthysteps4u.org**

Obtain the Summary Plan Description or Evidence of Coverage for the current retiree medical plan. (The hospitals reserve the right to change or terminate benefits for both active and retired employees at any time.)

Administrative Information

Stanford HEALTH CARE

Lucile Packard Children's Hospital Stanford

HealthySteps

Getting Information

This section provides information about your legal rights under the benefit plans offered by Stanford Health Care and Lucile Packard Children's Hospital Stanford.

The last part of this section contains the telephone numbers of the companies that administer the hospitals' benefit plans.

Your Privacy Rights Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as Protected Health Information (PHI), includes virtually all individually identifiable health information held by the plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of the following health plans sponsored by the hospitals: Stanford Health Care Alliance (SHCA) plan, Aetna Choice POS II, Kaiser Permanente HMO Plan, Delta Dental Basic PPO Plan, Delta Dental Buy-Up PPO Plan, DeltaCare® USA DHMO Plan, Aetna Behavioral Health/Substance Abuse Plan, VSP, Health Care Flexible Spending Account (FSA) Plan managed by HealthEquity and Employee Assistance Plan (EAP) managed by Beacon Health Option. The plans covered by this notice may share health information with each other to carry out treatment, payment or health care operations.

The plans noted above are collectively referred to as "the plan" in this notice, unless specified otherwise.

The Plan's Duties with Respect to Health Information about You

The plan is required by law to maintain the privacy of your health information and to provide you with this notice of the plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you also will receive a notice directly from the Insurer. It's important to note that these rules apply to the plan, not to the hospitals as employers. Different confidentiality policies may apply to other programs offered by the hospitals or to data unrelated to the health plan.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the plan may share health information about you with physicians who are treating you.*

- **Payment** includes activities by this plan, other plans or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection or reinsurance. *For example, the plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- **Health care operations** include activities by this plan (and, in limited circumstances, other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, certain customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan May Share Your Health Information with the Hospitals

The plan, or its health insurer or HMO, may disclose your health information without your written authorization to the hospitals for plan administration purposes. The hospitals may need your health information to administer benefits under the plan. The hospitals agree not to use or disclose your health information other than as permitted or required by the plan documents and by law. Staff within the following areas of responsibility are the only employees of the hospitals who will have access to your health information for plan administration functions: Benefits staff and staff performing duties in the following areas: plan data analysis, health and safety, finance, legal, the Employee Assistance Program, and Stanford Coordinated Care staff performing certain plan care management services.

Here's how additional information may be shared between the plan and the hospitals, as allowed under the HIPAA rules:

- The plan, or its insurer or HMO, may disclose "summary health information" to the hospitals if requested, for purposes of obtaining premium bids to provide coverage under the plan, or for modifying, amending or terminating the plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.

- The plan, or its insurer or HMO, may disclose to the hospitals information on whether an individual is participating in the plan, or has enrolled or dis-enrolled in an insurance option or HMO offered by the plan.

In addition, you should know that the hospitals cannot and will not use health information obtained from the plan for any employment-related actions. However, health information collected by the hospitals from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other policies and federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care.

Information describing your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Limited data set	Disclosures of a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.
Legally required	Use or disclosure of your PHI to the extent required by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.
Health or safety	Disclosure of your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others. The Plan can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, or reporting suspected abuse, neglect, or domestic violence.
Law enforcement	Disclosures to a law enforcement official if the Plan believes, in good faith, that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and disputes	Disclosure of your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.
Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.
Emergency situation	Disclosures to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.
Personal representatives	Disclosure to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) You have been or may be a victim of domestic abuse by your personal representative; OR 2) Recognizing such person as your personal representative may result in harm to you; or 3) It is not in your best interest to treat such person as your personal representative.
Public Health	To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.
Health Oversight Activities	Disclosures to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.
Coroner, Medical Examiner, or Funeral Director	Disclosure of your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death.
Specialized government functions	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.

Disclosures to you	When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Except as described in this notice, other uses and disclosures will be made only with your written authorization. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization with respect to disclosures the plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information, as required by law.

Your Individual Rights

You have the following rights with respect to your health information the plan maintains. These rights are subject to certain limitations, as discussed below. This section describes how you may exercise each individual right.

- **Confidential Communication by Alternative Means:**
  If you feel that disclosure of your PHI could endanger you, the plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The plan will notify you if it agrees to your request for confidential communication. You should not assume that the plan has accepted your request until the plan confirms its agreement to that request in writing.

- **Request Restriction on Certain Uses and Disclosures:**
  You may request the plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the plan discloses to someone who is involved in your care or the payment for your care.

  The plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the plan's agreement.

  To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify:
  1. What information you want to restrict;
  2. Whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and
  3. To whom you want the limits to apply (a particular physician, for example).

The plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the plan has accepted a requested restriction until the plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if

1. Except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and
2. The PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

- **Right to Be Notified of a Breach:**
  You have the right to be notified in the event that the plan discovers a breach of unsecured protected health information.

- **Electronic Health Records:**
  You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after
  1. January 1, 2014 for electronic health records acquired before January 1, 2009; or
  2. January 1, 2011 for electronic health records acquired on or after January 1, 2009.

  The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

- **Right to Access Your PHI:**
  You have a right to access your PHI in the plan's enrollment, payment, claims adjudication and case management records, or in other records used by the plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice.

  The plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

- **Right to Amend:** You have the right to request amendments to your PHI in the plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the plan's records should be made in writing to the contact person named at the end of this Notice. The plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the plan's records was not created by the plan, if the PHI you are requesting to amend is not part of the plan's records, or if the plan determines the records containing your health information are accurate and complete.

  If the plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the plan's records, and a description of how you may complain to plan or the Secretary of Health and Human Services.

- **Accounting:**

You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Personal Representatives:**
  You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

- **Paper Copy of This Notice:**
  You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time by contacting Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Stanford Human Resources Solutions Team at 650-721-5400.

Changes to the Information in This Notice

The plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice which will be sent to you in the same manner as this notice was provided.

Complaints

If you believe your privacy rights have been violated, you may complain to the plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Stanford Human Resources Solutions Team at 650-721-5400.

For More Information

For more information on the plan's privacy policies or your rights under HIPAA, contact Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Stanford Human Resources Solutions Team at 650-721-5400.

Your Rights and Privileges Under ERISA

Overview

As a participant in certain benefit plans offered by the hospitals, you are entitled to particular rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). The plans described in this Handbook which are **not** subject to ERISA include:

- Dependent Care Flexible Spending Account (FSA)
- California State Disability Insurance (SDI) Plan
- Paid Family Leave
- Educational Assistance Program
- Europ Assistance USA – The Hartford's Travel Assistance Program
- Back-up Care Program
- Adoption Assistance Program
- WorkLife Assistance Programs
- Employee Discount Programs
- Voluntary Benefits
- General Liability and Malpractice Insurance

Visit HealthySteps for more information about these benefits.

Statement of Participant Rights

The hospitals have established the plan described here for the exclusive benefit of its employees and employees of certain affiliates. As a participant in the plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you will be entitled to the following:

Receive Information about Your Plan and Benefits

You may:

- Examine, without charge, at the Plan Administrator's office or your work location, during normal working hours, all plan documents, including insurance contracts, 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 Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of all plan documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Plan Administrator may request a reasonable charge for the copies.

- Obtain, upon written request to the Plan Administrator, information as to whether a particular employer or employer organization is a sponsor of the plan and the address of any employer or employer organization that is a plan sponsor. Your beneficiaries also have the right to obtain this information upon written request to the Plan Administrator.

- Receive a summary of the plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, your spouse/eligible domestic partner or dependents if coverage is lost under the plan as a result of a qualified change in status. You, your spouse/eligible domestic partner or other dependents may have to pay for such coverage. Refer to "**When Coverage Ends**" section for more information on continued coverage.

Require Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon those who are responsible for the operation of your employee benefit plan.

The people who supervise the operation of your plans, called "fiduciaries," have a duty to do so prudently and solely in the interest of you and other plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good on any losses they have caused the plans.

Enforce Your Rights

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from the plan or exercising your rights under ERISA.

If your claim for a benefit under the plan is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relative to the decision (with no charge) and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack of one concerning the qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in federal court.

If the plan's fiduciaries should misuse the 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(s) 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 frivolous).

Assistance with Your Questions

If you have any questions about your benefits, contact Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Stanford Human Resources Solutions Team at 650-721-5400. If you have any questions or need assistance regarding this statement or about your rights under ERISA or HIPAA with respect to health benefits that are offered under a group health plan,

you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or on the U.S. Department of Labor's website, or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

Rights and Authority of the Plan Administrator

The Plan Administrator and organizations or persons authorized by the Plan Administratorhave the right and authority, in their discretion, to:

- Make final decisions regarding questions or disputes about eligibility for benefits including deciding facts and interpreting the plan.
- Disqualify an applicant for eligibility due to a false or incorrect statement or intentional omission on an application or claim form and require reimbursement of any benefits paid plus any expenses incurred by the company.
- Disqualify a participant if coverage was granted through an administrative mistake.
- Administer the plans, including determine all questions of interpretation, eligibility dates and other matters concerning participation and benefits.
- Require proof of the legal status of any child or spouse/eligible domestic partner listed as a dependent when first enrolling or any child or spouse/eligible domestic partner currently covered as a dependent.

- Delegate any decisions regarding benefits to a third-party Claims Administrator or insurer to resolve questions, problems or disputes, subject to the employee's or dependent's rights of claims appeals according to their respective insurance contracts and administrative guidelines and as required by ERISA. This includes making a decision in an employee's favor if the problem was not under the employee's control or due to a legitimate mistake or misunderstanding as determined by the company. A company's decision in any particular situation does not imply that the same decision will be reached in future similar situations. Failure of the employee to read this Summary Plan Description or other materials given to employees is generally not a reason for the company to decide in the employee's favor.

Any plan information or any materials sent to employees via U.S. mail will be considered delivered if they are mailed to a last known address, or if mailed and not returned by the post office.

If any benefits are paid in error, the company, Plan Administrator or Claims Administrator is entitled to recover them from a provider, the employee or the employee's dependent or beneficiary.

Any payment of benefits or a written or spoken statement by an employee, a representative of the company, the Plan Administrator or Claims Administrator that a claim will be covered is not binding if such statement was made in error and the benefit is not, in fact, covered by the plan.

The company reserves the right to terminate or modify the plan and cancel any related plans, insurance policy or policies at any time or under such circumstances it deems, in its sole discretion, appropriate including termination or modification as to any division, subsidiary or operating unit. The company or its designated agents will approve plan amendments or plan termination pursuant to a written instrument. Termination or modification of this plan will not affect coverage as to benefits or claims that were incurred before the termination or modification.

Rescission of Coverage

In general, the hospitals are not allowed to rescind (i.e., retroactively cancel or terminate) you or your dependent's coverage once you or your dependents become covered by the plan. However, you and/or your dependent's coverage under the plan for medical benefits may be rescinded (i.e., cancelled or discontinued retroactively) if you and/or your dependent performs an act, practice or omission that constitutes fraud or makes an intentional representation of material fact as prohibited under the terms of the plan.

For example, if the hospitals determine that you have enrolled an individual who does not meet the plan's eligibility requirements as stated in this Handbook, your enrollment of the ineligible individual(s) may be treated as an intentional misrepresentation of a material fact or fraud, and the hospitals reserve the right to rescind your and/or your dependent's coverage. If the hospitals seek to rescind medical coverage for fraud or an intentional misrepresentation of a material fact, you will be provided with written notice at least 30 days in advance before coverage is rescinded. You and/or your dependent's coverage also may be terminated retroactively for

failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances.

If a participant's coverage is rescinded due to an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, the rescission of coverage shall not cause the individual to incur a "qualifying event" as defined under COBRA. You may have the right to appeal a rescission of coverage. Please contact the Plan Administrator for more information.

How to Appeal a Denied Claim

Overview

A claim is a request for a plan benefit by a participant or beneficiary. If you (or your authorized representative) submit a claim for benefits and it is denied, in whole or in part, you or your beneficiary will receive a written explanation from the Plan Administrator or the Plan Administrator's delegate (the plan vendor) within the time period specified below.

If you do not agree with the reasons for denial of your claim, you may request a review. The claim denial will tell you the name and address of the person to whom you may write for an appeal of your claim.

Request for Appeal

You (or your authorized representative) should file an appeal within 60 days after receiving the denial for retirement benefits claims, and 180 days for health and welfare or disability benefits claims. A request for appeal must be in writing and delivered to the Plan Administrator or its delegate. You may submit additional information with your request for appeal. You may request to receive copies of relevant documents, records and other information free of charge although in some cases, approval may be needed for the release of confidential information, such as medical records. You must submit issues and comments in writing.

A decision will be made in writing within the time period specified in the succeeding sections.

Special Rules

A general description of the appeals procedures available under the plan are provided below. Please refer to the appeal procedures specified in the DeltaCare and Kaiser Permanente **Evidence of Coverage** and Disclosure booklets for specific information on how to file an appeal. Please see the ***Your Health Care Benefits*** section for the specific Aetna, Delta Dental, Aetna Behavioral Health and VSP appeal procedures. Please contact the Plan Administrator if you have any questions.

ERISA Claims and Appeal Procedures for Medical Claims

Claims for Benefits

A claim for benefits is a request for a plan benefit or benefits, made by a covered employee/dependent or their representative that complies with the plan's reasonable procedure for making benefit claims. A claim for benefits includes a request for a coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the plan.

Post-Service Claims

"Post-service claims" are those claims that are filed for payment of benefits after health care has been received. If your post-service claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

"Pre-service claims" are those claims that require notification or approval prior to receiving health care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Plan Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 15 days of receipt of the pre-service claim. You will be given at least 45 days from the receipt of this notice to correct your claim.

The Plan Administrator will notify you of its determination within 15 days after the claim is received, unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning at of the earlier of (1) the date the missing information is received by the Plan Administrator or (2) the end of the period afforded to you to provide the missing information. Otherwise, the extension shall not exceed 15 days from the end of the initial 15-day period.

If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims That Require Immediate Action

"Urgent care claims" are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.

If you filed an urgent care claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent care claim was received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided by the Plan Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Plan Administrator reduces or terminates such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, the Plan Administrator shall notify you (sufficiently in advance of the

termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

Notice of Adverse Benefit Determination

If a claim is wholly or partially denied, or if a rescission of coverage occurs (each, an "adverse benefit determination") the Plan Administrator will furnish the plan participant with a written notice of the adverse benefit determination. The written notice will contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Specific reference to those plan provisions on which the adverse benefit determination is based;
- A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if a plan participant wishes to submit the claim for review;
- In the case of an adverse benefit determination by the plan:
  - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the participant upon request;
  - If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.
- In the case of an adverse benefit determination, the plan must:
  - Ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the notice of the opportunity to request (1) the diagnosis code and its corresponding meaning, and (2) the treatment code and its corresponding meaning);

- Ensure that the reason or reasons for the adverse benefit determination include the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim;
- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

Appeals of Claim Denials

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

The review of your claims shall take into account all comments, documents, records and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the plan will identify, upon request to the Plan Administrator, any medical experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card;
- The date(s) of health care service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Plan Administrator.

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the

appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and 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.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which:

- You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and
- All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the participant by telephone, facsimile or other available similarly expeditious method.

The plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see “Timing of Notification of Benefit Determination on Review”) to give the claimant a reasonable opportunity to respond prior to that date.

Before the plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see “Timing of Notification of Benefit Determination on Review”) to give the claimant a reasonable opportunity to respond prior to that date.

Timing of Notification of Benefit Determination on Review

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted below due to a participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the participant until the date on which the participant responds to the request for additional information.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby consent to this referral and the sharing of pertinent health claim information. Upon request and free of

charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "**Urgent Claim Appeals That Require Immediate Action**" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days of the receipt of the first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the plan. The Plan Administrator's decisions are conclusive and binding. The Plan Administrator has final claims adjudication authority under the plan.

Manner of Notification of Final Internal Adverse Benefit Determination

The Plan Administrator shall provide a participant with written or electronic notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the participant:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific plan provisions on which the adverse benefit determination is based;
- A statement that the participant 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 participant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the plan and the participant's right to obtain the information about such procedures;
- A statement of the participant's right to bring an action under section 502(a) of the Act; and
- The following information:
  - If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or 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 Participant upon request;
  - If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”
- In the case of an adverse benefit determination the plan must:
  - Ensure that any notice of the final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

- Ensure that the reason or reasons for the final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the group health plan's standard, if any, that was used in denying the claim. This description must also include a discussion of the decision.
- Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

External Review

In the case of an adverse benefit determination, you may be entitled to request an independent, external review of our decision. If your situation is urgent, you may be entitled to an expedited external review. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Claims Administrator fails to respond to your appeal within the timelines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by contacting Stanford Health Care Human Resources at 650-723-4748 or Lucile Packard Children's Hospital Stanford Human Resources Solutions Team at 650-721-5400.

More information about your external review rights, including the timeframe and procedure for requesting an external review, will be provided to you in the Notice of Final Internal Adverse Benefit Determination.

ERISA Claims Procedures for Retirement Benefits

Please refer to the Retirement Savings Plan (RSP) document for details.

Claims Procedures for Disability Benefits

Manner and Content of Notification of Claims Decision

The Plan Administrator will provide a claimant with written or electronic notification of the Plan's claims decision. If a disability claim is wholly or partially denied, or in certain circumstances, if a retroactive rescission of disability coverage occurs, the Plan Administrator will notify the claimant of the Plan's benefit determination within a reasonable time period, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the extension is necessary due to matters beyond the control of the Plan. After the expiration of the first 30 day extension of time, an additional 30 day extension may be necessary due to matters beyond the control of the Plan. If an extension or an additional extension is required, the Plan Administrator will notify the claimant in writing or electronically prior to the commencement of the extension or additional extension. The notice to the claimant will state the reason for the extension and the date by which the Plan expects to provide a decision. If the extension is necessary because the claimant failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. The claimant then has 45 days from receipt of the notice within which to provide the specified information.

In the case of an adverse claims decision, the notification will include:

(i) The specific reasons for the adverse decision including, a full discussion of the basis for the adverse determination, including an explanation for disagreeing with (1) the views presented by the Claimant to the Plan of health care and/or vocational professionals treating or evaluating the Claimant, (2) the views of any medical or vocational experts who gave advice to the Plan Administrator in connection with the adverse determination, regardless of whether such advice was relied upon by the Plan Administrator in making the adverse determination and (3) a disability determination regarding the Claimant made by the Social Security Administration;

(ii) Reference to the specific Plan provisions on which the decision is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, including any reports, and the identifies of any experts whose advice was obtained;

(iv) A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why that material or information is necessary;

(v) A description of the Plan's review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action following an adverse claims decision on review;

(vi) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, a copy of the specific rule, guideline, or protocol relied upon, or if no such rule,

guideline, or protocol was relied upon a statement confirming no such rules, guidelines, protocols, standards or other similar criteria of the plan exist; and

(vii) If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (2) a statement that an explanation will be provided free of charge to the claimant upon request.

The written notice of an adverse claims decision will be provided in a culturally and linguistically appropriate manner, as described in Department of Labor regulation section 503-1(o).

Appeal of Adverse Claims Decisions

Upon receipt of an adverse claims decision, the claimant (or the claimant's authorized representative) has up to 180 days to file an appeal with the Plan Administrator. The claimant may submit written comments, documents, records, and other information relevant to the claim for benefits. In addition, the claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The appeal will be reviewed by an appropriate named fiduciary (the "reviewer") of the Plan who is neither the party who made the adverse claims decision that is the subject of the appeal, nor the subordinate of that party. The decision on appeal of an adverse claims decision will take into account all comments, documents, records, and other information submitted by the claimant (or the claimant's representative) relating to the claim, without regard to whether that information was submitted or considered in the initial claims decision. The appeal will not afford deference to the initial adverse claims decision.

If new or additional evidence or rationale that was not included in the determination of the original denial is considered, relied upon or generated in connection with the claim or if there is a new or additional rationale on which an adverse determination with respect to the appeal will be based, the Plan Administrator will provide the claimant, free of charge, with such new or additional evidence or rationale prior to making an adverse decision on appeal. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, as described below in order to give the claimant a reasonable opportunity to respond prior to that date.

Notification of Claims Decision on Review

The Plan Administrator will notify the claimant of the Plan's claims decision on review within a reasonable time period appropriate to the circumstances but not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse claims decision. The 45 day period may be extended for another 45 days if the reviewer finds that special circumstances warrant an extension of time. If an extension of time is required, notice of the extension will be furnished to the claimant prior to the commencement of the extension.

Manner and Content of Notification of Claims Decision on Review

The Plan Administrator will provide claimants with written or electronic notification of a Plan's benefit determination on review. If the disability claim is wholly or partially denied on review, the Plan Administrator will provide the claimant with a written notification that will include:

(i) The specific reasons for the adverse decision;

(ii) Reference to the specific Plan provisions on which the claims decision is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents and records relevant to the claimant's claim for benefits, without regard to whether those records were considered or relied upon in making the adverse claims decision on review, including any reports, and the identifies of any experts whose advise was obtained;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about those procedures;

(v) A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision on review, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(vi) If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, a copy of the specific rule, guideline, or protocol relied upon, or if no such rule, guideline, or protocol was relied upon a statement confirming no such rules, guidelines, protocols, standards or other similar criteria of the plan exist;

(vii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (2) a statement that the explanation will be provided free of charge to the claimant upon request; and

(viii) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your Local U.S. Department of Labor Office and your State insurance regulatory agency."

The written notice of an adverse claims decision on review will be provided in a culturally and linguistically appropriate manner, as described in Department of Labor regulation section 503-1(o).

More Information about Your Medical Benefits and Your Rights

Statement of Rights under the Newborns' and Mothers' Health Protection Act

The hospitals' group health plans and health insurance issues generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than

- 48 hours following a vaginal delivery; or
- 96 hours following a caesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider/physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call the Benefits Service Center at (855) 278-7157.

Benefits for Mastectomy-Related Services (Women's Health and Cancer Rights Act of 1998)

The medical plans will not restrict benefits if:

- You or your dependent receives benefits for a mastectomy; and
- You or your dependent elects breast reconstruction in connection with the mastectomy. Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with your or your dependent's physician and may include:
  - All stages of reconstruction of the breast on which the mastectomy was performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications of all stages of mastectomy, including lymphedemas.
- Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan. For more information about the Women's Health and Cancer Rights Act or the Newborns' and Mothers' Act, contact Aetna or Kaiser Permanente.

Additional Rights for Mental Health and Substance Abuse Benefits

If any health insurance option under the group health plan (1) provides for both medical and surgical mental health or substance use disorder benefits and (2) is not subject to an increased cost exemption (within the meaning of the Mental Health Parity and Addiction Equity Act of 2008 (MHPA)):

- The health insurance option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The health insurance option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the

predominant limitations applied to substantially all of the medical and surgical benefits in any classification.

- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPA) to any current or potential participant upon request.
- The reason for any denial under the Plan or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the MHPA, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPA.

"Mental health benefits" and "substance use disorder benefits" shall be defined in the welfare benefit contract applicable to the health insurance option, pursuant to applicable state and Federal law, and consistent with generally recognized standards of current medical practice.

Genetic Information Nondiscrimination Act

Stanford Health Care and Lucile Packard Children's Hospital Stanford and the medical plan options maintained under this plan will not request, require or otherwise collect genetic information pertaining to you or your family members for the purposes of limiting your benefits or for any other purpose in violation of the Genetic Information Nondiscrimination Act. For more information, please contact the Benefits Service Center at 855-278-7157.

Other Information

Official Plan Documents Govern

This Handbook and any Evidence of Coverage and Disclosure booklet together constitute the Summary Plan Description (SPD) for the hospitals Benefit Plans. The SPD does not replace the official documents that legally govern the operation of the plans. In any cases of conflict, the legal plan documents will be used to determine when, what and to whom benefits will be paid. Copies of the plan documents can be obtained from the hospitals' Human Resources. Written requests should be addressed to:

Stanford Health Care	Lucile Packard Children's Hospital Stanford
Stanford Health Care 300 Pasteur Drive, MC 5513 Stanford, CA 94305-5513 Attention: VP and Chief HR Officer	Lucile Packard Children's Hospital Stanford HR Solutions Team 725 Welch Road, MC 5861 Palo Alto, CA 94304-5861 Attention: Chief Human Resources Officer

Neither this Handbook nor any Evidence of Coverage and Disclosure booklet are to be considered an employment contract.

Amendment and Termination of the Plans

The hospitals have established the plans with the bona fide intention and expectation that they will be continued indefinitely, but the hospitals have shall not have any obligation whatsoever to maintain the plans for any given length of time, and the hospitals may at any time amend or terminate the plans, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an officer of the hospitals or his or her authorized delegate.

No vested rights of any nature are provided under the welfare plans. Any welfare benefit claims or expenses incurred before the date of any plan amendment or termination will be paid in accordance with the plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the plan in accordance with the applicable claims procedures and within the applicable time limits for filing such claims.

An amendment or termination of the Retirement Savings Plan will not reduce your account balance as of the date of the amendment or termination, except to the extent allowed by law. Further, no amendment or termination will eliminate an optional form of benefit with respect to the balance of your account accrued before such amendment or termination, except as permitted under, and in accordance with, ERISA and the Internal Revenue Code.

You will be notified of any changes that materially affect your benefits.

Plan Administrator's Discretion

The administration of the hospitals' Benefit Plans is under the supervision of the Plan Administrator. The Plan Administrator, or any authorized delegate, has the discretion to determine eligibility, coverage and benefits under the plans, and all matters relating to the interpretation and operation of the plan. Any determination by the Plan Administrator, or any authorized delegate, will be final and binding, in the absence of clear and convincing evidence that the Plan Administrator, or any authorized delegate, acted arbitrarily and capriciously.

Support Order Procedures

Upon request, copies of the hospitals' procedures for Qualified Domestic Relations Orders (QDROs) or Qualified Medical Child Support Orders (QMCSOs) may be obtained from the Plan Administrator free of charge.

Administrative Information

Retiree Medical Coverage Contribution Methodology

Retiree Group B

Option 1 — Enroll in a Stanford Health Care/Lucile Packard Children's Hospital Stanford Retiree Medical Plan with part of the premiums paid by the hospitals.

The hospitals pay a share of the cost of retiree medical coverage for you and your spouse up to a 1994/1995 plan year maximum contribution determined in accordance with the applicable table below, and you pay 20% of that cost plus any costs that exceed the hospitals' contribution.

The hospitals' maximum contribution was established using the following formula:

Step	For Retirees and Spouses Under age 65	Retiree	Spouse
1	1994/1995 plan year costs	$2,375	$2,196
2	Two times 1994/1995 plan year costs (2 x Step 1)	$4,750	$4,392
3	80% of two times 1994/1995 plan year costs (0.80 x Step 2)	$3,800	$3,514
4	The hospitals' maximum monthly contribution (Step 3 ÷ 12 months)	$317	$293

Step	For Retirees and Spouses Over age 65	Retiree	Spouse
1	1994/1995 plan year costs	$1,769	$1,574
2	Two times 1994/1995 plan year costs (2 x Step 1)	$3,538	$3,148
3	80% of two times1994/1995 plan year costs (0.80 x Step 2)	$2,830	$2,518
4	The hospitals' maximum monthly contribution (Step 3 ÷ 12 months)	$236	$210

Retiree Group C

Option 1 — Enroll in a Stanford Health Care/Lucile Packard Children's Hospital Stanford Retiree Medical Plan with part of the premiums paid by the hospitals.

Effective January 1, 2009 for Non-Represented retirees and spouses, retirees and spouses represented by CRONA, and effective August 27, 2009 for retirees and spouses represented by the SEIU-UHW, the hospitals will pay a share of the cost of retiree medical coverage for you and your spouse up to a maximum contribution determined in accordance with the applicable table below, and you pay 20% of that cost plus any costs that exceed the hospitals' contribution.

The hospitals' maximum contribution was established using the following formula:

Step	For Retirees and Spouses Under age 65	Retiree	Spouse
1	1997/1998 plan year costs	$1,643	$1,966
2	Two times 1997/1998 plan year costs (2 x Step 1)	$3,286	$3,932
3	80% of two times 1997/1998 plan year costs (0.80 x Step 2)	$2,629	$3,146
4	The hospitals' maximum monthly contribution (Step 3 ÷ 12 months)	$219	$262

Step	For Retirees and Spouses Over age 65	Retiree	Spouse
1	1997/1998 plan year costs	$456	$456
2	Two times 1997/1998 plan year costs (2 x Step 1)	$912	$912
3	The hospitals' maximum monthly contribution (Step 2 ÷ 12 months)	$76	$76

Group Insurance Plans

Official Plan Name	Stanford Health Care Employee Health and Welfare Benefit Plan
Plan Administrator Plan Sponsor Employer	Stanford Health Care 300 Pasteur Drive, MC 5513 Stanford, CA 94305-5513 Attention: VP and Chief HR Officer 650-723-4748
Employer I.D. Number	94-6174066
Plan Number	506
Type of Administration	The plans are administered by the Plan Administrator with benefits provided in accordance with written insurance policies and contracts between Stanford Health Care and the following companies: • Aetna POS II • Allstate Identity Protection • Beacon Health Options (EAP) • CVS/Caremark • Delta Dental • DeltaCare® USA DHMO • HealthEquity • Kaiser Permanente HMO • Metlife Legal • Stanford Health Care Alliance • VSP • The Hartford Business Travel Accident Insurance • The Hartford Executive Life Insurance • The Hartford Life, Absence and Disability See the following pages for the addresses and telephone numbers.
Agent for Services of Legal Process	For disputes arising under the plan, service of legal process may be made upon the Plan Administrator at the above address.
Plan Year	January 1 to December 31

Funding Medium and Claim Processing	Self-funded benefits are funded from the hospitals' general assets. Insured benefits are funded by premiums paid to the insurance companies. Vendors for the self-funded benefits provide claims payment and other administrative services on behalf of the hospitals but they do not assume any financial risk or obligation with respect to claims or the plan. Vendors for the insured benefits are responsible for financing and providing all benefits under the insurance contracts. The hospitals have no liability for any benefits due, or alleged to be due, under the insurance contracts.
Contribution Sources	Employees and Employer

Retirement Savings Plan

Official Plan Name	Stanford Health Care Retirement Savings Plan
Plan Administrator and Plan Sponsor	Stanford Health Care 300 Pasteur Drive, MC 5513 Stanford, CA 94305-5513 Attention: VP and Chief HR Officer 650-723-4748
Employer I.D. Number	94-6174066
Plan Number	002
Type of Plan	403(b) defined contribution retirement plan
Agent for Services of Legal Process	See Plan Administrator
Plan Year	January 1 – December 31
Plan Recordkeepers	Fidelity (current) Transamerica Retirement Services — frozen TIAA-CREF, Prudential, Lincoln (formerly UNUM) — frozen
Funding Mediums	The plan sponsor has entered into group annuity or custodial agreements with the investment companies holding the available investment funds. Certain plan assets are held in individual annuity contracts or custodial accounts.

Contribution Sources	• Eligible employees direct the employer to reduce their taxable income and contribute that amount to the plan. • Eligible employees may also contribute post-tax money. • The employer makes a 5% non-elective contribution to eligible employees and matches certain pre-tax and post-tax employee contributions. • All contributions and investment earnings are held under the group annuity or group custodial agreement.
Collective Bargaining Agreements	The plan is maintained in part pursuant to several collective bargaining agreements. Participants can obtain a copy of these agreements by sending a written request to the Plan Administrator.
Normal Retirement Age	65

When You Have Questions

Intent of the Handbook

This Handbook and the hospitals' benefits program apply to all eligible employees.

The information in this Handbook and the health booklets from the medical plans are intended to comprise the Summary Plan Description of the hospitals' benefits program. It is your responsibility to read this Handbook and the health booklets, and to ask questions if you need more information. It is also your responsibility to visit **www.healthysteps4u.org** to download your plan's health booklet. If you do not have access to a computer, please connect with Ask HR to have a paper copy mailed to you at no charge (SHC employees: **hr.stanfordmed.org**; LPCH employees: **stanfordchildrensaskhr.org**). This Handbook does not serve as a guarantee of continued employment or benefits. The hospitals may change, modify or terminate the benefits and policies described in this Handbook at any time.

Stanford Health Care Offices	
Address	**Telephone Number/Email/Website**
Stanford Health Care HR 300 Pasteur Drive, MC 5513 Stanford, CA 94305-5513	Phone: 650-723-4748 Fax: 650-618-2551 Monday – Friday, 9:00 a.m. – 4:00 p.m. PT **www.healthysteps4u.org**
Lucile Packard Children's Hospital Stanford Offices	
Lucile Packard Children's Hospital Stanford HR Solutions Team 725 Welch Road, MC 5861 Palo Alto, CA 94304-5861	Phone: 650-721-5400 Fax: 650-618-1843 Monday – Friday, 8:30 a.m. – 5:00 p.m. PT **www.accesshr.lpch.org**
Payroll Department 725 Welch Road, MC 5860 Palo Alto, CA 94304-5861	Phone: 855-345-5724 Monday – Friday, 8:00 a.m. – 5:00 p.m. PT

Stanford University Offices	
Stanford University Office of Parking & Transportation Services 415 Broadway Redwood City, CA 94063-8877	Phone: 650-723-9362 Fax: 650-724-8676 Monday – Friday, 7:30 a.m. – 4:00 p.m. PT transportation@stanford.edu **www.transportation.stanford.edu**
WorkLife Office, Stanford University 3160 Porter Drive, Suite 250 Palo Alto, CA 94304	Phone: 650-723-2660 helpcenter@lists.stanford.edu **www.cardinalatwork.stanford.edu/benefits-rewards/worklife/about-us/contact**
Retirement Savings Plan (RSP)	
Fidelity	800-343-0860 Website: **www.netbenefits.com/shclpch**
TIAA-CREF 730 Third Avenue New York, NY 10017	Customer Service Representative: 800-842-2776 Monday – Friday, 5:00 a.m. – 7:00 p.m. PT Saturdays 6:00 a.m. – 3:00 p.m. PT Website: **www.tiaa.org** 24-Hour Automated Telephone Service: 800-842-2252

Health Plans

	Address	Telephone Number/Email/Website	Group #
Aetna Choice POS II with HSA	Claims & Appeal: Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512	Member Services: 888-277-4041 **www.aetna.com**	868021
Beacon Health Options (EAP)	N/A	24/7 Customer Service Representative: 855-281-1601 **www.achievesolutions.net/shclpch**	N/A
CVS/Caremark	Claims: CVS/Caremark Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084	Member Services: 844-214-2607 **www.caremark.com** Specialty Pharmacy: 800-237-2767	204124

	Address	Telephone Number/Email/Website	Group #
	Attn: Commercial Claims		
Delta Dental PPO	Claims & Appeals: Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330	800-765-6003 Monday – Friday, 5:00 a.m. – 5:00 p.m. PT **www.deltadentalins.com**	1640

DeltaCare® USA DHMO	Claims: DeltaCare USA P.O. Box 1810 Alpharetta, GA 30023 Appeals: Quality Management Department MS QM600 12898 Towne Center Drive Cerritos, CA 90703-8546	Customer Service: 800-422-4234 Monday – Friday, 5:00 a.m. – 6:00 p.m. PT **www.deltadentalins.com**	01843
Dept. of Managed Health Care	Sacramento	1-888-466-2219 800-735-2929 (TTY) 888-877-5378 (TTY) **www.hmohelp.ca.gov**	N/A
Kaiser Permanente HMO	Claims: Attn: Claims Department Kaiser Foundation Health Plan, Inc. P.O. Box 12923 Oakland, CA 94604-2923 Appeals: Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623-0280	Claims: 800-464-4000 TTY: 800-777-1370 Member Services: 800-464-4000 English 800-788-0616 Spanish 7:00 a.m. – 7:00 p.m., week days 7:00 a.m. – 3:00 p.m. weekends **www.my.kp.org/stanfordmed**	38810 (CA) 45040 (HI)
Kaiser Permanente Senior Advantage (Medicare+ Choice HMO)	Claims: Kaiser Permanente Senior Advantage Northern California P.O. Box 12923 Oakland, CA 94604-2923 Appeals: P.O. Box 23280 Oakland, CA 94623-0280	Claims: 800-464-4000 Member Services: 800-464-4000 7:00 a.m. – 7:00 p.m., 7 days a week **www.my.kp.org/stanfordmed**	38810

Stanford Health Care Alliance (SHCA)	Claims & Appeal: Aetna Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512	Member Services: 855-345-SHCA (7422) **www.stanfordhealthcarealliance.org**	868021
VSP	Claims: P.O. Box 385018 Birmingham, AL 35238-5018 Appeals: contact member services for form or file on line	800-877-7195 TTY: 800-428-4833 Monday – Friday, 5:00 a.m. – 8:00 p.m. PT Saturday 7:00 a.m. – 8:00 p.m. PT Sunday 7:00 a.m. – 7:00 p.m. PT **www.vsp.com**	12120458

Other Benefit Plans

	Address	Telephone Number/ Email/Web Site	Group #
Adoption Assistance Program (for Stanford Health Care Employees)	Stanford Health Care HR 300 Pasteur Drive, MC 5513 Stanford, CA 94305-5513	650-723-4748 **www.healthysteps4u.org**	N/A
Adoption Assistance (for Lucile Packard Children's Hospital Stanford Employees)	Lucile Packard Children's Hospital Stanford HR Solutions Team 725 Welch Road, MC 5861 Palo Alto, CA 94304-5861	650-721-5400 **www.healthysteps4u.org**	N/A
BenefitHub (Online Discounts)	4030 W. Boy Scout Blvd, Suite 400 Tampa, FL 33607	866-205-7354 Monday – Friday, 5:30 a.m.– 5:00 p.m. PT **customercare@benefithub.com** **www.stanfordhospital.benefithub.com** Code: XMSJWR	N/A
Bright Horizons (Back-Up Care)	200 Talcott Avenue Watertown, MA 02472	877-242-2737 **www.backup.brighthorizons.com** **www.clients.brighthorizons.com/lpchs**	N/A

	Address	Telephone Number/ Email/Web Site	Group #
		Stanford Health Care Employees Username: SHC Password: backup 1 Lucile Packard Children's Hospital Stanford Employees Username: LPCH Password: backup1	
HealthEquity (Flexible Spending Accounts, Health Savings Account and Health Incentive Account)	HealthEquity, Inc. 15 W Scenic Point Dr. Ste. 100 Draper, UT 84020	877-395-6548 Available 24/7/365 Fax: 801-727-1005 **www.myhealthequity.com/shclpch**	N/A
Internal Revenue Service (IRS)	N/A	To request Publications 502 and 503: Call: 800-829-3676, or Visit: **www.irs.gov**	N/A
Mercer Voluntary Benefits Voluntary Benefits Program: • Auto and Home & Renters Insurance • Discount Programs • Metlife Legal Plan • Allstate Identity Protection • Pet Insurance **Purchase Program**	Marsh U.S. Consumer 12421 Meredith Drive Urbandale, IA 50398	LPCH Employees 800-689-9314 Monday – Friday 5:00 a.m. – 5:00 p.m. PT Saturday 6:00 a.m. – 10:00 a.m. PT Visit: **www.shclpchvoluntarybenefits.com** SHC Employees Metlife Legal Plan 800-821-6400 **www.legalplans.com** 800-689-9314 Monday – Friday 5:00 a.m. – 5:00 p.m. PT Saturday 6:00 a.m. – 10:00 a.m. PT Visit: **www.shclpchvoluntarybenefits.com**	N/A

	Address	Telephone Number/ Email/Web Site	Group #
Allstate Identity Protection		SHC Employees: Allstate Identitity Protection 800-789-2720 **www.myaip.com**	
Paid Family Leave (PFL)	N/A	877-238-4373 or go to **www.edd.ca.gov** and select “Paid Family Leave”	N/A
Stanford Health Care Compliance Department and Privacy Office		650.724.2572 24-hour Hotline: 800.216.1784 **ComplianceOfficer@stanfordhealthcare.org** or **PrivacyOfficer@stanfordhealthcare.org**	
State Disability Insurance	N/A	DI: 800-480-3287 PFL: 877-238-4373 **www.edd.ca.gov/disability/**	N/A
The Hartford (Life, Accident and Long Term Disability)		800-524-8504 5:00 am – 5:00 pm PST **www.abilityadvantage.thehartford.com**	GL-681491 GLT-681491
The Hartford (Short-Term Disability and LOA Administrator)		866-432-6721 **www.abilityadvantage.thehartford.com**	GRH-697481
The Hartford (Business Travel Accident Insurance and Personal Travel Assistance Services)		800-243-6108 **www.accidentlines.com**	ETB151022
Vita Administration Company (COBRA)	Vita Administration Company 900 North Shoreline Blvd. Mountain View, CA 94043-1933	COBRA Questions: 650-810-1480 Monday – Friday, 8:00 a.m. – 5:00 p.m. PT or go to **www.vitacobra.net** Email: **help@vitamail.com** Fax: 650-961-2285	N/A

Glossary of Terms

Below are defined terms for all sections of the Benefits Handbook.

Term	Definition
Accident	An unexpected, external, violent and sudden event.
Actively at Work (Disability Insurance)	Active employment means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the number of hours in the employer's normal work week. Normal vacation is considered active employment. Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.
Actively at Work (Life Insurance)	To be eligible to become insured or to receive an increase in the amount of insurance, you must be working for your employer for pay with the intent and ability of working the scheduled hours (the full-time hours as required by the participating employer, but not less than 40 hours per pay period and doing the normal duties of your job, whether you are working at your usual work location, a location that requires you to travel or at an alternative worksite. Normal vacation and Paid Time Off (PTO) time are considered active employment.
Adopted Child	A legally adopted child, including a child who is officially placed with you for adoption.
Annual Frozen Salary	Your salary as calculated on the day of eligibility or at annual open enrollment. Once the salary is determined, it is frozen so that your contributions for these benefits remain the same throughout the plan year.
Basic Yearly Earnings	The current yearly salary or wage you receive for work done for the hospitals. It does not include bonuses.
Bed and Board	All charges made by a hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.
Benefits-Eligible Employees	Full-time and part-time as defined for benefit eligibility. (Full-time is scheduled to work 80 hours per bi-weekly pay period and part-time is scheduled to work less than 80 hours but at least 40 hours per bi-weekly pay period.)
Calendar Year	January 1–December 31.
Chiropractic Care	The conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Term	Definition
COBRA	Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time and applicable regulations. This law gives covered persons the right, under certain circumstances, to elect continuation coverage under the plan when active coverage ends due to a qualifying event.
Coinsurance	The percentage of covered medical and dental expenses you are responsible for paying after you have met your deductible. Under each medical plan option, your coinsurance is lower when you use an in-network provider.
Contribution	Your share of the cost (or premiums) for benefits coverage for yourself and your dependents. Your contributions will be automatically deducted from each paycheck throughout the year. You will pay your contributions for medical, dental and vision coverage on a pretax basis; you will pay your contributions for domestic partner coverage, supplemental disability coverage and voluntary life insurance on an after-tax basis.
Conversion	Conversion allows you to convert all or a portion of the terminating life insurance coverage to an individual policy (subject to conversion amount limitations). Amounts you convert are no longer part of your hospitals' coverage, and you are solely responsible for keeping the individual policy(ies) active. You pay the insurance company directly. Your cost is based on the insurance company's standard individual rates, which may differ from the rates you currently pay.
Copayment	A preset dollar amount you pay upfront for certain medical, dental and vision services and prescription drugs.
Covered Health Service(s)	Health services which prevent, diagnose or treat a sickness, injury, mental illness or substance abuse or the symptoms thereof. Covered services include the health care services or supplies described in the "What's Covered" section for each plan. They do not include any services or supplies listed in the "What's Not Covered" sections, including experimental or investigational services. Covered health services must be provided: when the plan is in effect; before a participant loses coverage, based on the guidelines stated in this Summary Plan Description; and only when the person who receives services is covered and meets all eligibility requirements specified in the plan. The decision to add new technologies, procedures and treatments as covered services under the plan will be based on generally accepted medical research and findings from clinical trials or group studies.
Deductible	The amount of covered expenses which must be paid by the covered person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable deductible (if any) and the health care benefits to which it applies.

Term	Definition
Deductible Sources of Income (Long-Term Disability)	Your disability benefit under the plan will be reduced by the amount of all other income that was actually paid to you for the same disability for which you are claiming benefits under the plan. Other income includes: • Any disability benefits for you, your spouse or child(ren) under the: – Federal Social Security Act; – Canadian Pension Plan; – Quebec Pension Plan; – Railroad Retirement Act; or – Any similar plan or act: ▪ Temporary disability benefits under a workers' compensation law; ▪ Amounts under any other occupational disease law. • Any disability benefits under: – The Jones Act; – Any state compulsory/statutory benefit law; – Any government retirement system, including but not limited to the California State Teachers Retirement System (CALSTRS) and/or the California Public Employee Retirement System (CalPERS); or – The hospitals' retirement plan. • Any retirement benefits under the: – Federal Social Security Act; – Canadian Pension Plan; – Quebec Pension Plan; – Railroad Retirement Act; – The hospitals' retirement plan; or – Any similar plan or act: ▪ Third party liability payments by judgment, settlement or otherwise (minus attorneys' fees); ▪ Sick pay; ▪ Any salary continuation, personal time off and annual leave pay. If there is reasonable, good faith belief that you are entitled to disability benefits under the following sources of other income, you must apply for such benefits: ▪ Federal Social Security Act (Primary and/or Family Benefits); and/or ▪ Any state compulsory/statutory benefit law.

Term	Definition
	To apply for other income benefits referenced above means to pursue such benefits with reasonable diligence until you receive the respective approval from the Social Security Administration and/or the appropriate state agency. You must send the insurance company proof that you have applied for such benefits. If your application for such benefits is approved, the insurance company will reduce your benefit by the amount actually paid to you from such source(s). If you fail to : • Apply for any of the above referenced other income benefits; and • Pursue such benefits with reasonable diligence; and • If there is a reasonable means of estimating the amount of such benefits payable to you, the insurance company will reduce the amount of your disability benefit by the amount of such benefits the insurance company estimates that you, your spouse or child(ren) are eligible to receive because of your disability. The insurance company will start to do so with the first disability benefit payment coincident with the date you were eligible to receive such benefits unless the insurance company has received: – Proof that you have applied for and are pursuing such benefits with reasonable diligence; – Approval of your claim for such benefits; or – A notice of denial of such benefits.
Disability (for Short-Term Disability Benefits)	Disability means any physical or mental condition arising from a non-occupational injury, illness, or pregnancy that renders an employee incapable of performing the material duties of his or her regular job or any reasonably related job while covered under the plan. Pre-existing condition limitations may apply. An employee will also be considered to have sustained a disability if: • He or she is ordered not to work by written order from a state or local health officer because he or she is infected with, or suspected of being infected with, a communicable disease; or • He or she has been referred or recommended by a competent medical authority to participate as a resident in either an alcohol abuse treatment program or drug abuse treatment program, or to participate in an outpatient program for the treatment of drug or alcohol abuse which requires attendance for a minimum of five days per week for a minimum of six hours per day.

Term	Definition
	An employee will not be considered disabled if (i) he or she is performing work of any kind for remuneration or profit unless with the prior approval of the Plan Administrator, or (ii) he or she declines alternative employment by the hospitals which is within the employee's capabilities and, as determined solely by the hospitals, has status and compensation comparable to the employee's previous job.
Disability Earnings	The earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to the greatest extent possible. This would be based on your restrictions and limitation: • During the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation that is reasonably available. • Beyond 24 months of disability payment, the greatest extent of work you are able to do in any occupation that is reasonably available for which you are reasonably fitted by education, training and experience.
Doctor	A person (other than you or your immediate family members) performing tasks within the limits of his or her medical license. Doctors are licensed to practice medicine, prescribe and administer drugs or perform surgery. Specifically, these licensed practitioners may include the following: • Doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC) • Licensed doctoral clinical psychologist • Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist • Licensed physician's assistant (PA) if billed by a doctor • As required by law, any other licensed practitioner acting within the scope of his or her license and performing a service that would be covered by the plan if performed by an MD • The fact that the company describes a practitioner as a doctor does not mean that benefits for services from that provider are available under the plan.
Domestic Partner	An unmarried person of the same sex (or opposite sex if you or your eligible domestic partner is over the age of 62) with whom you share a committed relationship that meets the requirements established by the Administrator, as described below. An eligible domestic partner must meet the following guidelines: • You are opposite or same sex partners;

Term	Definition
	• You share an intimate and committed relationship of mutual caring; • You are both capable of consenting to the domestic partnership; • You are unmarried, at least 18 years of age and not related by Blood; • You have not dropped coverage for the same domestic partner (unless they have gained other coverage); and • You have not had a different domestic partnership within the last six months (unless your prior partner died). • You have registered your domestic partnership with the state of CA or the state or locality in which it was established.
Durable Medical Equipment (DME)	Medical equipment which meets all of the following criteria: • Can withstand repeated use • Is primarily used to serve a medical purpose with respect to an illness or injury • Generally is not useful to a person in the absence of an illness or injury • Is appropriate for use in the covered person's home.
Earnings for Disability Payments	Earnings are defined as annual base salary as determined at the time of the most recent quarterly update before the disability occurred, plus declared tips and tokens and commissions (if any) for the previous four consecutive fiscal quarters prior to the most recent quarterly update.
Eligible Dependents	Please see "**Eligible Dependents — A Definition of Dependents**" in the ***Using Your Handbook and Benefits Program*** section.
Eligible Domestic Partner	See "Domestic Partner" above.
Eligible Employees	Please see the "**Who is Eligible**" section in the ***Using Your Handbook and Benefits Program*** section.
Eligible Expenses	The amount the plan will pay for covered health services as long as the service was done while the plan is in effect. Depending on whether you get care from an in-network or out-of-network provider, eligible expenses are based on the following: • For in-network care: Eligible expenses are the provider's contracted fee(s).

Term	Definition
	• For out-of-network care: Unless you receive emergency services, eligible expenses are determined by the Claims Administrators based on one of the following: (1) Fee(s) that are negotiated with the service provider; or (2) 140 percent of the published rates allowed by Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market. • The specific reimbursement formula used will vary depending upon the physician, facility or service provider providing the service(s) and the type of service(s) received.
Elimination Period	This is the period of continuous disability which must be satisfied before you are eligible to receive benefits. For the Short-Term Disability Plan, the time period starts with the first day of disability and continues through the eighth day of disability, for which no benefits are provided. A participant may use paid time off for this time frame.
Emergency	A serious medical condition with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.
Emergency Services	Medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service required to treat a sudden unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis — whichever reasonably indicated an emergency medical condition — will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.
Employee	A person who is actively employed by the hospitals or by a participating employer in the plan.

Evidence of Insurability (EOI)	A statement of your medical history that the insurance company will use to determine if you are approved for coverage. This is usually a health questionnaire you complete and submit to the insurance carrier. A physical exam may be required at your own expense. Evidence of Insurability must be approved by the insurance company before the elected coverage becomes effective.
Exempt	Generally, a salaried employee who is not allowed to earn overtime pay under the requirements of the Fair Labor Standards Act.
Expense Incurred	An expense is incurred when the service or the supply for which it is incurred is provided.
Experimental or Investigational Drug, Device, Treatment or Procedure	Any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to: • Items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II or III clinical trials (unless identified as a covered service elsewhere); • Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies; • Items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established; • Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

	Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies and/or independent review organizations to evaluate the scientific quality of supporting evidence.
Flexible Spending Account (FSA)	An account where you set aside money on a pretax basis to pay for eligible health care or dependent daycare expenses.
Free-Standing Surgical Facility	An institution that meets all of the following requirements: • It has a medical staff of physicians, nurses, and licensed anesthesiologists; • It maintains at least two operating rooms and one recovery room; • It maintains diagnostic laboratory and X-ray facilities; • It has equipment for emergency care; • It has a blood supply; • It maintains medical records; • It has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis; and • It is licensed in accordance with the laws of the appropriate legally authorized agency.
Full-Time	See “Benefits-Eligible Employees” above.
Generic Drug	Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.
Health Reimbursement Account (HRA)	HRA is an account set up for you by the hospitals to hold the employee wellness incentive you earn by completing various programs, activities and/or assessments throughout the year under the HealthySteps to Wellness program.
Health Savings Account (HSA)	HSA is an employee-owned, tax-advantaged savings and investment account set up to pay for qualified health care expenses.
Hospital	The term hospital means:

	• A facility that is a licensed institution authorized to operate as a hospital by the state in which it is operating; and • Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment and care of injured and sick persons at the patient's expense; and • It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency and is qualified to receive payments under the Medicare program; or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and • It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and • Is not a place primarily for maintenance or custodial care; • A facility licensed as a residential treatment facility in the state in which it operates; and • For purposes of this plan, hospital also includes surgical centers and birthing centers licensed by the state in which it operates.
Hospital Confinement or Confined in a Hospital	A person will be considered confined in a hospital if he is: • A registered bed patient in a hospital upon the recommendation of a physician; • Receiving treatment for mental health and substance abuse services in a partial hospitalization program; or • Receiving treatment for mental health and substance abuse services in a mental health or substance abuse residential treatment center.
Illness	A bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "illness" when used in connection with a newborn child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.
In-Network	A provider that has agreed to accept contracted rates for service.
Injury	Under the Short-Term Disability Plan, any non-work related injury to your body that happened directly from an accident and not related to another cause. The injury must occur and disability must begin while you are covered under this plan. Under Long-Term Disability, a work-related injury is not excluded.
Maintenance Treatment	Treatment rendered to keep or maintain the patient's current status.
Maximum Reimbursable Charge	The lesser of: the provider's normal charge for a similar service or supply; or the policyholder-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.
Medicaid	A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity	Health care services provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, mental illness, substance use disorder, condition, disease or symptoms, that are all of the following as determined by us or our designee, within our sole discretion: • In accordance with Generally Accepted Standards of Medical Practice; and • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury, mental illness, substance use disorder, disease or symptoms; and • Not mainly for your convenience or that of your doctor or other health care provider; and • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms. The fact that a physician has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility medically necessary. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

	Aetna Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by Aetna Clinical Services and revised from time to time), are available to covered persons by calling Aetna at the telephone number on your ID card, and to physicians and other health care professionals on www.aetnanavigator.com.
Medicare	The program of medical care benefits provided under Title XVIII of the Social Security Act as amended.
Mental Illness	Psychiatric or psychological condition such as schizophrenia, depression, manic-depressive or bipolar illness, anxiety, somatization, substance-related disorders (including drug and alcohol abuse) and/or adjustment disorders. A mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment usually treats those conditions.
Necessary Services and Supplies	The term necessary services and supplies includes: • Any charges, except charges for bed and board, made by a hospital on its own behalf for medical services and supplies actually used during hospital confinement; • Any charges, by whomever made, for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided; and • Any charges, by whoever made, for the administration of anesthetics during hospital confinement. The term necessary services and supplies will not include any charges for special nursing fees, dental fees or medical fees.
Network	When used to describe a provider of health care services, this means a provider that has an agreement with the Claims Administrator or affiliate to provide covered health services to members. A provider can choose to stop participating in the network or apply to join the network at any time.
Non-exempt	Generally, hourly employees who are allowed to receive overtime pay under the Fair Labor Standards Act (FLSA).
Nurse	A Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.” or “L.V.N.”
Office	A location where a doctor, as defined above, primarily performs covered medical services that are provided by scheduling an appointment. Typically, the doctor’s office is the only location of the doctor’s private practice or a group of clinics. A “doctor’s office” may be an urgent care facility if: • The doctor practices only out of the urgent care facility or

	• The care is received through a scheduled appointment and does not qualify as "urgent care" as defined by the plan. • Emergency rooms, hospitals or freestanding surgical centers are not considered "doctors' offices."
Other Health Care Facility	A facility other than a hospital or hospice facility. Examples of other health care facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.
Other Health Professional	An individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other health professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.
Out-of-Network	A provider that has chosen not to participate in a particular network.
Out-of-Pocket Maximum	The most you will pay for covered medical and pharmacy expenses in a year, equal to your deductible plus your employee share amount. Once you reach this amount, the hospitals pay 100% of these expenses for the remainder of the year.
Partially Disabled (for Long-Term Disability Benefits)	You are considered partially disabled if you you are not totally disabled while actually working in your own occupation, as a result of injury or sickness you are unable to earn 80% or more of your basic monthly earnings.
Partially Disabled (for Short-Term Disablity Benefits)	You are considered partially disabled if you are working fewer hours than you are regularly scheduled to work while you receive weekly Short-Term Disability benefits.
Participating Provider	A hospital, a physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Aetna to provide covered services with regard to a particular plan under which the participant is covered.
Physician	A licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a physician.
Portability	Portability allows you to continue all or a portion of your life insurance coverage (for yourself, your spouse/eligible domestic partner and/or your dependents) under the hospitals plan when that coverage would otherwise terminate. You pay the insurance company directly. Your cost is based on the insurance company's standard group rates, which may differ from the rates you currently pay.

Preventive Treatment	A prescribed standard procedure that is ordered by a physician to evaluate or assess the covered person's health and well-being, screen for possible detection of unrevealed illness or injury, improve the covered person's health, or extend the covered person's life expectancy. Generally, a procedure is routine if there is no personal history of the illness or injury for which the covered person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this plan, or treatment after the diagnosis of an illness or injury, except as required by applicable law.
Psychologist	A person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a psychologist.
Qualified Medical Child Support Order (QMCSO)	A judgment, decree or order resulting from a divorce, separation, annulment or custody change that requires your dependent child (including a foster child who is your tax dependent) to be covered for medical, dental or vision coverage.
Qualified Medical Practitioner	A licensed doctor or other person (other than you or an immediate family member) qualified by law and who the insurance company approves to treat your condition.
Reasonable and Customary Charge	The maximum amount that the carrier will pay for a particular out-of-network service under the plan, generally applicable to medical and dental services. These limits can be based on what other providers in your geographic area charge for the service or supply, or based on the Medicare allowable rate, as applicable.
Recurring Disability	Disability caused by a worsening in your condition and due to the same cause(s) as your prior disability for which you received a disability payment.
Rehabilitation Program	This is a program designed to assist you to return to work. The program may include, but is not limited to, the following services: • Coordination with your employer to assist you to return to work; • Evaluation of adaptive equipment to allow you to work; • Vocational evaluation to determine how your disability may impact your employment options; • Job placement services; • Resume preparation;

	• Job seeking skills training; • Retraining for a new occupation; or • Assistance with relocation that may be part of an approved rehabilitation program.
Sickness	Any disorder of your body or mind, but not an injury; includes pregnancy, abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan; The term sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine hospital and pediatric care of a newborn child prior to discharge from the hospital nursery will be considered to be incurred as a result of sickness.
Terminal Condition	An injury or sickness which is expected to result in your death within 12 months and from which there is no reasonable chance of recovery.
Terminal Illness	Life expectancy of about six months.
Termination of Employment	The date you leave the company for any reason. Your employment is considered terminated when Paid Time Off (PTO) and any authorized leave of absence expires and you are not actively working. Termination can also occur if you fail to appear for work or are terminated for cause without notice.
Totally Disabled (for Long-Term Disability Benefits)	You are considered totally disabled if: • During the elimination period and the next 24 months of disability, you are, as a result of an injury or sickness, unable to perform with reasonable continuity the substantial and material acts necessary to pursue your own occupation in the usual and customary way; and • After 24 months of disability, you are unable to perform, with reasonable continuity, the substantial and material acts of any occupation, meaning that as a result of sickness or injury you are not able to engage with reasonable continuity in any occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity.
Totally Disabled Child	A child who is physically or mentally incapable of self-support and qualifies as your dependent for federal income tax purposes. Proof of disability must be provided and approved by the Medical Plan Administrator.
Urgent Care	The delivery of ambulatory care in a facility dedicated to the delivery of care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Often urgent care centers are not open on a continuous basis, unlike a hospital emergency room that would be open at all times.

Usual, Customary and Reasonable (UCR) Charge	See "**Reasonable and Customary Charge**" above.