Answers to Commonly Asked Questions about your Dignity Health Benefits

DIGNITY HEALTH BENEFIT PROGRAM

1. Q: What is FlexAbility?

A: FlexAbility is the Dignity Health employee benefit program that is designed to offer you a variety of benefit choices, which may include medical, dental, vision, life insurance, long-term disability and more. Dignity Health recognizes that no single benefit plan is right for everyone and FlexAbility allows you to select the benefits package that best fits the needs of you and your family. While FlexAbility is offered to most benefit-eligible Dignity Health employees, the plan options vary by employee group. Refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal for the benefit options available at your location.

2. Q: Who is eligible for Dignity Health Benefits?

A: The specific eligibility criteria are determined by each Dignity Health location. Refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal for the eligibility requirements at your location.

3. Q: When can I enroll in Dignity Health Benefits?

A: You should enroll in Dignity Health Benefits as soon as you meet the initial eligibility criteria, but not later than your enrollment deadline as shown on the Welcome page of the Dignity Health Total Rewards Portal and on the 5 Easy Steps screen on My Health. If you do not enroll when you are first eligible, you will receive coverage under the Default Plan as described in your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health.

4. Q: When can I make changes to my benefit elections?

A: After your initial enrollment deadline has passed, you may change your benefit elections during the annual Open Enrollment Period in the fall or within 31 days after you experience a qualified life event. Refer to the FlexAbility Summary Plan Description under Quick Links on My Health of the Dignity Health Total Rewards Portal for more information about qualified life events affecting your coverage. You can also view an informational video. Just click on Learn about Family Status Changes under Quick Links on the Dignity Health Total Rewards Portal Welcome page.
Answers to Commonly Asked Questions about your Dignity Health Benefits

5. Q: Who are my eligible dependents?

A: Generally, the following individuals are eligible dependents; however eligibility varies by location so refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal for the eligible dependents at your location.

One Adult from the following categories:

- **Spouse** – Legally married spouse, as defined by the law of the jurisdiction where the marriage was performed.

- **Registered Domestic Partner (RDP)** – for California employees only – An individual who is a same-sex or opposite-sex partner with whom the employee has registered with any state or local government domestic partner registry. (See your Facility Specific Benefit Information document to determine if you are eligible to cover this type of dependent.)

- **Legally Domiciled Adult (LDA)** – An individual who is not Medicare eligible, is of the same or opposite sex from the employee, is in a committed relationship with a benefited employee, has been domiciled with the employee for at least one year, who is not a blood relative, and neither the LDA nor the employee are in a registered domestic partnership with another individual. (See your Facility Specific Benefit Information document to determine if you are eligible to cover this type of dependent.)

- **Adult Tax Dependent (ATD)** – Adult, over age 18, residing in the same home as the employee who is an IRS tax dependent of the employee, who is not an eligible dependent child, and who is not Medicare eligible. (See your Facility Specific Benefit Information document to determine if you are eligible to cover this type of dependent.)

- **Child** – Employee’s biological, adopted, step, legal guardianship children through age 25. Children of a registered domestic partner, legally domiciled adult or adult tax dependent are also eligible through age 25 if you are eligible to cover these types of adult dependents.

- **Disabled Child Age 26 and Older** – Employee’s unmarried, biological, adopted, step, legal guardianship children and/or children of a registered domestic partner who became mentally or physically disabled prior to age 26, who are incapable of self-sustaining employment and chiefly dependent upon the employee for support. (Social Security disability determination or physician-documented incapability of self-support due to disability is required).
MEDICAL PLANS

6. Q: What types of medical plans are available to me?

A: Depending on your location, you may be able to choose from the following types of medical plans: HMO (Health Maintenance Organization), EPO (Exclusive Provider Organization), POS (Point of Service) or PPO (Preferred Provider Organization). When you enroll the medical plans available to you are shown on the Medical page of My Health on the Dignity Health Total Rewards Portal. At any time you may select the Medical Plan Comparison Tool to compare the coverage provisions for each medical plan offered at your location. You may also refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health for more detailed information about the specific medical plans available at your location.

7. Q: Can I waive medical plan coverage?

A: Yes, if you have coverage from another source such as your spouse’s employer. To waive medical coverage, you must provide information about your other coverage on the Medical page of My Health on the Dignity Health Total Rewards Portal.

8. Q: What should I consider before selecting a medical plan?

A: You may want to ask yourself the following to help identify which medical plan is best for you:

- What are the premiums, copayments and coverage limits?
- Would I prefer going directly to a specialist, rather than contacting my primary care physician (PCP) for a referral?
- Am I willing to pay a deductible and accept a lower level of benefit in exchange for the freedom to go out-of-network for medical care?
- Is there a particular doctor or physician group I want to provide my care?

9. Q: What do I need to know about HMOs?

A: If you choose an HMO, you and your dependents must select a Primary Care Physician (PCP). When services are provided or coordinated by your PCP, you pay a small copayment, but there are no claim forms to file and no medical bills to pay. A referral from your PCP is needed in order to see a specialist (some exceptions may apply). There is generally no benefit coverage for out-of-network care, except for emergency services.
Answers to Commonly Asked Questions about your Dignity Health Benefits

10. Q: Why do I have to choose a PCP if I enroll in an HMO?
A: Your PCP coordinates all of your medical care, from routine physicals to specialist referrals and hospital stays. The physician you choose will help you make the most of your medical plan. If required by your medical plan, you must designate a PCP for yourself and each covered dependent. Each medical plan has a provider list from which you can make your selection. You can link to your medical plan provider’s website and physician directory when you enroll on the Medical page of My Health on the Dignity Health Total Rewards Portal. If you do not choose a PCP, the medical plan will assign one to you.

11. Q: Are all covered family members required to have the same PCP?
A: No, you may select a different PCP for each dependent.

12. Q: What if I want to change my PCP?
A: Call member services for the medical plan you have chosen and give them the name of the new physician. The member services representative will tell you the effective date of your physician change and a new I.D. card will be sent to you. The member services number is on your medical plan I.D. card.

13. Q: How does a Point of Service (POS) plan work?
A: A POS plan offers you freedom of choice; you are not locked into a single provider network. This plan combines the features of an HMO, PPO and a traditional indemnity plan. With a POS plan, each time you or your covered dependent needs medical care, you decide which provider will care for you; your level of coverage will depend on your choice of providers. A POS plan gives you the flexibility of choosing among three levels of coverage.

14. Q: How does a PPO plan work?
A: A PPO offers more freedom in accessing health care providers. PPO plans offer in-network and non-network coverage levels. If you use network (or preferred) providers for your health care needs, you receive a higher level of benefit coverage and are responsible for a deductible and/or copayments or coinsurance. If you use non-network providers, your benefits are lower and you are responsible for greater out-of-pocket expenses.
Answers to Commonly Asked Questions about your Dignity Health Benefits

15. Q: How does my coverage under a Dignity Health medical plan coordinate with other coverage I may have, for example through my spouse’s employer?

A: There are special procedures for coordinating benefits when you are covered by more than one medical plan. Refer to your health plan provider communications to learn more about the coordination of benefit rules for your medical plan.

16. Q: Is prescription drug coverage included with the medical plan?

A: Yes. You should present your medical plan I.D. card or, if separate, your prescription drug card, to the pharmacy along with your prescription from your physician. For most plans, you can obtain up to a 30-day supply of medication from a network retail pharmacy. Your coverage and copayment may depend on whether your prescription is filled with a generic or brand name drug and whether or not your plan has a preferred drug list or formulary.

17. Q: Is there a mail order prescription program?

A: Most plans include a mail order prescription program for maintenance medication. The mail order program generally allows you to obtain up to a 90-day supply of medication conveniently delivered to your home. Refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal or your health plan provider communications for more information about the mail order prescription program, including copayments and quantity limits.

DENTAL PLANS

18. Q: What types of dental plans are offered to me?

A: Dignity Health offers several dental plans. Most of the dental plans offered pay a percentage of the cost of covered services, up to an annual maximum benefit, and you are responsible for paying a deductible and coinsurance, where applicable. The CIGNA plan, available in certain locations, is a dental program similar to a medical HMO. You must select a participating CIGNA dentist to provide your dental care and you are responsible for a copayment according to a specific schedule of benefits. See your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal for more information about the specific dental plans available at your location.
Answers to Commonly Asked Questions about your Dignity Health Benefits

19. Q: Can I choose to carry only dental insurance without taking medical insurance?
A: Yes, you may enroll in a dental plan even if you waive Dignity Health medical plan coverage.

20. Q: Do the dental plans cover orthodontia?
A: Certain dental plans offer orthodontia coverage. You may select the Dental Plan Comparison Tool to compare the coverage provisions, including orthodontia, of each dental plan offered at your location. You may also refer to your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal to determine which plans in your location cover orthodontia services and the corresponding benefit levels.

21. Q: What if I have other dental coverage?
A: There are special procedures for coordinating benefits when you are covered by more than one dental plan. Refer to your dental plan provider communications to learn more about the coordination of benefit rules for your dental plan.

22. Q: Do I need an I.D. card to obtain services if I am enrolled in a Dignity Health dental plan?
A: An I.D. card is required under the CIGNA DHMO plan. If you enroll in another Dignity Health dental plan, no I.D. card is needed. However, you should tell your dentist which plan you’re enrolled in and provide your social security number and employer name or group number, if possible.

VISION PLANS

23. Q: What types of vision plans are offered to me?
A: Dignity Health offers several vision plans. See your Facility Specific Benefit Information in Summary Plan Descriptions under Quick Links on My Health of the Dignity Health Total Rewards Portal for the plans available at your location.

24. Q: Do I have a deductible?
A: There may be a copayment for exam and materials but no deductible.
Answers to Commonly Asked Questions about your Dignity Health Benefits

25. Q: Can I use a non-participating provider?
   A: Yes, services can be received from any licensed provider. If you use an out-of-network provider, you must pay in full and your vision plan carrier (VSP or MES) will reimburse you up to the amount allowed under the plan’s out-of-network schedule of benefits. To receive reimbursement, you must submit an itemized billing to the vision plan carrier.

26. Q: How can I contact VSP?
   A: For claims, eligibility and benefit information link to the VSP website through Useful Links under Quick Links on My Health of the Dignity Health Total Rewards Portal or call VSP member services at 800.877.7195.

27. Q: How can I contact MES?
   A: For claims, eligibility and benefit information link to the MES website through Useful Links under Quick Links on My Health of the Dignity Health Total Rewards Portal or call MES member services at 800.877.6372.

LIFE INSURANCE PLANS

28. Q: How much life insurance can I elect without proof of good health (Evidence of Insurability or EOI)?
   A: Most employees may elect up to three times their annual base pay in life insurance coverage (as long as it does not exceed $500,000) when first eligible. Thereafter, you may increase your coverage by one-time your annual base pay each year during the annual Open Enrollment Period as long as it does not exceed three times pay and/or $500,000. If you wish to elect coverage of more than three times your annual base pay (or more than $500,000) or you wish to increase by more than one times pay above your current level during the annual Open Enrollment Period, you will need to provide Evidence of Insurability by completing and submitting a Statement of Health and be approved for the higher coverage amount by the insurance carrier.
Answers to Commonly Asked Questions about your Dignity Health Benefits

29. Q: When can I enroll my spouse, registered domestic partner and/or dependent children for life insurance coverage? Do I need to provide Evidence of Insurability (EOI) for them?

A: You can enroll your spouse, registered domestic partner and/or dependent children when first eligible, or within 31 days of a qualifying life event (e.g., marriage, birth) without providing EOI. However, EOI is necessary anytime you elect coverage of $25,000 or $50,000 for your spouse or registered domestic partner or if you elect coverage for your spouse or registered domestic partner after your initial enrollment period. EOI is not required for your child(ren).

30. Q: How do I provide Evidence of Insurability?

A: You provide Evidence of Insurability by completing an online Statement of Health form when required. A link to your online Statement of Health is available from your Benefits Summary screen when you elect coverage or under “Manage Information” on the left side of My Health on the Dignity Health Total Rewards Portal.

31. Q: Can I waive my life insurance?

A: If offered, you must enroll for at least $10,000 (or, if less, the equivalent of one times your annual base pay) in life insurance coverage for yourself. The premium for this minimum level of coverage is fully paid by Dignity Health.

32. Q: Can I continue my life insurance if I leave Dignity Health or take a non-benefited position?

A: Yes, you may continue coverage for yourself and your covered dependents. To apply for continuation, you must contact the insurance carrier within 31 days of your loss of group coverage.

33. Q: How do I (or my beneficiaries) file a claim for life insurance benefits?

A: Contact the Dignity Health HR Service Center and they will assist you in filing the claim.

34. Q: If I become disabled and can no longer work, am I permitted to continue my group life insurance?

A: If you are totally disabled prior to age 65, you may apply for Waiver of Premium by submitting a life insurance disability claim form. If the claim is accepted by the insurance carrier, your life insurance coverage will remain in force without payment of premium until you reach age 65, as long as you continue to be totally disabled as certified initially and periodically by the insurance carrier.
Answers to Commonly Asked Questions about your Dignity Health Benefits

35. Q: Who can I name as my beneficiary?

A: You may name anyone you choose, and you may change your beneficiary at anytime. You should designate and update your beneficiary information by selecting Update Beneficiaries for Death Benefits under Quick Links on the Home page of the Dignity Health Total Rewards Portal. If you name more than one beneficiary at a time, benefits would be paid out equally unless otherwise indicated.

36. Q: Can I name my minor children as my beneficiaries?

A: Yes. In the event of a claim, the life insurance carrier will require a certified copy of the court order appointing a guardian or conservator of the estate of the minor children. Generally, benefits cannot be paid to a minor child until age 18 when the child has the legal capacity to sign a release.

37. Q: If I elect Accidental Death and Dismemberment (AD&D) coverage, and I die in an accident, how will the claim be paid?

A: If you have AD&D coverage and die as a result of an accident, the beneficiary you designated for your life insurance coverage would receive the benefits from your life insurance plus the benefit amount you elected for AD&D.

LONG-TERM DISABILITY INSURANCE PLANS

38. Q: How long do I have to be off work to become eligible for long-term disability (LTD) benefits?

A: The amount of time you must be disabled before you can begin collecting LTD benefits is called the “elimination period”. Under the Dignity Health LTD plan, the elimination period is 180 days. If you think you may be off work that long, you should apply for LTD benefits as soon as possible.

39. Q: If I’m unable to work due to a work-related illness or injury, can I apply for LTD?

A: Yes, regardless of the reason for your disability, you can file a claim for LTD benefits.

40. Q: How do I file a claim for LTD?

A: Contact Liberty Mutual at 855.832.9300 to initiate the claim process.
Answers to Commonly Asked Questions about your Dignity Health Benefits

41. Q: How is the amount of my LTD benefit payment determined?

A: LTD benefits are paid according to the level of coverage you elected, (e.g., 40% of base pay), less any offsets from other employer income sources, such as SDI (California employees only), Worker’s Compensation, Social Security, etc. Benefits from LTD are considered taxable income.

42. Q: What is considered a disability and how long can I collect LTD benefits?

A: If certified by a physician and recognized by the insurance carrier, you are considered disabled if you are unable to perform all the material duties of your regular occupation. You may receive benefits for up to 24 months. To receive benefits after 24 months, you must be unable to perform each of the material duties of any gainful occupation for which you are or may reasonably become qualified based on your education, training or experience. If you meet this requirement, you may be eligible for benefits until age 65.

43. Q: Are there any pre-existing conditions limitations for LTD?

A: Yes, any condition for which you’ve received medical care, taken medication, or received diagnostic treatment during the three months prior to the date of coverage would be considered a pre-existing condition. LTD benefits will not be paid for pre-existing conditions during the first 12 months of coverage.

44. Q: May I change my LTD coverage amount?

A: Yes. You may increase coverage by one level during the annual Open Enrollment Period. However, if you received treatment for a condition in the three months just prior to the increase in benefits, and a disability occurs from that condition within 12 months of the increase, it would not be covered by the increase. You may decrease coverage by one or more levels during the annual Open Enrollment Period as long as you maintain coverage of at least the minimum level required by your location.

45. Q: May I continue LTD coverage if I leave Dignity Health or become non-benefited?

A: You may be entitled to convert your LTD coverage to a private policy. Refer to your LTD carrier communications for more information about conversion privileges.
Answers to Commonly Asked Questions about your Dignity Health Benefits

FLEXIBLE SPENDING ACCOUNTS

46. Q: Where do I send my receipts for reimbursement?
   A: Dignity Health contracts with PayFlex Systems to administer spending account claims. You may file your claim online through the PayFlex website for fast and easy reimbursement of your expenses. You may also download and print a copy of the claim form and forward it, along with your receipts, to PayFlex by fax or mail as directed on the claim form. For either method, get started by linking to the PayFlex website through Useful Links under Quick Links on My Health of the Dignity Health Total Rewards Portal.

47. Q: What kind of documentation must I send with my claim form as proof of payment?
   A: PayFlex Systems will accept invoices, itemized receipts, and explanation of benefit statements from your insurance carrier. It is important that the invoice, receipt, or statement reflect the date of service, the individual who received services, the type of service rendered, and your portion of the expense.

48. Q: What is a spending account payment card and how does it work?
   A: The payment card is an alternate payment option available to spending account participants. It can be used whenever you incur qualified Health Care or Dependent Care expenses at eligible providers where major credit cards are accepted. You do not need to submit a claim when using the payment card; however, you should keep copies of all itemized receipts and explanation of benefit statements in case you are required to verify that you used your payment card for an eligible expense.

49. Q: How can I get a payment card for my spending account?
   A: PayFlex will automatically send you a payment card after you enroll. You can request additional payment cards by calling PayFlex Customer Service at 800.284.4885. Or you can order payment cards online by linking to the PayFlex website through Useful Links under Quick Links on My Health of the Dignity Health Total Rewards Portal. You should receive it within two weeks after your request.

50. Q: Is there a cost to me for using the payment card?
   A: No.
Answers to Commonly Asked Questions about your Dignity Health Benefits

51. Q: If, during the year, I change my mind or my situation changes, can I stop or change my contributions to the spending account?

A: The Internal Revenue Service (IRS) will not allow mid-year changes, unless you experience certain qualified life events that may affect your election. Refer to the Eligibility and Enrollment section of the Summary Plan Description under Quick Links on My Health of the Dignity Health Total Rewards Portal for more information about how qualified life events may affect your coverage.

HEALTH CARE SPENDING ACCOUNT

52. Q: If I submit a claim that is larger than the current balance in my Health Care Spending Account, how will my claim be paid?

A: Your claim would be paid up to the amount of your annual election. The IRS rules that govern this plan require that the employee be reimbursed for qualified expenses up to the full annual election even though the employee has not yet made all of the contributions for the year. This provision only applies to Health Care Spending Accounts; it does not apply to Dependent Care Spending Accounts.

53. Q: If my family members are not covered by a Dignity Health health plan, can I still submit receipts for reimbursement of deductibles and copayments that I paid for them?

A: You may file a claim for reimbursement of eligible health care expenses for any person you claim as an IRS dependent.

54. Q: What is the last date possible to submit my claim for a specific year to PayFlex Systems for reimbursement?

A: All expenses must be incurred from January 1st of the current plan year through March 15th of the following plan year. You must submit your claims with a postmark date not later than March 31st.

55. Q: Can I still file a claim for reimbursement of my health care expenses after I leave Dignity Health or become non-benefited?

A: If your participation in the Health Care Spending Account ends because you are no longer employed by Dignity Health or you become non-benefited, you may claim reimbursement of eligible expenses incurred up to the date your participation ended. However, you may have the option to continue your Health Care Spending Account participation for the remainder of the plan year through COBRA after you leave Dignity Health or become non-benefited. By electing to continue your Health Care Spending Account contributions
Answers to Commonly Asked Questions about your Dignity Health Benefits

through COBRA, you may continue to claim reimbursement of eligible health care expenses incurred after your employment ends or you become non-benefited.

**DEPENDENT CARE SPENDING ACCOUNT**

56. Q: What is the Dependent Care Spending Account?

A: This account is for the day care of children 12 years of age and under or any person who is mentally or physically unable to care for himself/herself, and who qualifies as your dependent for federal income tax purposes. These expenses must be incurred so that you and, if married, your spouse may work.

57. Q: If I utilize the Dependent Care Spending Account, can I also itemize the expense on my tax return?

A: No. Per the IRS an expense reimbursed through the Dependent Care Spending Account cannot also be itemized as a tax credit. If your expenses exceed your annual Dependent Care Spending Account election, consult your tax advisor to determine if you qualify for a tax credit.

58. Q: Do I have to utilize a licensed day care provider to obtain reimbursement from the Dependent Care Spending Account?

A: No, but a claim must have the taxpayer identification number or social security number of the provider you received services from.

59. Q: How often can I submit receipts for reimbursement?

A: You may submit a claim at any time and as often as you have incurred expenses. Your claim will be paid, based on the balance in your Dependent Care Spending Account at the time the claim is processed. If the claim is larger than the current account balance, the remainder will be paid automatically after each subsequent contribution until the claim has been paid in full, up to your annual election.

60. Q: What is the last date possible to submit my claim for a specific year to PayFlex Systems for reimbursement?

A: All expenses must be incurred from January 1st through December 31st of the current plan year. You must submit your claims with a postmark date not later than the following March 31st.
Answers to Commonly Asked Questions about your Dignity Health Benefits

COBRA CONTINUATION COVERAGE

61. Q: If my benefits end because I move to a non-benefited position or leave Dignity Health, can I still continue my coverage?

A: You may be eligible to continue your medical, dental, and vision coverage and your Health Care Spending Account for a limited period of time in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

62. Q: What do I need to do to continue my benefits under COBRA?

A: Shortly after your benefits end, you will be notified in writing of your right to continue coverage and provided with the necessary information to complete your COBRA election. You will have 60 days from the date coverage ends or, if later, the date the COBRA notice is received, to complete and return your election to the COBRA administrator, BenefitConnect COBRA. However, the coverage is not reported to the carrier(s) until the COBRA payment is received. If you have questions about continuation coverage, you may call BenefitConnect COBRA at 877.292.6272, write to them at P.O. Box 1185, Pittsburgh, PA 15230, or visit their website https://cobra.ehr.com.

63. Q: How much does COBRA coverage cost?

A: You will be charged the full premium for coverage plus 2% to cover administrative expenses. You will receive written notice of the cost of continuation coverage at the same time you receive your COBRA notice and election materials. You will have an additional 45 days after you make your COBRA election to pay your initial COBRA premium. Subsequent monthly premium payments are due on the first of each month.