SUMMARY PLAN DESCRIPTION FOR THE CEDARS-SINAI MEDICAL CENTER HEALTH AND WELFARE PLAN

July 1, 2021

This document and attachments together are the Summary Plan Description for the Cedars-Sinai Medical Center Health and Welfare Plan. Please review the attachments in addition to this wrap document for detailed information regarding your benefits.

BENEFIT RESOURCES

MBC HR Employee Benefits Help Desk

Contact...		For information about...
Phone:	888-302-3941	• General benefit questions • Where to go/who to call for what: start here if you have a benefits question and don't know who to ask • Eligibility and enrollment—general information or coverage issues • Prescription drug benefit creditable coverage notices for MedImpact pharmacy benefits in the Blue Cross HMO and Blue Cross PPO (for Medicare Part D) • Silver Passport program • Employee benefits while on a leave of absence (for questions about different types of leave or eligibility for leave, contact the Leave and Disability Management Team)
Fax:	206-299-3158	
Email:	MBC.cshs@milliman.com	
Web:	Cedars-Sinai.MyBenefitChoice.com	
Hours:	Monday–Friday 5 a.m.–5 p.m. PT	
Address	Cedars-Sinai c/o MBC Employee Benefits Help Desk P.O. Box 600610 Dallas, TX 75360-0610	

Medical and Prescription Drugs

Vivity HMO | Anthem: Medical and Prescription Drugs (IngenioRx)

Phone:	844-659-6878 (medical) 833-267-2130 (pharmacy)	• What's covered • Finding a network PCP, provider or IngenioRx pharmacy • Preauthorization • Medical/prescription drug benefit creditable coverage notices • Disagreement about claims payment • Questions about medications, the formulary and Rx prior authorization • Group numbers: Cedars-Sinai Medical Center: 57ANCA Medical Network (Foundation): 57ANCD
Hours:	Monday–Friday 6:30 a.m.–midnight PT	
Web:	vivityhealth.com	
Pharmacy Finder:	anthem.com/ca	
Claims Address:	Anthem Blue Cross Grievance and Appeal Management P.O. Box 4310 Woodland Hills, CA 91367	

Contact...	For information about...

Blue Cross HMO and Blue Cross PPO | Anthem: Medical

Phone:	833-913-2238 (HMO in CA) 877-800-7339 (PPO in and out of CA)
Hours:	Monday–Friday 6:30 a.m.–midnight PT
Web:	anthem.com/ca
PCP/Provider Finder:	anthem.com/ca
Claims Address:	Anthem Claims/Inquiries P.O. Box 60007 Los Angeles, CA 90060

- What's covered
- Finding a network PCP or provider
- Preauthorization
- Medical benefit creditable coverage notices
- Disagreement about claims payment
- Group numbers:
  - Blue Cross HMO:

Cedars-Sinai Medical Center	57ADZG
Medical Network (Foundation)	57ADZK
Silver Passport:	57ADZJ

  - Blue Cross PPO (Inside CA):

Cedars-Sinai Medical Center	1858RE
Medical Network (Foundation)	1858RH
Silver Passport:	1858RG

  - Blue Cross PPO (Out of CA)

Active employees	1858RL
Silver Passport	1858RM

Blue Cross HMO and Blue Cross PPO | Prescription Drugs: MedImpact

Phone:	800-788-2949
Web:	medImpact.com/members
Claims Address:	Attn: Claims Dept. 10680 Treena St., 5th Floor San Diego, CA 92131

- What's covered
- Questions about medications, formulary and prior authorization
- Finding a MedImpact network pharmacy
- Disagreement about claims payment

Blue Cross HMO and Blue Cross PPO | Mail Order Prescription Drugs: MedImpact Direct

Phone:	855-873-8739 (TTY dial 771)
Email:	customerservice@medimpactdirect.com
Web:	medimpactdirect.com
Specialty Drugs:	877-391-1103
Email:	specialtyhub@medimpactdirect.com

- Mail order prescriptions

Contact...		For information about...
Dental		
DeltaCare USA		
Phone:	800-422-4234	• What's covered • Preauthorization • Disagreement about claims payment • Group number: 75012
Web:	deltadentalins.com	
Claims Address:	Customer Service P.O. Box 1803 Alpharetta, GA 30023 Claim Forms P.O. Box 1810 Alpharetta, GA 30023	
Delta Dental PPO		
Phone:	800-765-6003	• What's covered • Preauthorization • Disagreement about claims payment • Group number: 05356
Web:	deltadentalins.com	
Claims Address:	Attn: Customer Service Department P.O. Box 997330 Sacramento, CA 95899	
Vision		
Blue View Vision (Anthem)		
Phone:	866-723-0515	• What's covered • Preauthorization • Disagreement about claims payment • Group number: – Cedars-Sinai: 1858RR – Medical Network (Foundation): 1858RU
Web:	anthem.com/ca	
Claims Address:	Anthem Blue View Vision P.O. Box 8504 Mason, OH 45040-7111	

Contact...		For information about...
Spending Account Benefits		
TRI-AD		
Phone:	855-460-6971	• Wellness incentive activities documentation and HRA claims • Healthcare flexible spending account • Child/adult care flexible spending account • Account balances • TRI-AD debit cards • Disagreement about benefit reimbursements
Hours:	Monday–Friday 5 a.m.–6 p.m. PT	
Fax numbers:	866-233-4741 (for wellness incentive activities documentation) 844-791-8318 (for HRA or healthcare FSA claims)	
Web:	tri-ad.com	
App:	TRI-AD Benefits on the Go Android/iPhone/iPad mobile app	
Claims Address:	TRI-AD Reimbursement Plans Department 221 West Crest Street, Suite 300 Escondido, CA 92025-1737	
Basic and Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance		
Voya Life		
Phone/email:	For death benefits: 844-893-2115 For accelerated death and AD&D benefits: 913-638-9866; molly.wymore@voya.com	• Disagreement about claims payment • Plan numbers for life insurance: – 70080-1GAT1 (CS Staff+ MN Staff) – 70080-1GAT2 (Executives, Cedars-Sinai Faculty and Directors, Medical Network (Foundation) Medical Directors and Executive Directors) – 70080-1GAT2 (Physicians, PhD Faculty, Research Scientists, Managers) – 70080-1GAT2 (Physicians in Training) • Plan number for AD&D Insurance: – 70080-1PAI (All groups)
Claims Address:	Voya Life Claims P.O. Box 1548 Minneapolis, MN 55440	
Overnight Address:	Voya Life Claims 20 Washington Ave. South, Minneapolis, MN 55401	

Contact...		For information about...
Disability Insurance		
Reliance Standard		
Phone:	To ask questions, call customer service: 800-351-7500 Monday–Friday 5 a.m.–4 p.m. PT	• Disability benefit claims • Disagreement about disability claims payment • Long Term Disability (LTD) group policy number: LSC 100,002—Participating Unit No. LTD 128787 – Class 1: Cedars-Sinai Staff – Class 2: Executives, Cedars-Sinai Faculty and Directors, Medical Network (Foundation) Medical Directors and Executive Directors and Cedars-Sinai Managers, Physicians, PhD Faculty and Research Scientists – Class 3: MN Staff and MN Managers – Class 4: Physicians in Training • Short Term Disability (STD) group policy number: G 100,003—Participating Unit No. STD 165574 – Class 1: Physicians in Training
Web:	To submit claims online: reliancestandard.com/cedars-sinai	
Leaves of Absence and Disability		
Cedars-Sinai Leave and Disability Management		
Email:	myHR@cshs.org	• Leaves of absence and time away from work
Fax:	310-473-0018	
Intranet:	csmc.service-now.com/cssp/id=cs_home	
Leaving Cedars-Sinai Employment | COBRA		
TRI-AD		
Phone:	855-460-6971	• COBRA continuation coverage • Update address after leaving Cedars-Sinai
Hours:	Monday–Friday 5 a.m.–6 p.m. PT	
Fax:	760-233-4742	
Email:	cobmail@tri-ad.com	

Contact...		For information about...
Mailing Address:	TRI-AD Continuation of Benefits Department, P.O. Box 2059 Escondido, CA 92033	
Web:	tri-ad.com/cobra	

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WHAT'S INSIDE

This "wrap" Summary Plan Description (SPD) covers healthcare, the wellness incentive contribution, insurance and flexible spending account (FSA) benefits. It includes information such as:

- Eligibility and enrolling for coverage
- When coverage begins and ends
- When you can change benefits
- Coverage during leaves
- Coverage continuation
- Taxes on benefits
- Choosing beneficiaries
- Eligibility and enrollment claims and appeals, and
- Legal information and your rights.

Tiene preguntas o necesita ayuda?

Si tiene preguntas de los beneficios que le ofrece Cedars-Sinai o de como enrolarse a ellos, el Centro de Ayuda MBC HR tiene representantes en Español para asistir con cualquier duda o pregunta.

Favor de llamar al 888-302-3941 o mande un correo electrónico a MBC.cshs@milliman.com.

Questions about your benefits?

Contact the MBC HR Employee Benefits Help Desk

Phone:	888-302-3941 Monday–Friday, 5 a.m.–5 p.m. PT (Closed major holidays)
Fax:	206-299-3158
Email:	MBC.cshs@milliman.com
Web:	Cedars-Sinai.MyBenefitChoice.com

Details about benefits (such as what's covered, copays and how to submit claims) are in the benefit booklets, certificate or policy of insurance booklets or other documents issued by the insurers/claims administrators, as listed in the following table and included as attachments. Together, this Summary Plan Description (SPD) and those documents (referred to in this SPD as "benefits booklets") are the SPD for your healthcare, wellness incentive contribution, insurance and FSA benefits. The SPDs for retirement benefits are separate. You can also find out more about your benefits in the Benefits Reference Guide.

If you're enrolling for Cedars-Sinai benefits for the first time, see your personalized enrollment checklist to find out which benefits you can enroll in. If you're already enrolled and want to check which benefits you're enrolled in, see your most recent confirmation statement or go to Cedars-Sinai.MyBenefitChoice.com and click View Benefits. For assistance, call the MBC HR Employee Benefits Help Desk at 888-302-3941.

Summary Plan Description Controls

Every effort has been made to ensure the information in this SPD is complete and accurate. If there is a conflict between the formal plan document and the attached benefits booklets, the formal plan document will govern with regard to enrollment and eligibility and the attached benefits booklets will govern with regard to other issues such as covered services and claims/appeals, unless otherwise required by law. In addition, if there is a conflict between this SPD and the formal plan document, the terms of the SPD document will govern. No participant or beneficiary will have any right to a benefit beyond that specifically described in this document or applicable benefit booklet.

Benefit Plan	See the Attachment for Benefit Description	Payment Responsibility	Who Can Be Covered
Medical Benefits (including prescription drug benefits)	**Attachment 1**: Vivity HMO, including prescription drug benefits through IngenioRx (in Los Angeles and Orange counties) **Attachment 2**: Blue Cross HMO (in California) **Attachment 3**: Blue Cross PPO (in or outside California) **Attachment 4**: MedImpact Prescription Drugs (for those in Blue Cross HMO and Blue Cross PPO medical plans)	Shared between you and Cedars-Sinai, usually pretax*	Employees and eligible dependents
Dental Benefits	**Attachment 5**: DeltaCare USA **Attachment 6**: Delta Dental PPO	Shared between you and Cedars-Sinai, usually pretax*	Employees and eligible dependents
Voluntary Vision	**Attachment 7**: Blue View Vision (Anthem)	You pay 100%, usually pretax*	Employees and eligible dependents
Basic and Supplemental Life Insurance	**Attachment 8**: Basic and Supplemental Life Insurance	Basic: Cedars-Sinai pays 100% Supplemental: You pay 100%	Basic: Employees Supplemental: Employees and eligible dependents
Basic and Supplemental Accidental Death & Dismemberment Insurance	**Attachment 9:** Basic and Supplemental AD&D Insurance	Basic: Cedars-Sinai pays 100% Supplemental: You pay 100%, after tax	Basic: Employees Supplemental: Employees and eligible dependents
Basic Short Term Disability Insurance	**Attachment 10**: Basic Short Term Disability	Cedars-Sinai pays 100%	Physicians-in-training
Basic Long Term Disability Insurance	**Attachment 10:** Basic Long Term Disability	Cedars-Sinai pays 100%	Employees

Benefit Plan	See the Attachment for Benefit Description	Payment Responsibility	Who Can Be Covered
Supplemental Long Term Disability Insurance	**Attachment 10:** Supplemental Long Term Disability	You pay 100%, after tax	Cedars-Sinai staff
Repatriation of Remains and Medical Evacuation Expense Insurance	**Attachment 11:** Medical Evacuation Plan	Cedars-Sinai pays 100%	Foreign national employees in the Exchange Visitor Program who meet the eligibility requirements
MetLife Legal Plan	**Attachment 12**: Legal Plan	You pay 100%	Employees
Wellness Incentive Contribution	Included in this SPD	Cedars-Sinai pays 100%	Employees
Flexible Spending Accounts (FSAs) • **Healthcare FSA** • **Child/Adult care FSA**	Included in this SPD	You pay 100%, pretax	Employees

* Premiums for per diem employees, domestic partners and their children are after tax.

ELIGIBILITY

EMPLOYEES

The following groups of employees are eligible for coverage in some, or all, of the healthcare, insurance and spending account benefits described in this SPD.

Benefits-Eligible Employees

- Employees of a Cedars-Sinai employer, which includes Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (usually referred to as Cedars-Sinai Medical Network), who are regularly scheduled to work 20 or more hours per week.
- This group includes SEIU United Healthcare Workers West employees, but no other bargaining units.

Employment Services Agreement Employees

- Employees under a written employment services agreement with a Cedars-Sinai employer
- This group includes physicians in training.

Even if you are eligible for coverage, not all benefit programs may be available to you. Some benefit programs are available only to specific groups of eligible employees or to employees and dependents who live within the coverage service area.

Per Diem Employees

Employees classified as per diem under normal payroll practices can enroll in the Blue Cross HMO on a self-pay basis but are not eligible for any other benefits under this plan.

Employees Generally Not Eligible for Benefits

Employees in the following classifications under normal payroll practice are not eligible for any benefits under this plan:

- Part-time (regularly scheduled less than 20 work hours a week)
- Visiting scientists
- Temporary employees, employees working on a project basis or less than full-time faculty
- Not in a benefits-eligible position, but may be covered for medical benefits, dental benefits and/or life insurance through Silver Passport
- Leased employees (as defined in section 414(n) of the Internal Revenue Code of 1986), consultants, independent contractors, non-resident aliens and others not considered employees, including any person Cedars-Sinai does not treat as a common-law employee (including but not limited to independent contractors, persons the Cedars-Sinai employer pays outside of its payroll system and outsourced workers) for federal income tax withholding purposes, regardless of any determination by any court or administrative agency or other entity that the individual is an employee or a leased employee
- Employees of a Cedars-Sinai employer who are covered by a collective bargaining agreement but have not bargained to be covered under Cedars-Sinai benefits (except for SEIU United Healthcare Workers West employees)
- Employees in the active service of the armed forces of any country or subdivision of any country
- Marina Del Rey Hospital employees.

FAMILY MEMBERS

If you are an eligible employee, you may cover your spouse or domestic partner (DP), your children and your spouse's/DP's children, as defined in this section.

It is your responsibility to make sure your family members meet the eligibility requirements before you enroll them. Cedars-Sinai reserves the right to conduct ongoing eligibility audits and to seek reimbursement of any benefits paid for individuals who are enrolled in the plan but not eligible.

Your Spouse

Your opposite or same-sex spouse is eligible to be covered under these benefits if you provide evidence of marriage. If you cannot provide evidence of marriage, you are required to meet the qualifications for domestic partnership and complete a domestic partner affidavit.

Your Domestic Partner (DP)

Under the Cedars-Sinai policy, DPs are defined as two adults (same or opposite sex) who reside together, sharing their lives in an intimate and committed relationship with a mutual obligation of support. For your DP to be eligible for benefits, you must either:

- Be publicly registered as domestic partners under state or local law, or
- Complete (and have notarized) a Cedars-Sinai DP affidavit, and meet all of the following criteria:
  - Have been sharing a common residence* for at least six months and intend to do so indefinitely
  - Are not related by blood to a degree of closeness that would prohibit marriage
  - Have assumed mutual responsibility for basic living expenses*
  - Are at least age 18 and capable of consenting to the domestic partnership
  - Are not married to anyone else or in a declared domestic partnership with anyone else.

*Although you don't have to show proof of common residence or evidence of joint responsibility for basic financial obligations to enroll, the insurance company may require it before paying claims.

If you're in a new domestic partnership, your DP (and children) become eligible for benefits on the date you:

- Have lived together for six months, or
- Received your state- or local-issued domestic partnership certificate.

Within 30 days from the date your DP becomes eligible, you must:

- **Enroll online** at Cedars-Sinai.MyBenefitChoice.com (from the Benefits Portal home page: > BENEFITS ENROLLMENT SITE > VIEW YOUR BENEFITS > MAKE CHANGES > CREATE LIFE EVENT > SELECT "DOMESTIC PARTNER—NEW")
  or
- Enroll by calling the MBC HR Employee Benefits Help Desk at 888-302-3941.

You then have an additional 15 days (45 days total from the date your partner becomes eligible for benefits) to complete and return a DP affidavit or send a copy of your domestic partnership registration to the MBC HR Employee Benefits Help Desk and enroll your DP and/or their children. If you miss this deadline, you must wait until the next open enrollment period to enroll your DP and/or their children. If you don't meet the criteria, your DP (and/or children) cannot be covered.

Documentation required for family coverage

When you enroll family members, you are required to provide documentation that they are eligible for coverage (based on their relationship to you).

You may upload the documentation to the enrollment site or send it to the MBC HR Employee Benefits Help Desk within 45 days of the date the benefits start; otherwise, your family member cannot be covered. See Qualified Life Events starting on page 23 for acceptable documents.

You will also be asked to enter their Social Security Number (SSN) or Federal Tax ID Number. If your dependent does not have an SSN or Federal Tax ID number, you'll be required to complete a pop-up screen indicating the reason you're not providing the ID number.

Contact the MBC HR Employee Benefits Help Desk at 888-302-3941 with questions.

Your Children

You can cover children until age 26 if they are your or your current spouse's/DP's:

- Biological children
- Stepchildren (the children of your current spouse/DP)
- Adopted children
- Children placed with you for adoption
- Children for whom you are the legal guardian
- Children a court ordered you to cover under your healthcare plan including a Qualified Medical Child Support Order (QMCSO); Cedars-Sinai determines whether an order qualifies as a QMCSO; you can obtain a free copy of QMCSO procedures by emailing GroupHRBenefits@cshs.org.

Children age 26 and older can be covered if, at the time your child turns age 26, in addition to meeting the above requirements for children under age 26, all the following apply:

- A doctor certifies in writing that they are incapable of getting a self-supporting job because of a physical or mental condition (and the certification is approved by the insurance company).
- They are unmarried and chiefly dependent on you or your spouse/DP for support and maintenance.
- They have six months of creditable coverage or were already covered under Cedars-Sinai benefits when they turned age 26.

If you do not submit your request, and any requested certification of disability or dependent status, within 30 days of your child's 26th birthday, your child will not be eligible to continue coverage. You cannot enroll your child later, and if you drop coverage for your child following his or her 26th birthday, you cannot under any circumstances re-enroll your child. You must submit the doctor's certification to the insurer/benefit provider within 30 days of request (or a later deadline, if provided by the insurance company). To continue coverage, you may have to provide the doctor's certification once a year. To get the Anthem Physician Certification form, call the customer service number on your Anthem ID card. For an application to continue Supplemental Child Life Insurance, contact the MBC HR Employee Benefits Help Desk.

Family Members Not Eligible for Coverage

You cannot enroll the following family members, even if they otherwise meet the eligibility requirements described in this section:

- Other family members (like parents, aunts, etc.), even if they are legal dependents
- Foster children*
- Grandchildren*
- Stepchildren* from a former spouse/DP

  ** These children can be covered only if you are their legal guardian or a court ordered you to cover them under your healthcare plan (including a QMCSO).*
- Family members in active service of the armed forces of any country or subdivision of any country
- Family members living outside the U. S. (in this context, U.S. includes the 50 states, District of Columbia, Commonwealth of Puerto Rico, U.S. Virgin Islands, Northern Mariana Islands, Guam and American Samoa). If otherwise-eligible family members lawfully enter the U.S. (or any of the U.S. territories noted above), you then may enroll them in your benefits coverage, if you contact the MBC HR Employee Benefits Help Desk within 30 days of entry (see Family Member Becomes Eligible for Coverage on page 25 for details).
- Family members who are already covered; if you and/or your spouse/DP and/or child work at Cedars-Sinai and enroll as an employee, you cannot be enrolled as a dependent at the same time (or vice versa); in addition, children can be enrolled as a dependent under only one parent's coverage.

Note: If you enroll someone who is not eligible or you keep someone on benefits when they are no longer eligible (for example, your ex-spouse after a divorce), it will be treated as fraud, misrepresentation or intentional misrepresentation of material fact and when discovered, their coverage will be canceled. If canceled retroactively, you may have to repay premiums or benefits to

Cedars-Sinai or the insurer/claims administrator that paid claims for or benefits to the person you fraudulently enrolled. You will not be refunded for any premiums you paid.

ENROLLING IN OR CHANGING BENEFITS

ENROLL ONLINE

Cedars-Sinai-sponsored healthcare, insurance and FSA benefits enrollment is online.

Enroll online at
Cedars-Sinai.MyBenefitChoice.com

You can enroll from most computers with internet access. If you have any difficulty using the website, try logging in and enrolling from your home computer or tablet, or just call the MBC HR Employee Benefits Help Desk and they can enroll you over the phone.

MBC HR Employee Benefits Help Desk
Phone: 888-302-3941
Email: MBC.cshs@milliman.com

For details about earning a wellness incentive, see Wellness Incentive Contribution starting on page 44.

YOUR SHARE OF COSTS

Although Cedars-Sinai pays most of your benefit costs, you pay a portion of your monthly medical and dental premiums, and 100% of any supplemental benefits you elect to purchase (such as voluntary vision or supplemental life insurance). Any changes to premiums or benefits are announced each year in the open enrollment materials, and premiums are shown on the website so that you can see your costs before enrolling.

The attached benefit booklets contain details about plan benefits and limitations. The Vivity HMO, Blue Cross HMO, Blue Cross PPO, Delta Dental and Blue View Vision booklets also include general descriptions of network providers (go to their website for network provider names, credentials and contact information), coverage of preventive services, conditions or limits on selection of primary care providers or specialists, conditions or limits on obtaining emergency care, preauthorization requirements and more.

REQUIRED DOCUMENTATION FOR FAMILY MEMBERS

Evidence of Eligibility

To enroll your family member, you are required to provide the MBC HR Employee Benefits Help Desk with proof that your family member is eligible.

Deadline applies! If you don't provide documents showing your family member is eligible within 45 days of the date benefits start, their coverage will not become effective. See Qualified Life Events starting on page 23 for documents that can be provided.

Social Security Number for Medical Benefits

To cover your dependents for medical benefits, you must provide their Social Security Number (SSN), Federal Tax ID Number or complete the pop-up screen indicating the reason why you are not providing it when you enroll on Cedars-Sinai.MyBenefitChoice.com. Contact the MBC HR Employee Benefits Help Desk with questions.

We send SSNs to Anthem, who must report SSNs to the Centers for Medicare & Medicaid Services so that CMS can coordinate payments for employees (and family members) who also receive medical coverage through government programs like Medicare, Medicaid or a state Children's Health Insurance Program. We must also send SSNs to the IRS for required reporting under the Affordable Care Act.

BENEFIT RULES TO KNOW BEFORE ENROLLING

This section describes things you need to know when you enroll, including what you must do to be covered, benefit waiting periods and service areas. Detailed descriptions of the benefits covered are in the insurance company booklet in the attachments.

Healthcare Plans Premium Payment Program

If you enroll in a Cedars-Sinai medical or dental benefit plan, or in voluntary vision, you automatically become a participant in the healthcare premium payment program, which means:

- The amounts deducted from your pay for plan premiums are not taxed (except for certain domestic partner coverage – see below).
- In addition, the amounts Cedars-Sinai pays for your premiums are not taxed.

There are exceptions if you cover a domestic partner and/or their children under your healthcare benefits. See Taxes on Benefits on page 53 for details.

Deductibles and Limits Follow the Calendar Year (Not the July 1–June 30 Benefit Year)

Although healthcare coverage starts each July 1, medical, dental and voluntary vision plan deductibles, out-of-pocket maximums and limits run on a calendar year basis (Jan. 1 to Dec. 31). This means that the first year you're enrolled in one of these plans, you may have to pay the calendar-year deductible, or any limit or maximums would start again after six months. For instance, the Blue Cross PPO requires a calendar-year deductible before the plan starts paying benefits. If you enrolled in the PPO starting July 1 and paid the calendar-year deductible between July 1 and Dec. 31, starting Jan. 1 you would have to pay the calendar-year deductible again, before the PPO starts paying benefits again.

Elections last for one year

Your healthcare, insurance and FSA elections last through the next June 30. You cannot change your benefit elections until the next open enrollment (for a July 1 start date), unless you have a qualified life event allowing a benefit change. See page 23 for details.

What You Should Know Before Enrolling in Medical

HMOs Have Limited Service Areas

The Vivity HMO service area is limited to L.A. and Orange counties only. The Blue Cross HMO service area is limited to California. If you live outside California, your only Cedars-Sinai sponsored medical plan option is the Blue Cross PPO.

If you live in California but a covered family member lives outside of the state (for instance, a child away at college), before enrolling in the Blue Cross HMO or Vivity HMO you may want to check into the Blue Cross Blue Shield guest membership program. The guest membership program is available in 33 states. Call Anthem's guest membership coordinator at 800-827-6422 to find out if it's available where your family member resides.

HMOs Require a Primary Care Provider (PCP)

When you first enroll in the HMO you will have the opportunity to sign up for a PCP in the HMO network who is taking new patients. For children, you can designate a pediatrician as their PCP. You and your family members do not have to enroll in the same medical group.

If you don't select a PCP when you first enroll, Anthem will assign you one close to your home (or for children under age 18, a pediatrician).

Your PCP will be part of a contracting medical group. There are two types of medical groups.

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other healthcare providers.
- An independent practice association (IPA) is a group of doctors in private offices who usually have ties to the same hospital.

You do not need a referral or prior authorization to get obstetrical or gynecological care from an OB-GYN specialist in your medical group. The OB-GYN, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact Anthem (see the contact information below.) You can change your PCP (or medical group) anytime, unless you are in a course of treatment with your current PCP. You may not change PCPs (or medical groups) until after the course of treatment is completed, except during open enrollment (for a July 1 effective date).

Go through Anthem to change your PCP:

Blue Cross HMO	Vivity HMO
• Phone: 833-913-2238	• Phone: 844-659-6878
• Web: anthem.com/ca	• Web: anthem.com/ca

Log in (or register on your first visit) to access your personal information, including changing your PCP.

Finding a PCP

Use the Find A Doctor search tool at anthem.com/ca. (Both the Blue Cross HMO and Vivity HMO are Anthem medical plans.)

When selecting the criteria in the Find a Doctor search tool, you'll be asked to select a plan/network. Choose either:

- Blue Cross HMO (CACare) – Large Group, or
- Vivity HMO.

Be sure to check the box that says "Able to Serve as Primary Care Physician" when selecting the criteria for your search.

When you find a doctor you want to be your PCP, click on the doctor name hyperlink to see that doctor's group practice and hospital affiliation(s) (note that some doctors are in several group practices). Remember, if you need medical services your PCP does not provide, your PCP will refer you to doctors and specialists in that same group practice. You will be referred to facilities that contract with that group practice. You will receive hospital services only from the hospital affiliations listed there (except for emergencies).

To receive Cedars-Sinai hospital services, you must select a PCP with Cedars-Sinai Medical Group™ (CSMG) or Cedars-Sinai Health Associates™ (CSHA). Some doctors are in several group practices. Click on the Doctor's Name hyperlink to find out which hospitals and group practices the doctor is affiliated with.

Pharmacy Benefits

When you enroll in a Cedars-Sinai medical plan, you're automatically covered by a prescription drug plan:

- Vivity HMO pharmacy benefits are through Anthem—See the attached **Anthem Vivity HMO** booklet for more information.
- Blue Cross PPO and Blue Cross HMO pharmacy benefits are through MedImpact—See the attached **MedImpact Prescription Drug Benefit** booklet for more information.

What You Should Know Before Enrolling in Dental

If You Live Outside of California

The Delta Dental PPO is your only out-of-state option. As an HMO, the DeltaCare USA plan service area is limited to California.

DeltaCare USA Requires a Primary Dentist

You can select your primary dentist for yourself and each covered family member when you enroll online. If you don't select a primary dentist when you first enroll, DeltaCare USA makes a default selection for you. If you'd like a different primary dentist, you can use the online provider finder at deltadentalins.com (choose the DeltaCare USA plan), and then call Delta at 800-422-4234 to change your primary dentist.

What You Should Know Before Enrolling in Flexible Spending Accounts (FSAs)

Annual Enrollment Required

Unlike other healthcare and insurance elections that carry over from year to year, you must re-enroll each year in the FSAs. If you don't re-enroll during open enrollment, your participation ends June 30.

Use it or Lose it

Cedars-Sinai offers two types of FSAs—a healthcare FSA and a child/adult care FSA. When deciding how much to contribute to the FSAs, estimate your expenses very carefully. In general, FSAs have a "use it or lose it" rule—use every dollar you contribute each year or forfeit it. The one exception is that the healthcare FSA allows up to $550 to rollover from this plan year to next. See page 45 for more details about FSA rules.

Funds cannot be transferred between the FSAs. Any forfeited funds are used to pay for FSA administration and may be used in any manner permitted by applicable law.

Medical Coverage Not Required for Healthcare FSA

You don't have to be covered by a Cedars-Sinai medical plan to enroll in the healthcare FSA. Plus, you can use your healthcare FSA to pay for the eligible healthcare expenses of your tax dependents (or children under age 26 at the end of the calendar year), even if they aren't eligible to enroll in a Cedars-Sinai healthcare plan.

Possible Refund/Reduced Contributions

Under federal tax regulations, the FSAs must pass various tests annually to ensure higher-paid participants don't receive more value than lower-paid participants. For example, a child/adult care FSA is considered to unfairly favor higher-paid participants if, as a group, they receive more than 25% of all non-taxable benefits provided by the FSA.

The healthcare and child/adult care FSAs are tested separately each year. If either/both do not pass, Cedars-Sinai must refund contributions to higher-paid participants, which become subject to income and Social Security/Medicare taxes. Cedars-Sinai reserves the unilateral right at any time to modify elections (for example, to limit contribution amounts) to satisfy the Internal Revenue Code's non-discrimination testing requirements.

To prevent having to refund child/adult care FSA contributions to pass these tests, Cedars-Sinai limits contributions for higher-paid participants.

Annual Contribution Limits

To avoid having to return FSA contributions to higher-paid participants, each year before open enrollment Cedars-Sinai determines in its sole discretion (subject to IRS rules) the maximum amount employees may contribute to the FSAs. These amounts are communicated to participants annually in the open enrollment materials. However, there is no guarantee that higher-paid participants will not be refunded contributions if the necessary tests are not passed.

Child/Adult Care FSA Tax Considerations

Federal tax regulations also make available a tax credit for deductible dependent care expenses. Before you enroll in the FSA, you may wish to investigate the federal tax credit and see which provides the greater benefit. You may even be able to use both the child/adult care FSA and federal tax credit, but not for the same expenses. See IRS Publication 503 for more information or ask your tax advisor which is better for you.

- Filing your income tax return—If you participate in the child/adult care FSA, you must complete an IRS Form 2441 (Child and Dependent Care Expenses) and attach it to your federal income tax return Form 1040. If you use a 1040A, attach a Schedule 2. On the form, you show expenses reimbursed through the account.
- Additional rules to consider—There are some child/adult care FSA reimbursement eligibility rules about your marital status, dependent age and the portion of the year the dependent lives in your home to consider. See Spending Your Child/Adult Care FSA on page 49. Review these rules carefully to ensure that you will be able to claim reimbursement from your account. If your claims are not eligible, you will forfeit any unspent amounts at the end of the year.

Evidence of insurability (EOI) form may be required

If you (or your spouse) apply for new or additional supplemental life insurance, you may need to complete an EOI form and receive approval from our life insurance carrier, Voya Life. Voya Life will mail this form to your home address at the end of your enrollment period. You'll have 35 days to submit a completed form to Voya Life; otherwise, the application for this new or additional amount will be closed.

What You Should Know Before Enrolling in Insurance Coverage

Supplemental Life Insurance for Your Spouse/Domestic Partner (DP)

You must purchase supplemental employee life insurance for yourself to purchase life insurance for your spouse/DP (this does not apply to coverage for your children).

The maximum amount of supplemental spouse life insurance you may purchase is 50% of your supplemental life insurance amount ($200,000 maximum)**.**

You can enroll for supplemental life insurance (employee, spouse and/or child) without filling out an Evidence of Insurability (EOI) form or receiving insurer approval ONLY in the following situations:

- **The first time you're eligible for benefits**, you can apply for up to the **guaranteed issue** amounts of coverage without insurer approval:

Guaranteed Issue	
Employee:	2 x annual base pay up to $2 million
Spouse:	$25,000

  If you apply for more than the guaranteed issue during this initial enrollment, you receive the guaranteed issue coverage amount until your additional coverage is approved by the insurer. If the insurer denies the additional coverage amount, you'll be able to keep the guaranteed issue amount in coverage.
- **If you already have supplemental employee life insurance equal to 1 x annual pay**, you can increase your coverage to 2 x annual base pay during open enrollment (described starting on page 23).

Supplemental Life Insurance for Your Children

You do not need to purchase supplemental employee life insurance for yourself in order to purchase life insurance for your children).

When you enroll in supplemental life insurance for your children, one premium covers all your eligible children. Supplemental child life insurance may be purchased in increments of $2,500 up to a maximum of $10,000.

Supplemental life insurance for children does not require EOI.

Supplemental life insurance for your children will be terminated when your youngest child on record turns age 26. Keep your dependent list up to date on the enrollment site to be sure coverage isn't cancelled too soon or too late.

When Supplemental Life and AD&D Rates Change

Your supplemental life insurance (employee, spouse and/or child) and supplemental AD&D insurance premiums are set each July 1, based on your annual pay as of May 1 and age on July 1, and remain the same through the next June 30.

If your pay rate changes, your premiums will not change until the next July 1. However, your coverage will change to mirror your new pay rate. Increases take effect the first day of the next month (or that day, if the pay change is effective the first day of the month). Pay decreases take effect immediately.

Actively at Work Requirement

You must be actively at work for coverage to start under the following plans: basic life insurance, supplemental life insurance (employee, spouse and/or child), basic AD&D insurance, supplemental AD&D insurance, basic long term disability (LTD) insurance and short term disability (STD) insurance (physicians in training only). See Not Actively at Work on page 35 for details.

In addition, for supplemental spouse or child life insurance to start, your family members may not be confined at home under a physician's care, hospitalized, or receiving (or applying to receive) disability benefits from any source.

If you are on a leave of absence and applying for new or increasing existing supplemental employee or spouse life insurance because of a qualified life event (such as the birth or adoption of a child), you must apply within 30 days of the date of birth or placement. Coverage will not go into effect until you return to work from the leave.

Pre-Existing Condition Exclusion for Disability

During your first 12 months of coverage, long term disability (LTD) insurance (and STD insurance for physicians in training) does not cover conditions you've had for three months before your coverage started; it does cover new conditions. See the attached LTD (and STD) insurance booklet for more information.

Not Part of the Healthcare, Insurance and Spending Account Benefits

Auto & Home Insurance and Pet Insurance

These insurance policies are not part of Cedars-Sinai's plan or enrollment process. The insurance companies offer these programs at discounted rates to Cedars-Sinai employees, but they are individual insurance policies, not group insurance. The insurance company will review your application and decide whether or not to insure your auto and/or home or pet.

Apply directly to the insurance carrier for auto or home insurance and for pet insurance, any time after the first of the month following your hire date (when they can identify you as a Cedars-Sinai employee). They will not be able to offer the Cedars-Sinai discount or payroll deduction before then.

Legal Plan

The Legal Plan is an ERISA plan providing group legal services and is included in this SPD. You may enroll (or drop coverage) online through Cedars-Sinai.MyBenefitChoice.com during the permitted enrollment periods. Refer to the Employee Benefits Reference Guide for more information regarding the Legal Plan.

The Legal Plan does not cover legal matters already in progress or for which you've already hired an attorney when your coverage starts. See the Legal Plan booklet for details.

BENEFITS THAT REQUIRE ENROLLMENT

Cedars-Sinai pays for some of your benefits, and those benefits start automatically. Other benefits require you to pay some or the entire premium; you must enroll in those benefits.

Benefits that start automatically:

- Medical
  If you don't enroll in a Cedars-Sinai medical plan or attest to having coverage elsewhere, you'll be automatically enrolled for employee-only medical coverage based on your home address:

Home Address:	Default Medical Plan:
Vivity HMO service area (generally L.A. and Orange counties)	→ Vivity HMO
In California, but not in the Vivity HMO service area	→ Blue Cross HMO
Outside California	→ Blue Cross PPO

- Basic life insurance (Cedars-Sinai paid)
- Basic AD&D insurance (Cedars-Sinai paid)
- Basic LTD insurance (Cedars-Sinai paid)
- Short term disability insurance (Cedars-Sinai paid; physicians in training only)
- Healthcare premium payment program (for pretax premiums), if you have medical, dental or vision benefits.

Benefits you must enroll in to be covered:

- Dental benefits
- Voluntary vision benefits
- Supplemental life insurance (for employee, spouse and/or children until age 26)
- Supplemental accidental death & dismemberment (AD&D) insurance
- Supplemental long term disability (LTD) insurance (Cedars-Sinai non-management employees only)
- Legal plan.

Once you enroll, your coverage for the benefits listed above will usually roll over from year to year, and you will not be required to re-enroll in these benefits.

You must re-enroll in the flexible spending accounts every year to continue participation:

- Healthcare FSA
- Child/Adult Care FSA.

To receive the annual wellness incentive contribution, you must:

- Be covered by a Cedars-Sinai medical plan, and
- Complete the required healthy activities for the current benefit year within the given deadline.

Flexible Spending Account elections *do not* roll over

FSA enrollment does not roll over from year to year. You must re-enroll in FSAs during open enrollment each year to continue to participate.

WHEN YOU MAY ENROLL OR CHANGE BENEFITS

Enrollment Periods

You may enroll yourself or your family members (or change benefits or drop coverage):

- Within 30 days of being hired or first becoming eligible for benefits, or upon rehire or reinstatement
- During open enrollment
- Within 30 days of having a special enrollment right or qualified life event that changes your eligibility for benefits or 60 days of gaining state Children's Health Insurance Program (CHIP) or Medicaid assistance (see details on page 22).

Enrolling for the First Time

When you first start working at Cedars-Sinai, you receive information about benefits in several stages. When you are first hired, you receive a Benefits Reference Guide from your HR recruiter. If you didn't receive it or misplaced it, you can get another one online at Cedars-Sinai.MyBenefitChoice.com or from the MBC HR Employee Benefits Help Desk (call 888-302-3941 or email MBC.cshs@milliman.com).

During your first weeks of employment (or upon being rehired or changing to or from a benefits-eligible position or job transfers that change eligibility for certain benefits), an enrollment packet is mailed to your home. You have until that deadline noted in the packet to enroll.

Enroll by computer at Cedars-Sinai.MyBenefitChoice.com. You will need to register on your first visit (using company code CSHS). If you have any difficulties using the website, call the MBC HR Employee Benefits Help Desk at 888-302-3941 and they can enroll you over the phone.

Coverage start dates vary by situation; see When Coverage Starts on page 33 for details.

Confirmation Statement

At the end of your enrollment period, you will receive a confirmation statement mailed to your home showing your benefits through the end of the benefit year (June 30). Please check your confirmation statement to make sure you're enrolled in the correct benefit plans and family members are covered (check your paycheck deductions, too). If the information does not accurately reflect your benefit choices, contact the HR Employee Benefits Help Desk immediately.

If you don't enroll by the enrollment due date, or if your benefit elections are incorrect and you don't call the MBC HR Employee Benefits Help Desk to correct them, you cannot make changes until the next open enrollment (unless you have one of the special enrollment right situations or qualified life events described starting on page 23).

Open Enrollment

Open enrollment is held each year during May for coverage that starts the following July 1. Healthcare, insurance and FSA benefits follow Cedars-Sinai's fiscal year: July 1 to June 30. Once you enroll, your healthcare and insurance benefit elections *usually** carry over from year to year (without the need to re-enroll), except for the FSAs which require annual enrollment. If you wish to add or drop eligible family members, switch plans or coverage amounts, you can make these changes during open enrollment.

Before open enrollment starts, Cedars-Sinai will send you an enrollment packet with information about changes to benefits for the upcoming benefit year.

* *Usually*, but not always. There may be times when you will be required to affirmatively enroll or re-enroll to continue certain benefits coverage. If enrollment (or re-enrollment) is required, you will be notified in open enrollment materials.

Confirmation Statement

Following the enrollment period, you will receive a confirmation statement mailed to your home showing your benefit elections for the next benefit year. A statement is sent to everyone eligible to enroll, whether or not you made any benefit changes during open enrollment.

If there is a mistake in your elections, you have until the last working day in June to call the MBC HR Employee Benefits Help Desk and make corrections. If you miss that deadline, you cannot change your benefits until the following year's open enrollment (unless you have one of the special enrollment right situations or qualified life events, described starting on page 23).

CHANGING BENEFITS WHEN YOUR LIFE, JOB OR INSURANCE CHANGES

Special Enrollment Rights

In the following situations, you have special enrollment rights and don't have to wait until the next open enrollment to enroll:

- **Loss of other group healthcare coverage:** If you are an active, benefits-eligible employee who did not enroll in Cedars-Sinai healthcare coverage for yourself or eligible family members because you had other coverage, you may be able to enroll in a Cedars-Sinai plan if you lose that other coverage (or if the employer stops contributing toward your or your family member's coverage). To enroll you must contact the MBC HR Employee Benefits Help Desk within 30 days after your other coverage ends and provide proof that you were covered and provide the coverage dates.
- **New family members:** If you have new family members who are eligible because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible family members. To enroll, you must contact the MBC HR Employee Benefits Help Desk within 30 days after the marriage, birth, adoption or placement and provide documentation of eligibility.
- **CHIP or Medicaid assistance**: If you or your eligible family members gain financial assistance for Cedars-Sinai healthcare contributions through a state Children's Health Insurance Program (CHIP) or Medicaid, or you are covered under CHIP or Medicaid and lose eligibility, you and your eligible family members may enroll in Cedars-Sinai healthcare coverage. You must contact the MBC HR Employee Benefits Help Desk to enroll within 60 days of gaining financial assistance or losing coverage.

If the Plan Changes

In addition to special enrollment rights, you may change benefits if the Cedars-Sinai benefits change in the following ways:

- **If your share of healthcare premiums increases significantly or your healthcare benefits decrease significantly** sometime during the benefit year (from July 1 to June 30), you may be able to switch medical and/or dental plans, or drop your medical, dental or voluntary vision coverage entirely if no other option providing similar coverage is available. A change in healthcare premiums does not allow you to change your Healthcare FSA contributions.
- **If Cedars-Sinai adds a new healthcare plan option or eliminates an existing option sometime during the benefit year**, you may be able to switch to the new option or elect another option within 30 days.

CERTAIN DEADLINES EXTENDED DURING THE CORONAVIRUS PANDEMIC

During the COVID-19 national emergency that began March 1, 2020, some deadlines were extended. For more information, contact the MBC HR Employee Benefits Help Desk at 888-302-3941.

Qualified Life Events

A qualified life event is a situation that allows you to change some or all of your healthcare and insurance (or flexible spending account) benefits outside of the normal enrollment periods.

Because the IRS considers healthcare (and FSA) benefits tax-free compensation, they impose rules on when employees can enroll in and change benefits. Cedars-Sinai must follow these rules so employees can receive the tax breaks. Otherwise, the IRS could take away the plans' tax-advantaged status, and all employees would owe income tax, Social Security and Medicare taxes and penalties on the cost of healthcare benefits. We are strict about following these enrollment rules to protect your tax advantages.

When you enroll for healthcare and insurance benefits (and FSAs), in most situations you're enrolling for the next 12 months and may change benefits only during open enrollment. Recognizing that family or job changes that affect your benefit needs may not correspond to enrollment periods, the IRS allows you to make specifically listed benefit changes within 30 days of the qualified life events, as described on the following pages.

It's up to you to contact the MBC HR Employee Benefits Help Desk within 30 days of a job or family change

It is your responsibility to notify the MBC HR Employee Benefits Help Desk within 30 days (or 60 days for CHIP or Medicare assistance) if you or an eligible family member has a special enrollment right or qualified life event change that would allow you to enroll or change benefits.

MBC HR Employee Benefits Help Desk

- Phone: 888-302-3941
- Fax: 206-299-3158
- Email: MBC.cshs@milliman.com

Or update your benefit change within 30 days online at: Cedars-Sinai.MyBenefitChoice.com

Log in to the benefits enrollment site > VIEW YOUR BENEFITS > MAKE CHANGES

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Birth of a Child **Adoption of a Child** **Placement for Adoption of a Child**	Medical, Dental and Voluntary Vision • Enroll your new child • Enroll yourself, if not already enrolled • Enroll any eligible family members not already enrolled Supplemental Life Insurance and Supplemental AD&D Insurance • Add or increase your coverage • Add or increase spouse/DP coverage • Add child coverage Flexible Spending Accounts • Enroll or increase healthcare FSA contributions • Enroll or increase child/adult care FSA contributions	Documentation • For newborns, birth certificate or hospital certificate of birth showing you and/or your current spouse/DP as parent(s) • For adoption, court records showing either the date the child was placed in your home for adoption or the adoption date • For spouse or child (who is not already enrolled), a copy of: – Birth certificate or hospital certificate of birth showing you and/or your current spouse/DP as parent(s) – Marriage license – State-issued domestic partnership certificate or Cedars-Sinai's domestic partnership affidavit signed by you and your DP and notarized. • To purchase or increase supplemental life insurance, you must complete, and the insurer must approve, the insurer's evidence of insurability (EOI) form. However, to cover a new child, EOI is not required. Effective Date • For medical, dental and voluntary vision, coverage starts the date of birth or placement—whichever is later • For supplemental life insurance* and flexible spending accounts, coverage starts the first day of the month following the birth or placement—whichever is later • Supplemental life insurance* increases or additions requiring insurer approval are effective the first day of the month after approval (subject to the actively at work requirements on page 35). *If not actively at work, coverage starts upon return to work.

Keep in Mind...
Coverage for a new child is *not* automatic

You must enroll a new child within 30 days of birth, adoption or placement. If you're on family leave, don't wait until you return from leave; the new family member may not be eligible then.

If you want additional life insurance because of the birth or placement of a child, you have 30 days from the birth or placement date to apply for supplemental life insurance. **Don't wait until you return from leave—you won't be eligible then**, and you'll have to wait until open enrollment to apply. Supplemental life insurance coverage (once approved by the insurance company) will not start until you return from leave.

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Family Member Becomes Eligible for Coverage Other than for birth, adoption, placement for adoption, marriage or domestic partner (DP) becoming eligible	Medical, Dental and Voluntary Vision • Enroll the family member(s) who became eligible Flexible Spending Accounts • Enroll or increase Healthcare FSA contributions • Enroll or increase child/adult care FSA contributions	Documentation • Proof that your family member has become eligible for coverage, such as a visa stamp in passport showing entry date into the U.S. (along with passport ID page), final court order naming you and/or your current spouse/DP as legal guardian(s) Effective Date • Coverage starts the first day of the month following the date of the court order or, if enrolled for other reasons, the first day of the month after the event
Marriage or New Domestic Partnership Because the IRS and federal government don't recognize domestic partnerships, you won't receive tax-favored treatment; the cost of your DP's (and their children's) premiums may be taxable income to you, unless they are your tax dependents. If you marry your DP and submit a family status change within 30 days of marriage, tax on their premium cost will stop (retroactive to the date of marriage). If you miss the 30-day deadline, the tax will continue until you submit proof of marriage (and then will stop on the first day of the following month).	Medical, Dental and Voluntary Vision • Enroll your spouse/DP and your spouse's/DP's eligible children • Enroll yourself, if not already enrolled Supplemental Life Insurance/ Supplemental AD&D Insurance • Add or increase your coverage • Add spouse coverage • Add child coverage Flexible Spending Accounts* • Enroll or increase healthcare FSA contributions • Enroll or increase child/adult care FSA contributions * FSA changes are not permitted for new domestic partnerships	Documentation • Marriage license • State-issued domestic partnership certificate or Cedars Sinai's domestic partnership affidavit signed by you and your DP • To purchase or increase supplemental life insurance, you must complete, and the insurance company must approve, a health questionnaire Effective Date • Coverage starts the first day of the month after marriage or the commencement of a state-issued domestic partnership, or on the date of your six-month anniversary of being DPs (instead of establishing a state-issued domestic partnership) and having met all the other domestic partner eligibility requirements outlined on page 11 • Supplemental life insurance increases or additions requiring insurer approval are effective the first day of the month after approval (subject to the actively at work requirements on page 35).

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Child No Longer Eligible for Coverage	Medical, Dental and Voluntary Vision • Drop the child from these healthcare benefits (this change is required) Supplemental Life Insurance/ Supplemental AD&D • Drop the child from coverage Flexible Spending Accounts • Decrease healthcare FSA contributions • Decrease child/adult care FSA contributions if the child was receiving dependent care • Stop or reduce child/adult care FSA contribution when a child turns 13 and is no longer eligible for dependent care	Documentation • Proof that your child has lost eligibility for coverage, such as court records or proof of other healthcare coverage Effective Date • Coverage ends the last day of the month the child loses eligibility • Your child is eligible for COBRA continuation coverage for healthcare benefits for up to 36 months on a self-pay basis; see page 38 for details • If your child is not eligible, you are required to drop that child from benefits; if Cedars-Sinai or the insurers/claims administrators find that you lied about your child's eligibility and fraudulently continued coverage, Cedars-Sinai or the insurers/claims administrators can refuse to pay claims for the time your dependent was not eligible—even if you paid the premiums
Death of Covered Family Member	Medical, Dental and Voluntary Vision • Drop the deceased family member from these healthcare benefits; however, you cannot drop other family members' coverage unless the death causes the family member to become ineligible Supplemental Life Insurance/ Supplemental AD&D Insurance • Drop the family member from coverage • File a claim for their life and/or AD&D insurance (if covered) Flexible Spending Accounts* • Decrease healthcare FSA	Effective Date • Coverage ends the date of death (no claims paid after date of death) • If the employee dies, family members continue coverage through the end of the month

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
	contributions • Decrease or stop child/adult care FSA contributions if the family member was receiving dependent care * FSA changes are not permitted for domestic partner death.	
Divorce **Legal Separation** **Annulment** **Termination of Domestic Partnership** See Involuntary Loss of Other Healthcare Coverage in this table if you have lost coverage under another plan due to your divorce. If you cover your DP, remember to complete the termination of domestic partnership affidavit	Medical, Dental and Voluntary Vision • Drop these healthcare benefits for your former spouse/DP and any child who no longer meets the definition of family member (this change is required) Drop Supplemental Life Insurance/ Supplemental AD&D Insurance • Drop spouse/DP (and their children's) coverage Flexible Spending Accounts* • Decrease healthcare FSA contributions • Decrease or stop child/adult care FSA contributions if the family member was receiving dependent care * FSA changes are not permitted for changes to a DP relationship.	Documentation • The final decree (divorce, separation or annulment) • Cedar-Sinai's termination of domestic partnership affidavit signed by you and your domestic partner or a copy of the state-issued termination of domestic partnership certificate Effective Date • Coverage ends the last day of the month of the divorce, legal separation, annulment or dissolution of domestic partnership • Your ex-spouse/DP and their children are eligible for COBRA continuation coverage for health benefits up to 36 months on a self-pay basis; see page 38 for details • Upon finalization, your ex-spouse/DP and any children are not eligible, and you are required to drop them from coverage; if Cedars-Sinai or the insurers/claims administrators find that you lied about your relationship and you fraudulently continued coverage, Cedars-Sinai or the insurers/claims administrators can refuse to pay claims for the time your ex-spouse/DP and any children were not eligible—even if you paid the premiums
Gaining Coverage Under Another Employer Health Plan Example: enrolling under your spouse's coverage during his or her employer's benefit enrollment period	Medical, Dental and Voluntary Vision • Drop these healthcare benefits for yourself and your family members who became covered under the other plan(s) • You must remain covered under the Cedars-Sinai plan to cover family members	No Documentation required • When you cancel your coverage on the Cedars-Sinai.MyBenefitsChoice.com enrollment site, you will need to attest (declare) that you have other group medical coverage. Effective Date • Coverage ends the last day of the month

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
		before the month the new coverage starts **This is NOT a COBRA qualifying event**—if your family members lose coverage because you've dropped your Cedars-Sinai coverage, they won't be offered COBRA continuation coverage
Enrolling in a State or Federal Marketplace Plan During its open enrollment or a special enrollment period	Medical, Dental and Voluntary Vision • Drop these healthcare benefits for yourself and your family members who became covered under the other plan(s) • You must remain covered under the Cedars-Sinai plan to cover family members	No Documentation Required • When you cancel your coverage on the Cedars-Sinai.MyBenefitsChoice.com enrollment site, you will need to attest (declare) that you have other group medical coverage. Effective Date • Coverage ends the last day of the month before the month the new coverage starts **This is NOT COBRA qualifying event**—if your family members lose coverage because you've dropped your Cedars-Sinai coverage, they won't be offered COBRA continuation coverage
Enrollment in Another Plan Because Regular Work Schedule Drops Below 30 Hours... ...per week and you are enrolling in another health plan with minimum essential coverage**	Medical, Dental and Voluntary Vision • Drop these healthcare benefits for yourself and your family members who became covered under the other plan(s) • You must remain covered under the Cedars-Sinai plan to cover family members	Documentation • Letter or confirmation statement from the other plan showing what coverage has been acquired, effective date and who is covered Effective Date • Coverage ends the last day of the month before the month the new coverage starts **This is NOT a COBRA qualifying event**—if your family members lose coverage because you've dropped your Cedars-Sinai coverage, they won't be offered COBRA continuation coverage ** Please note: This life event reflects the ACA rule that employers must provide medical coverage for employees regularly scheduled to work 30 or more hours per week. However, because Cedars-Sinai requires you to be regularly scheduled to work 20 or more hours per week to be eligible for medical (and other) benefits, you will not lose Cedars-Sinai coverage if your hours drop below 30 hours (but are at least 20 hours) per week.

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Enrolling in Medicare You or your covered family members do not automatically lose Cedars-Sinai medical plan coverage upon becoming eligible for or enrolling in Medicare.	Medical, Dental and Voluntary Vision • Drop these healthcare benefits for yourself and your family member who became covered under Medicare • You must remain covered under the Cedars-Sinai plan to cover family members	No Documentation Required • When you cancel your coverage on the Cedars-Sinai.MyBenefitsChoice.com enrollment site, you will need to attest (declare) that you have other medical coverage. Effective Date • Coverage ends the last day of the month (or whichever occurs later): – You ask the MBC HR Employee Benefits Help Desk to cancel your Cedars-Sinai coverage because of your Medicare coverage – Before your Medicare coverage starts **This IS a COBRA qualifying event**—If your family members lose coverage due to your Medicare enrollment (and dropping Cedars-Sinai coverage), they'll be offered COBRA continuation coverage (and will also be eligible for a 60-day special enrollment period to enroll in a health insurance marketplace or exchange plan)
Involuntary Loss of Other Healthcare Coverage For reasons other than failure to pay premiums or termination of coverage for cause; examples include employee's or dependent's loss of other coverage or using up COBRA	Medical, Dental and Voluntary Vision • Enroll yourself and any eligible family members, if not already enrolled, who lost coverage under the other plan Flexible Spending Account • Enroll or increase Healthcare FSA contributions	Documentation • Letter or confirmation statement from the other plan showing what coverage has been lost, effective date, who lost coverage and why coverage was terminated Effective Date • Coverage starts the first day of the month after the loss of other coverage

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Significant Increase in Premiums or Decrease in Benefits	Medical, Dental and Voluntary Vision Enroll yourself and any eligible family members in another plan option offered by Cedars-Sinai Flexible Spending Accounts • Increase child/adult care FSA contributions if a dependent care provider (who is not your relative) increases the costs • A change in healthcare premiums does not allow you to change healthcare FSA contributions.	Documentation • Letter, notice or confirmation statement showing the significant premium increase or benefit reduction, the effective date and who was covered Effective Date • Coverage starts the first day of the month after the change to the previous coverage is effective
Judgment, Decree or Order Including Qualified Medical Child Support Orders	Medical, Dental and Voluntary Vision • Add or drop the dependent, based on what the document orders • There is no child-only coverage; if you (the employee) are not already enrolled for healthcare coverage, you'll be enrolled as a result of the court order; if you and your child live in California, you'll be enrolled in the HMO for medical and DeltaCare USA for dental; otherwise, you and your child will be enrolled in the PPO for medical and the Delta Dental PPO for dental. • The plan does not cover ex-spouses, if the order is for ex-spouse benefits, you must purchase coverage elsewhere Flexible Spending Account • Increase or decrease healthcare FSA contributions, based on what the document orders	Documentation • Copy of the final judgment, decree or order Effective Date • Coverage starts the first day of the month after the final judgment, decree or order is issued • Coverage ends the last day of the month the final judgment, decree or order is issued • Your ex-spouse will be offered COBRA continuation coverage if covered when the divorce is final • If the order is to drop a child from coverage, this is not a COBRA-qualifying event so the child won't be offered COBRA continuation coverage

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
Gaining Premium Assistance from Medicaid or CHIP (State Children's Health Insurance Program)	Medical, Dental and Voluntary Vision • Drop coverage for yourself and your family member who became covered under Medicaid or CHIP within 60 days of the date you become eligible for financial assistance • You must remain covered under the Cedars-Sinai plan to cover family members	No Documentation Required • When you cancel your coverage on the Cedars-Sinai.MyBenefitsChoice.com enrollment site, you will need to attest (declare) that you have other medical coverage. Effective Date • Coverage ends the last day of the month (or whichever occurs later): – You ask the MBC HR Employee Benefits Help Desk to cancel your Cedars-Sinai coverage because of Medicaid or CHIP coverage – Before Medicaid or CHIP coverage starts
Losing Eligibility for Coverage Under Medicaid or CHIP (State Children's Health Insurance Program)	Medical, Dental and Voluntary Vision • Enroll yourself, if not already enrolled, and any eligible family members who lost Medicaid or CHIP coverage in the Cedars-Sinai plans within 60 days of the date coverage ends Flexible Spending Account* • Enroll or increase healthcare FSA contributions * FSA changes are not permitted for domestic partner enrollment.	Documentation • Copy of the state's notice showing termination of assistance Effective Date • Coverage starts the first day of the month after loss of Medicaid or CHIP assistance
Moving Into or Outside the HMO or DeltaCare USA Service Area	Medical and Dental Plans • If moving from California, switch to the medical Blue Cross PPO and/or Delta Dental PPO plans; Cedars-Sinai Vivity HMO, Blue Cross HMO and DeltaCare USA plans are available only to California residents • If moving to California, switch to a medical HMO (a switch to DeltaCare USA is not permitted)	Documentation • None; based on your address on file in the HR Records Department Effective Date • You must notify Cedars-Sinai (or the MBC HR Employee Benefits Help Desk) within 30 days of your address change to change benefits; changes are then effective the first day of the month after your address change • If the MBC HR Employee Benefits Help Desk

Qualified Life Event	Benefit Changes Permitted	Required Documentation and Benefit Change Effective Dates
	This is based on the employee's address in the HR Records Department database; if the employee moves and the family follows later, the family move is not a status change.	is notified of your move outside of California through a payroll change, and you're enrolled in the Vivity HMO, Blue Cross HMO, or the DeltaCare USA (which are not available outside of California), the MBC HR Employee Benefits Help Desk will contact you about changing your benefits
Going on an Unpaid Leave of Absence	Your options when you won't be getting a paycheck: • Continue your benefits on a self-pay basis (by check or money order) • Drop benefits	Documentation • If you are not using paid time off (vacation, sick or Approved Paid Leave) while you are on leave (and not getting a paycheck) the HR Employee Benefits Department will contact you to make arrangements to pay your share of premiums Effective Date • If you choose not to continue benefits or fail to pay the premiums while on unpaid leave, your coverage will end on the last day of the month in which your paychecks stop or for which your benefit premiums are paid
Returning from an Unpaid Leave of Absence	When You Return to Work: • If you continued paying your premiums during leave, all benefits you were enrolled in continue as before • If you didn't continue paying while you were on leave, contact the MBC HR Employee Benefits Help Desk at 888-302-3941 within 30 days of returning to work; depending on the reason for your leave, your previous benefits may be reinstated	Documentation • None; contact the MBC HR Employee Benefits Help Desk at 888-302-3941 upon your return to restart your benefits. **If you do not contact MBC, you will not be enrolled**. Effective Date • Coverage starts the first day of the month after returning from leave

Benefit Change Must Match the Event

If you want to change benefits because of a qualified life event, the change must be consistent with the life event. Generally, this means that the election change must be on account of and correspond with a change in status that affects eligibility for coverage under an employer's plan.

Cedars-Sinai pays premiums monthly. If you have a mid-month change to coverage, your premiums are not prorated.

Silver Passport: Special Enrollment Rights and Qualified Life Event Rules Don't Apply

Silver Passport self-pay medical coverage is an alternative to COBRA continuation coverage for long-service employees. Therefore, special enrollment rights and qualified life events available for employees do not apply to former employees covered by Silver Passport. See the Silver Passport section on page 37 for details.

Benefit Change Confirmation Statements

Shortly after you enroll or change benefits because of a special enrollment right or qualified life event, a confirmation statement is mailed to your home. Please check your confirmation statement to make sure you're enrolled in the correct benefit plans and family members are covered (check your paycheck deductions, too). If the information does not accurately reflect your benefit choices, contact the MBC HR Employee Benefits Help Desk immediately (phone 888-302-3941 or email MBC.cshs@milliman.com).

WHEN COVERAGE STARTS

New Employee or Newly Benefits-Eligible Enrollment

If you enroll when first eligible for healthcare, insurance and/or flexible spending account benefits, coverage for yourself and eligible family members starts the first day of the month following your hire date. For instance, if you are hired on Aug. 1, coverage would start Sept. 1. However, if you enroll a child age 26 or over, coverage does not become effective until approved by the insurer/claims administrator.

The rules and timing for other Cedars-Sinai benefits (such as retirement) are different.

Reinstatement (Within 30 Days)

If you come back to work within 30 days after leaving Cedars-Sinai employment, your medical, dental, vision, insurance and FSA benefits will automatically resume per the elections that were in place on the date your employment ended.

Rehires (After 30 days)

If you come back to work at Cedars-Sinai more than 30 days after leaving, you are treated like a new employee. You need to enroll, and coverage starts the first day of the month following your rehire date.

New Physicians-in-Training

Medical coverage for yourself and eligible family members starts on your date of hire, reinstatement or rehire.

The rest of your healthcare (dental and vision), insurance and FSA benefits coverage starts on the first day of the month following your date of hire, reinstatement or rehire.

Open Enrollment

If you enroll or make any benefit changes during open enrollment in May, the enrollment and changes are effective July 1.

Special Enrollment Rights and Qualified Life Events

In most situations, benefit changes because of a special enrollment right or qualified life event start the first day of the month after the date of the event; however, there are exceptions and special Changing Benefits When Your Life, Job or Insurance Changes situations. See the starting on page 21 for details.

Job Changes and Transfers

If your job change or transfer changes your benefits, in most situations your new benefits start on the first of the month following the date of transfer.

If your job change/transfer is effective the first day of the month, your new benefits are effective the first day of the following month. There is an exception if transferring from a per diem or "non-benefited" position to a benefits-eligible position, in which case benefits start on the first day of the month if your transfer occurs on that day.

Contact the MBC HR Employee Benefits Help Desk at 888 -302-3941 to find out how a job change or transfer affects your benefits or when the benefit changes start.

COVERAGE START EXCEPTIONS

Birth, Adoption or Placement for Adoption

In these situations, if you enroll your new child within 30 days, medical, dental and voluntary vision coverage for the new child (and other family members, if enrolling at that same time) is retroactive to the birth, adoption or placement date. Enrollment and/or changes in supplemental life insurance* (and flexible spending accounts) are effective the first day of the next month.

Not Actively At Work

The life, AD&D and disability insurers require employees to be actively at work (and family members to not be disabled or hospitalized) for group insurance policies to start.

For life, AD&D, and disability insurance (except group supplemental long-term disability), if you are not actively at work (or your family member is disabled or hospitalized) on the date your insurance is scheduled to start, coverage will be delayed until the date you return to work. (How "return to work" is defined may vary by insurance company and policy. See the attached insurer/claims administrator booklet for details.)

If you elected group supplemental LTD coverage and you are not actively at work on the day coverage is scheduled to begin, your election will be cancelled. You must wait until the next open enrollment period to re-elect coverage.

Life Insurance for Employee and Spouse

Any life insurance coverage requiring insurer approval (EOI) starts the first day of the month after receiving approval, except that elections made during open enrollment cannot become effective before July 1.

LEAVES OF ABSENCE

BENEFITS DURING A PAID LEAVE

If you are paid during your leave, your employer-sponsored healthcare and insurance benefits may continue for up to one (continuous) year of authorized leave (except for personal leave), as long as you continue to pay the employee portion of premiums. If you are paid during your authorized leave, your premiums will continue through paycheck deduction while you are on leave.

BENEFITS DURING AN UNPAID LEAVE

Your employer-sponsored healthcare and insurance benefits may continue for up to one (continuous) year of authorized leave (except for personal leave), if you continue to pay the employee portion of premiums. If you are not using paid time off (vacation, sick or approved leave pay) to continue to pay your share of premiums through paycheck deduction while on leave, you are responsible for paying them.

When the HR Employee Benefits Department is notified of your leave of absence status, they mail you an Unpaid Leave of Absence Benefits Form. To continue your benefits while on leave, you must complete that form and notify HR Employee Benefits how you'll pay for your benefits while you're not getting a paycheck.

If you're not getting a paycheck, and you don't complete and return the form (and pay for coverage if required), Cedars-Sinai could cancel your coverage while you are on leave.

If you are on family leave (under California law or FMLA, the federal Family and Medical Leave Act) or military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994, you have special benefit continuation rights and may be able to continue your coverage during your leave.

When you return to work:

- If you return from an FMLA or military leave within the time frames set by law, your coverage is reinstated. Call the MBC HR Employee Benefits Help Desk to restart benefits enrollment; if you do not call the Help Desk, you will not be enrolled.
- Otherwise, if you return to work within one year, you will need to re-enroll; healthcare and insurance coverage for yourself and eligible family members starts the first day of the month after your return to work.

In most cases, if your leave lasts longer than one year, you enter "non-benefitted" status and your employer-sponsored healthcare benefits end. At that time, you have the option of continuing healthcare benefits through COBRA or medical coverage through the state or federal health insurance marketplace. Soon after, you will receive COBRA enrollment information. Go to coveredca.com or healthcare.gov for information about health insurance marketplaces.

ACTIVELY AT WORK REQUIREMENTS

You must be actively at work for life, AD&D and disability insurance coverage to start or increase, as discussed under Benefit Rules to Know Before Enrolling and When Coverage Starts.

This means if you have a qualified life event while on leave (for instance, you have a baby) and want to increase supplemental life insurance coverage, you must contact the MBC HR Employee Benefits Help Desk to request the increase within 30 days of the event (the birth or placement of the child), even though the coverage increase will not take effect until you return to work. See the life insurance and disability insurer booklets for more information.

LOA policies and procedures

Leave of absence policies and procedures posted on the Cedars-Sinai intranet (the service center portal) describe eligibility for leaves and time off, and how these leaves work and coordinate with various state and federal leave laws. If you have questions about leave of absence policies, contact the Cedars-Sinai Leave and Disability Management Team.

Email: myHR@cshs.org
Fax: 310-473-0018
Cedars-Sinai intranet: csmc.service-now.com/cssp/id=cs_home

WHEN COVERAGE ENDS

Medical, Dental and Voluntary Vision

Coverage ends:

- The last day of the month your Cedars-Sinai employment ends
- The last day of the month you stop being a benefits-eligible employee.

Wellness Incentive(HRA) and Flexible Spending Accounts (FSAs)

Coverage ends the later of:

- The last day of the month your Cedars-Sinai employment ends, or
- The last day of the month you stop being a benefits-eligible employee.

FSA and HRA expenses incurred through the last day of the month your Cedars-Sinai employment ends are eligible for reimbursement. (Please note, your TRI-AD debit card may be turned off before that date.)

You must submit claims by Sept. 28 for eligible expenses incurred between July 1 and the last day of the month you stopped participating.

Life and AD&D Insurance

Coverage ends:

- The day your Cedars-Sinai employment ends
- The day you stop being a benefits-eligible employee.

Disability Insurance

Coverage ends:

- The day your Cedars-Sinai employment ends
- The day you stop being a benefits-eligible employee.

All Benefits

In addition to the benefit-specific situations outlined, all benefits end in these situations:

- The date you have served full time in the armed forces of any country for more than 30 days
- The date Cedars-Sinai Medical Center (the plan sponsor) terminates any benefit plan or stops covering the group of employees you belong to or stops covering family members (dependents).
- Any earlier date specified in the applicable benefit booklet.

Family Member Coverage

If your coverage ends, family coverage also ends. In addition to the situations listed above:

- If you divorce, legally separate or annul your marriage, or if your domestic partnership ends, coverage for your ex-spouse/DP ends the last day of the month in which the breakup occurs
- If a child no longer meets the eligibility requirements (described on page 12), coverage ends the last day of the month of losing eligibility status.

BENEFIT CONTINUATION PROGRAMS

SILVER PASSPORT

Cedars-Sinai offers the Silver Passport program to certain long-term benefits-eligible employees who are retiring at or after age 55. You're eligible for the Silver Passport program if you retire from Cedars-Sinai employment as a benefits-eligible employee:

- Age 55 to 64 with at least 20 years of Cedars-Sinai employment, or
- Age 65 or older with at least 15 years of Cedars-Sinai employment.

Note: Employment does not need to be continuous to count.

Under the Silver Passport program, you're eligible for:

- **Medical coverage until age 65** for yourself and eligible family members, on a self-pay basis (cost slightly reduced from COBRA). Instead of Silver Passport, you may be able to get medical coverage through COBRA. The Silver Passport program is an alternative to COBRA or health insurance marketplace coverage – you cannot be covered by both for the same benefit. If you choose to enroll in the Silver Passport program and do not elect COBRA when you retire, you will not be offered COBRA when you turn age 65.
- If 65 or older, an annual taxable Medicare subsidy (a small payment you can use toward your medical expenses).
- **Dental coverage** for you and eligible family members.
- **Life insurance** for you only.
- Continued use of Cedars-Sinai facilities and gift offerings.

Enrolling in Silver Passport

If you leave Cedars-Sinai employment and you're eligible for Silver Passport, enrollment information will be sent to your home.

Please refer to the Silver Passport FAQs posted on the benefits website at Cedars-Sinai.MyBenefitChoice.com for more information, including how the Silver Passport program interacts with COBRA and Medicare.

If You Enroll in COBRA instead of Silver Passport

You cannot delay Medicare enrollment with COBRA coverage. For Medicare Parts A and B enrollment (and some Medigap policies), COBRA is NOT considered coverage based on current employment. If you wait to enroll in Medicare because you have medical coverage through COBRA (after your initial Medicare enrollment period upon turning 65), you'll be penalized with a lifetime of higher premiums.

For information about Silver Passport, contact the MBC HR Employee Benefits Help Desk:

Phone:	888-302-3941
Secure Fax:	206-299-3158
Email:	MBC.cshs@milliman.com
Address:	MBC HR Employee Benefits Help Desk P.O. Box 600610 Dallas, TX 75360-1719

COBRA CONTINUATION COVERAGE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. This section generally explains COBRA coverage, when it may become available and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

COBRA continuation coverage is a temporary extension of your current healthcare coverage (medical, dental, voluntary vision and in some cases the healthcare flexible spending account and/or wellness incentive/HRA) on a self-pay basis if you and/or your covered family members lose this coverage because of one of the qualifying events listed under COBRA Qualified Beneficiaries and Events (see below). COBRA does not extend other types of employee benefits, such as life insurance.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the health insurance marketplace. By enrolling in coverage through the marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage is a continuation of healthcare coverage when it would otherwise end because specified events called "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse/DP and your eligible children could become qualified beneficiaries if you lose Cedars-Sinai healthcare coverage because of the qualifying event. Although COBRA does not apply to DPs, Cedars-Sinai offers COBRA coverage to DPs.

COBRA Qualified Beneficiaries and Events

Employee: becomes a qualified beneficiary by losing Cedars-Sinai coverage because:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct.

Your spouse/DP: becomes a qualified beneficiary by losing Cedars-Sinai healthcare coverage because:

- Your employment ends for any reason other than your gross misconduct
- Your hours of employment are reduced
- You die
- You enroll in Medicare (under Part A, Part B or both) and you drop your Cedars-Sinai coverage, or
- You and your spouse divorce or legally separate.

Your covered children: become qualified beneficiaries by losing Cedars-Sinai healthcare coverage because:

- Your employment ends for any reason other than your gross misconduct
- Your hours of employment are reduced
- You die
- You enroll in Medicare (Part A, Part B or both) and you choose to drop your Cedars-Sinai coverage
- You and your spouse/DP divorce or legally separate
- The child stops being eligible for coverage under the plan.

Please note:

- Federal law does not give COBRA continuation coverage rights to DPs and their children; this is something that Cedars-Sinai offers over and above federal requirements.
- Cedars-Sinai employees and covered family members do not lose Cedars-Sinai healthcare benefits upon becoming eligible for or enrolling in Medicare. However:
  - Employees may drop their Cedars-Sinai coverage within 30 days of being covered by Medicare; in this situation any covered family members would

lose their Cedars-Sinai coverage and become eligible for COBRA.

- If covered by COBRA, you might lose your COBRA coverage upon enrolling in Medicare. Contact the COBRA administrator at 855-460-6971 for details.

When COBRA Coverage is Available

COBRA is offered to qualified beneficiaries only after the COBRA administrator has been notified that a qualifying event has occurred.

Cedars-Sinai and/or the MBC HR Employee Benefits Help Desk notifies the COBRA administrator of the following qualifying events:

- Your employment ends for any reason other than your gross misconduct
- Your hours of employment are reduced
- You die
- You drop your coverage because you enrolled in Medicare.

You must notify the MBC HR Employee Benefits Help Desk within 60 days after the following qualifying events:

- Divorce or legal separation
- A covered child's losing eligibility.

You must provide this notice to:
MBC HR Employee Benefits Help Desk
P.O. Box 600610
Dallas, TX 75360-0610
Phone: 888-302-3941
Fax: 206-299-3158

If the MBC HR Employee Benefits Help Desk is *not notified* that your family member is no longer eligible for coverage within 60 days of the qualifying event, Cedars-Sinai is not required to offer COBRA.

Changes During the Coronavirus Pandemic

During the COVID-19 national emergency, some COBRA deadlines were extended. For more information, contact TRI-AD, the COBRA administrator, at 855-460-6971.

How COBRA Coverage is Provided

Once the MBC HR Employee Benefits Help Desk receives notice that a qualifying event has occurred, they notify the COBRA administrator and COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Much COBRA Costs

Usually you pay 100% of the premium (both the employer and employee portions) plus a 2% administrative fee. However, if you have a disability extension for COBRA, you pay 150% of the premium during the extension period.

How Long COBRA Lasts

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of COBRA continuation coverage:** If you or anyone in your family covered under the plan is determined by Social Security to be disabled and you notify the COBRA administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
  If you are not yet covered through COBRA, notify the MBC HR Employee Benefits Help Desk. If covered by COBRA, notify the COBRA administrator following the procedures described in the COBRA Election Notice.
- **Second qualifying event extension of 18-month period of continuation coverage:** If a covered family member experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse/DP and covered children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the COBRA administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any covered children getting COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) and drops Cedars-Sinai coverage, divorces or legally separates or if the covered child stops being eligible. This extension is only available if the second qualifying event causes the spouse/DP or covered child to lose coverage under the plan had the first qualifying event not occurred.

Coverage Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the health insurance marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at coveredca.com or healthcare.gov.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit DOL.gov/EBSA. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the marketplace, visit coveredca.com or healthcare.gov.

If You Have Questions

For questions about the plan or your COBRA continuation coverage rights, contact:

MBC HR Employee Benefits Help Desk

P.O. Box 600610
Dallas, TX 75360-0610
MBC.cshs@milliman.com
888-302-3941

TRI-AD COBRA Administrator

P.O. Box 2059
Escondido, CA 92033
866-512-9270

Keep Us Informed of Address Changes

To protect your family's rights, keep your address up to date.

While employed with Cedars-Sinai, change of contact information forms are posted on the Cedars–Sinai Intranet:

- Click Service Center (under Helpful Links)
- Click Changing Your Address And/Or Phone Number (under Frequently Asked Questions)
- Click Change My Address or Phone Number eForm in the article or under Additional Resources near the bottom of the page
- Complete the online eForm and click the Submit button (on the right)

If you are no longer working at Cedars-Sinai or need help, contact the HR Service Center:
Call: 424-314-myHR (6947)
Email: myHR@cshs.org

OTHER HEALTHCARE INSURANCE PROGRAMS

CalCOBRA

If you live in California and you are covered by the Cedars-Sinai offered Blue Cross HMO or Vivity HMO medical plan, Delta Dental plan and/or the Voluntary Vision plan, you may be able to extend your current coverage on a self-pay basis through a California state-mandated program called CalCOBRA. This program may be available to you after you have been covered under the federal COBRA program for the maximum time available.

Although you receive the same benefits as active Cedars-Sinai employees, CalCOBRA is administered directly by the healthcare insurers/claims administrators (Anthem, Delta, etc.). Please see their booklets or contact their member services departments for information about CalCOBRA. Because it's administered by the insurers/claims administrators, CalCOBRA may not be available to domestic partners and their children.

See the attached insurer/claims administrator booklets for more information about CalCOBRA.

Health Insurance Marketplace Coverage

If you're under age 65, another option for healthcare coverage is a state or the federal health insurance marketplace (also called exchanges in some states). It's possible that marketplace premiums will be lower than Silver Passport or COBRA premiums.

Like employer-sponsored coverage, the marketplace has limited times during which you can enroll. Certain life events (such as losing employer-sponsored coverage as an active employee) qualify you for a 60-day special enrollment period. (You have 60 days to contact the marketplace, report the qualifying event, provide documentation and enroll.) If you miss your special enrollment period, you'll have to wait until the marketplace's next open enrollment to enroll and could end up with no coverage in the interim. For information or to enroll, go to:

- coveredca.com—If you live in California (open enrollment is usually held Oct. 15–Jan. 31)
- healthcare.gov—To find a link to your state's exchange or to use the federal marketplace if your state does not have an exchange (open enrollment is usually held Nov. 1–Dec. 15).

CONTINUING LIFE INSURANCE AND DISABILITY INSURANCE

You might be able to continue or convert your basic life insurance and/or supplemental life insurance (for you and covered family members) to a private policy upon leaving Cedars-Sinai. AD&D, long term disability and short term disability (for physicians in training) insurance cannot be continued or converted.

Shortly after you leave Cedars-Sinai, information about these options will be sent to your home. You will have a short amount of time to apply for these insurance coverages.

For details, see the attached insurer/claims administrator booklets.

For a high-level explanation of which benefits are portable, see the What to Do When Leaving Cedars-Sinai summary posted on Cedars-Sinai.MyBenefitChoice.com (or ask the MBC HR Employee Benefits Help Desk to send it to you, by calling 888-302-3941 or emailing MBC.cshs@milliman.com).

Proof of coverage

If you are asked to provide evidence you are covered by a Cedars-Sinai healthcare or insurance plan, contact the MBC HR Employee Benefits Help Desk at 888-302-3941

WELLNESS INCENTIVE CONTRIBUTION

At Cedars-Sinai, your health is important—for your personal wellbeing and also for your work at Cedars-Sinai. When you're at your healthiest, our patients benefit, too. To support your commitment to personal wellness, we offer an incentive to encourage participation in your personal wellness. You can earn the wellness incentive contribution from Cedars-Sinai once a year if:

- You are covered under one of the Cedars-Sinai sponsored medical plans, and
- You complete the current year's required healthy activities within the given deadline.

Family members are not eligible to participate.

The wellness incentive program is discretionary, which means Cedars-Sinai decides whether to make contributions, the contribution amount (if any) and the required healthy activities for earning a contribution.

Healthy Activities

Healthy activities are wellness steps you take to earn a wellness incentive contribution. They may change from year to year, and changes will be announced in wellness or open enrollment materials.

Alternate wellness measures

If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact myHR and they will work with you (and, if you wish, with your doctor) to find a reasonable alternative that is right for you in light of your health status.

Annual Contribution

Once a year, if you meet the eligibility requirements, Cedars-Sinai credits an amount to your health reimbursement arrangement (HRA) account with TRI-AD. Your credit is based on your pay rate.

2021–2022 Incentive Credit	
Under $35/hour	$300/year
$35 or more/hour	$150/year

Only Cedars-Sinai may contribute to your HRA, and there is an $1,000 account limit.

Wellness incentive credits are available around the middle of the month following the month you fulfill the incentive requirements.

Your Account

No money is actually deposited into your HRA account (so no interest is earned). Instead, benefits are paid from Cedars-Sinai's general funds.

TRI-AD administers our wellness incentive/HRA (and also the flexible spending accounts). They keep a record of your account and the funds available to you, tracking payment of eligible healthcare expenses.

You can access your account information in several ways:

- Setting up an account at tri-ad.com
- Using the TRI-AD mobile app: search for "TRI-AD Benefits on the Go" at your mobile phone app store
- Calling the number on your TRI-AD debit card to find out your account balance
- If you need to submit proof a TRI-AD debit card expense was eligible, you'll receive a letter from TRI-AD.

And you can always visit tri-ad.com or call TRI-AD at 855-460-6971 for forms or assistance.

Rollover Funds

If you earn a contribution and have remaining funds in your HRA account on July 1, your account balance will automatically roll over to use in the new benefit year (unless the balance reaches the $1,000 limit; then contributions will stop until you spend some of your funds).

Log in to your TRI-AD account to view your account balance, including funds in excess of $1,000, for which you need to submit claims by Sept. 28.

Eligible Expenses

The wellness incentive contribution deposited in your HRA account can be used to pay for healthcare expenses, such as copays for doctors' office visits or glasses—expenses not paid by your healthcare insurance ("out-of-pocket" expenses). There are hundreds of eligible expenses, including:

- Copays/coinsurance
- Over-the-counter drugs, menstrual care products and amounts paid for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes
- Hearing aids
- Vision exams
- Dental and orthodontia
- Acupuncture
- Physical therapy
- Glasses and contact lenses
- Chiropractic care
- Speech therapy
- Public transportation or mileage to and from a healthcare facility to receive healthcare services.

For a complete list of eligible expenses, log on to tri-ad.com and search for the healthcare FSA eligible expenses list.

If you also participate in the healthcare FSA, please note: The HRA and healthcare FSA share most—BUT NOT ALL—of the same eligible healthcare expenses.

Spending Your Wellness Incentive Contribution

When you have an eligible healthcare expense, you can:

- Pay with your TRI-AD debit card (also used for the healthcare FSA)
- Pay with a personal credit card or another form of payment, and then submit a claim and be reimbursed from your HRA account.

Eligible health care expenses include only those you incur after you earn your first wellness incentive contribution (that is, you cannot be reimbursed for expenses incurred before you became a Cedars-Sinai employee and start participating in the wellness incentive program/HRA).

The main benefit of the debit card is convenience: it allows you to pay the provider directly from your HRA account instead of paying out of pocket, filing a claim and then waiting for reimbursement.

If you have both a wellness incentive/HRA and healthcare FSA, funds from your FSA are used first; once FSA funds are gone, credits from your HRA account are used.

Whether you pay with your own money or use the debit card, it's a good idea to keep receipts in case TRI-AD or the Internal Revenue Service requests proof the expense was eligible.

See **page 50** for details on using your TRI-AD debit card.

When You Leave Cedars-Sinai

Shortly after your employment ends, your TRI-AD debit card will be de-activated. You have until the next Sept. 28 to submit claims for healthcare services you received from the first day of the current benefit year through the last day of the month of Cedars-Sinai employment. Any funds left in your HRA account after Sept. 28 will be forfeited.

Note: If you are planning to buy individual insurance in the health insurance marketplace, any unused amounts in your HRA account may disqualify you from being eligible to receive a premium tax credit, unless you permanently opt out of and waive any right to reimbursements from your HRA account for expenses incurred after you opt out.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending account benefit allows you to transfer part of your paycheck to an account from which you pay for healthcare or child/adult care daycare expenses on a tax-free basis. Cedars-Sinai offers two types of FSAs:

- Healthcare FSA: Participation allows you to use pay that is excluded from your taxable income for specific out-of-pocket healthcare expenses, like copays or glasses.
- Child/Adult care FSA: Participation allows you to use pay that is excluded from your taxable income for dependent care so you can work.

The FSAs are part of the Flex Benefits Plan. Another important part of the Flex Benefits Plan is the healthcare premium payment program, which allows you to pay for healthcare premiums pretax.

Eligibility

As a benefits-eligible employee, you can elect to have some of your pretax pay contributed to the FSAs. Your FSA contributions are not subject to federal income tax, state income tax or Social Security and Medicare taxes, allowing you to use tax-free dollars to pay for qualified expenses.

If you are reimbursed for an expense from an FSA, you cannot claim a federal income tax credit or deduction on your return.

Benefit Year: July 1–June 30

The FSAs run on a plan year basis—and you must re-enroll every year to participate. Your annual contribution amount is deducted from 24 of your 26 annual paychecks. If you enroll mid-plan-year, your annual contribution is divided equally over the number of pay periods through June 30.

Annual Contribution Limits

Healthcare FSA

- **Minimum contribution:** $120 per year ($5 per paycheck).
- **Maximum contribution*:** The IRS sets the maximum annual contribution amount. For July 1, 2021 to June 30, 2022, the maximum contribution is $2,750. This amount will be indexed, increasing periodically based on inflation.

Child/Adult Care FSA

- **Minimum contribution** $120 per year (or $5 per paycheck).
- **Maximum contribution:*** For July 1, 2021 to June 30, 2022, the maximum contribution is $5,000 (or $1,200 if you earn $125,000 or more per year).

  However, for the child/adult care FSA, you cannot contribute more than your or your spouse's earned income for the year (whichever is lower). For example, if your spouse is employed part time and earns $1,500, then $1,500 is your limit for the year. If you find your contributions are exceeding this limit, report it to the MBC HR Employee Benefits Help Desk. The amount in excess will be reported as income on your W-2.
  - For spouses who are unemployed full-time students or incapable of self-care due to disability, earned income is assumed to be $250 a month (if you have one dependent) or $500 a month (two or more dependents).
  - The IRS maximum contribution is $5,000/year for unmarried individuals or for married individuals filing jointly; for married individuals filing separately the maximum contribution is $2,500/year each. If your spouse's employer sponsors a dependent care account like this, you can use either account or split the limit between accounts.

*Maximum Child/Adult Care FSA Contributions May Change

The maximum contribution is set by Cedars-Sinai each year before open enrollment, based on participation in the previous year.

Deadline for Submitting Claims

Generally, FSA rules require you to spend every dollar by the last day of the benefit year—or forfeit any remaining money. The exception is that IRS rules allow rollovers of up to $550 in healthcare FSA funds from this plan year to the next (but not for the Child/Adult care FSA). To be eligible for an FSA rollover, you must remain employed with Cedars-Sinai on July 1 of the following benefit year.

Expenses are considered "incurred" when the service is performed, not when you pay the caregiver or healthcare provider.

For example:

- Under the child/adult care FSA, if you pay for daycare on a monthly basis, you can seek reimbursement after the last day of the month (even if you pay the caregiver on the first day of the month).
- Under the healthcare FSA, if you go to the doctor in May, but you are billed for your portion of the coinsurance in June, the expense was incurred in May.

Following the end of the benefit year (June 30), you have a 90-day claims run-out-period (until Sept. 28) to submit claims for reimbursement for the previous benefit year. (Note: Due to the COVID-19 national emergency, the deadlines for incurring expenses and submitting claims for 2020-2021 were extended.)

Benefit Year	Deadline for Incurring Expenses	Deadline for Submitting Claims
7/1/2020–6/30/2021	6/30/2022	9/28/2022
7/1/2021–6/30/2022	6/30/2022	9/28/2022

Funds Remaining After Sept. 28, 2021

The FSA rollover rules for 2020-2021 had some temporary changes due to the pandemic. **If you had funds left in either FSA on Sept. 28, 2021, your funds rolled over and remained available for you to use through June 30, 2022.**

Keeping Tabs on Your Balance

Your FSA records are with TRI-AD, our FSA administrator. You can access your account information at any time—including your current balance and claim reimbursement status—by going to tri-ad.com or the mobile app: search for "TRI-AD Benefits on the Go" at your mobile device app store.

TRI-AD will also email you the following (at the email address provided when you register):

- Quarterly statements
- A letter when proof of eligibility is needed

If you don't have access to a computer or smartphone, you will still be able to keep track of your FSA account:

- TRI-AD will send you letters if you need to submit proof claim is eligible
- You can call the number on your TRI-AD debit card to find out your account balance.
- And you can always call the MBC HR Employee Benefits Help Desk for forms or assistance at 888-302-3941.

When You Leave Cedars-Sinai

Healthcare FSA:

- Shortly after your employment ends, your TRI-AD debit card will be de-activated. Even so, eligible healthcare services received or purchased between July 1 of the current benefit year (or the date your participation started, if later) through the last day of the month Cedars Sinai employment ends are eligible for reimbursement.
- The FSA benefit year is July 1–June 30. You have 90 days after the end of the benefit year (until Sept. 28) to submit claims for reimbursement to TRI-AD. Any money left in your account after Sept. 28 is forfeited.
- If you qualify, you may be eligible to continue participation until the end of the benefit year (June 30) through COBRA. To continue, you must keep contributing the same amount, but on an after-tax basis, plus a 2% administrative fee. You'll send contributions to TRI-AD, who is also our COBRA administrator.
- If eligible, you'll receive a COBRA election notice from TRI-AD about three to four weeks after your Cedars Sinai employment ends. (You cannot enroll in COBRA before leaving Cedars-Sinai because a record of your termination and COBRA eligibility must first be transferred to TRI-AD.)
- If you're not eligible to continue participation, the account will not be listed as an option on your COBRA election notice.

Child/Adult Care FSA:

- You can use your funds for child/adult care services received from July 1 (or the day your participation started, if later) through the last day of the month your employment ends.
- The FSA benefit year is July 1–June 30. You have 90 days after the end of the benefit year (until Sept. 28) to submit claims for reimbursement to TRI-AD. Any money left in your account after Sept. 28 is forfeited.
- COBRA continuation is not available.

Spending Your Healthcare FSA

When you have an eligible healthcare expense, you can either:

- **Use the TRI-AD debit card to pay** for qualifying expenses from participating merchants or healthcare providers. The TRI-AD debit card gives you quicker access to your healthcare FSA funds; it may not, however, eliminate having to submit itemized receipts or documentation showing the expense is qualified. See TRI-AD Debit Card on page 50 for details.
- **Pay the expense out of pocket** and then submit a claim and itemized receipt from the healthcare provider or merchant to the claim administrator, TRI-AD, for reimbursement. See Reimbursement Procedures – HRA and FSAs on page 52 for details.

When Funds are Available

Your entire annual healthcare FSA is yours to spend as of the first day of the benefit year (July 1), regardless of the amount contributed from your paycheck. For instance, if you have healthcare expenses that exceed the amount deducted from your paychecks, the expenses will be reimbursed up to the full amount of your annual FSA election. Your payroll deductions will continue through the end of the year, even though the funds have already been spent.

Rollover funds: If you remain employed with Cedars-Sinai on July 1 and have remaining funds in your healthcare FSA, up to $550 of your account balance will roll over for you to use in the new benefit year. Any amount above the limit is forfeited.

Note: Due to the COVID-19 national emergency, any funds remaining in your 2020-2021 healthcare FSA on Sept. 28, 2021 rolled over for use in the new benefit year.

Ineligible Expenses

The best source for finding out which healthcare expenses can be paid or reimbursed from your account is TRI-AD, our FSA claim administrator.

Website: tri-ad.com
Phone: 855-460-6971

Eligible Expenses

The healthcare FSA enables you to pay for out-of-pocket healthcare expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code that are not paid by your healthcare plans and save on taxes at the same time. Typical out-of-pocket healthcare expenses that may be reimbursed with healthcare FSA funds include:

- Medical, dental and vision care copays and coinsurance
- Prescription drug copays and coinsurance
- Over-the-counter drugs, menstrual care products and amounts paid for personal protective equipment, such as masks, hand sanitizer and sanitizing wipes
- Medical and dental benefit plan deductibles
- Glasses, contact lenses or laser eye surgery
- Orthodontia (non-cosmetic only)
- Acupuncture and chiropractic care
- Public transportation or mileage to and from a healthcare facility to receive healthcare services
- Insulin.

For a complete list of eligible expenses, log on to tri-ad.com and search for the healthcare FSA eligible expenses list.

If you also receive a wellness incentive contribution, please note: The HRA and healthcare FSA share most—BUT NOT ALL—of the same eligible healthcare expenses.

Dependent Expenses

You can use your healthcare FSA to pay eligible expenses for you, your spouse and children (until the end of the calendar year in which children turn 26) and any family member you claim as your federal tax dependent.

You don't have to be covered under a Cedars-Sinai sponsored healthcare plan to participate in the healthcare FSA; for example, if you and your spouse are covered under your spouse's employer medical plan, you could be reimbursed for your and your spouse's copays under the Cedars-Sinai healthcare FSA.

Your family members do not have to be eligible for coverage under the Cedars-Sinai-sponsored healthcare plans for you to have their expenses reimbursed through the healthcare FSA. For example, if your mother-in-law lives with you and is your federal tax dependent, you could use your healthcare FSA for her eligible out-of-pocket healthcare expenses.

You cannot use the healthcare FSA for domestic partner (DP) healthcare expenses, unless the DP is claimed as a dependent on your most recent tax returns.

See page 50 for details on using your TRI-AD debit card.

Spending Your Child/Adult Care FSA

The child/adult care FSA enables you to pay for out-of-pocket, work-related dependent care costs with pretax dollars.

There is no debit-type card for the child/adult care FSA. You'll need to pay the expense out of pocket and then submit a claim for reimbursement and itemized receipt from the care giver to the claim administrator, TRI-AD, for reimbursement. See page 52 for details.

You may be reimbursed only up to the actual contributions in your account.

For example, your fee for daycare from June 1 to June 30 is due June 1; however, on June 1 your account balance is $0. You may submit your claim for reimbursement right away; however, the claim cannot be paid until you have contributions posted to your account. Approved claims will continue to be paid out as additional contributions each pay period are made.

Eligible Expenses

To qualify to have the expense reimbursed from your child/adult care FSA, the situation must the following qualifications.

You must be one of the following:

- A single parent
- Married and both you and your spouse work
- Married; you work and your spouse is a full-time student, looking for work or physically or mentally incapable of self-care
- If you are divorced or unmarried and share custody of your child(ren), you must be the custodial parent.

Contact TRI-AD at 855-460-6971 if you need help determining if your child/adult care expenses are eligible for reimbursement.

Care must be for one of the following qualifying child or adult dependent(s):

- Your child, stepchild, adopted or placed for adoption child, foster child, sibling (or descendent of any of these) under age 13 who lives with you for more than half the year and for whom you provide more than half their support
- Your spouse who is physically or mentally incapable of self-care and lives with you for more than half the year
- Another dependent (for instance, a child for whom you are the legal guardian or a parent who is unable to care for themselves who you claim as a dependent on your income tax return) who is physically or mentally incapable of self-care and who lives with you more than half the year and is your tax dependent.

If a child or adult does not meet the above criteria, they are not eligible for reimbursement under the child/adult care FSA.

Non-resident aliens are not qualifying dependents, except non-resident alien dependents living in Canada or Mexico (but no other country) for a portion of the year and with you for a portion of the year.

Child/adult care arrangements that qualify include:

- A dependent (day) care center, if care is provided by the facility for more than six individuals and the facility complies with applicable state and local laws; this includes small home daycare centers, nursery schools, after-school care (for children up to age 13) or day camps (but not overnight camps)

Eligible and ineligible expenses

The best source for finding out which child/adult dependent care expenses can be paid or reimbursed from your account is TRI-AD, our FSA claim administrator.

Website: tri-ad.com

Phone: 855-460-6971

- An educational institution for preschool children; for older children, only expenses for non-school care are eligible
- An individual (such as a babysitter, nanny or grandparent) who provides care inside or outside your home; she or he may not be a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

You'll be required to provide the caregiver's name, address, Social Security Number or taxpayer ID number and the amount of the expense on the reimbursement form and your tax form for the year.

Eligible expenses include:

- Child care at a day camp, preschool or by a private sitter
- Before-school or after-school care (other than tuition)
- Licensed daycare centers
- Nursery schools or preschools (before kindergarten)
- Placement fees for a dependent care provider, such as an au pair
- Care of a tax-dependent incapacitated adult who lives with you at least eight hours a day
- Late pick-up fees
- Summer or holiday day camps
- Expenses that are incidental to and inseparably part of the care (for instance, a daycare center that provides meals or bus service).

For a complete list of eligible expenses, go to tri-ad.com.

You cannot use child/adult care FSA funds to pay for:

- Care expenses for children 13 and older
- Educational expenses, including kindergarten or private school tuition fees
- Amounts paid for food, clothing, sports lessons, field trips or entertainment
- Overnight camp expenses
- Registration fees
- Care for dependent while sick employee stays home
- Late payment fees
- Payment for services not yet provided
- Any dependent care expenses claimed as deductions on your personal income tax return.

USING THE TRI-AD DEBIT CARD

Use your TRI-AD debit card to pay for eligible expenses with funds from your HRA account and/or healthcare FSA.

Debit Card Features

- Your TRI-AD debit card is automatically activated the first time you use it.
- When requested, select "credit." If you are required to enter a PIN, you can access your assigned PIN through the TRI-AD Benefits on the Go app or through your tri-ad.com log in
- Always keep the itemized receipt. Even when you use your debit card, you may need to submit proof the expense is eligible.
- If you have a wellness incentive/HRA account and healthcare FSA, you'll use the same debit card for both accounts. Funds are automatically deducted first from your FSA and then from your HRA account.

Receipt required? Text me!

Sign up for TRI-AD mobile text alerts and you'll get a text message immediately after you use your TRI-AD debit card when the purchase requires you to submit documentation. This way, you always know when to save your itemized receipts.

Where You Can Use It

Most doctors' offices, pharmacies, hospitals, labs, outpatient facilities and approved merchants (such as grocery store or drugstore pharmacies) will accept the TRI-AD debit card. If the card is not accepted, it's usually because some merchant locations opt not to participate or are not approved.

If your account has insufficient funds, the entire card transaction will be declined, unless the provider or merchant has the ability to accept partial authorization. Cards are limited to 15 authorizations in one day.

Keep Your Card Safe

About two weeks after participation begins, you'll receive your TRI-AD debit card in the mail. If you exhaust your account balance before the end of the year, keep your card to use the next year, as cards are only reissued every four years. If your card is lost or stolen, notify TRI-AD right away so they can deactivate it and reissue a new one.

Submitting Proof of Expenses

Sometimes when you use your debit card, expenses are automatically verified as eligible; other times you'll need to submit proof. As a general rule, it's smart to keep itemized receipts in case documentation **is requested.**

Because income taxes are waived on HRA and FSA contributions, the Internal Revenue Service requires TRI-AD to verify that every expense is eligible.

If your expense wasn't automatically substantiated, you must submit required documentation to TRI-AD. If you don't submit proof that the expense is eligible within 70 days of the purchase or service date (or 45 days from the date TRI-AD sends the first email reminder), your TRI-AD debit card could be deactivated (that is, temporarily suspended).

The itemized receipt* must show:

- Merchant or provider name
- Name of person receiving the service
- Date of purchase or service (not the date you were billed)
- Item purchased or description of the service received
- Amount of purchase or service.

For prescription drugs, you must also include the:

- Prescription number.

For over-the-counter medications, you must also provide a:

- Copy of the prescription from your doctor.

Some procedures, prescriptions and treatments can be considered ineligible for reimbursement unless accompanied by a **Letter of Medical Necessity** from the provider. If requested, you can download TRI-AD's form letter from their website at tri-ad.com:

- TRI-AD Letter of Medical Necessity

*You can submit any documentation that has all the items listed above, for instance an Explanation of Benefits from the insurance company or the prescription "bag tag." Credit card receipts are NOT an accepted form of documentation

Recovery of Improper Payments

If Cedars-Sinai or TRI-AD becomes aware of an improper payment through use of your TRI-AD debit card, federal law requires the plan to recoup the money using the following progressive correction procedures:

- Cedars-Sinai uses a claim substitution or offset approach to resolve improper payments, such as reducing the reimbursement for a subsequent, substantiated expense claim by the amount of the improper payment (as described in the example below).
- You are required to repay the plan, on an after-tax basis, an amount equal to the improper payment.
- If repayment is not made as described above, Cedars-Sinai may withhold the amount of the improper payment from your wages or other compensation, on an after-tax basis, to the extent consistent with applicable law.

In addition to the above correction procedures, you can't use your TRI-AD debit card until the improper payment is offset or repaid. If it's deactivated, you must pay for out-of-pocket healthcare expenses and then submit receipts or invoices, as described above.

Finally, if all the above procedures are unsuccessful, or otherwise unavailable, you remain indebted for the improper payment, and Cedars-Sinai treats it as any other business indebtedness.

Example: Recovery of Improper Payments

If Sue received an improper payment of $200, no healthcare FSA reimbursement can be made until the improper payment is fully recouped. So, if Sue submits a substantiated claim for $250 incurred during the same year, she receives only a $50 reimbursement. The remaining $200 is applied to recover the outstanding improper payment.

Reimbursement Procedures—HRA Account and FSAs

If you pay for eligible healthcare expenses out of pocket, you must submit a claim online or via mobile app and documentation showing the expense is eligible to be reimbursed from your wellness incentive contribution/HRA account or healthcare FSA. You may also use these methods to be reimbursed from your child/adult care FSA for eligible expenses.

Claims Submission

Online

- Scan or take a photo your receipt to make an electronic copy
- Sign in to tri-ad.com with your username and password
- Select Reimbursement Plan Accounts > Enter a New Claim and follow the online prompts.

Register with TRI-AD

To submit claims online or by mobile app, you must first be registered on TRI-AD's website: tri-ad.com.

Mobile app

- Download the **TRI-AD** Benefits on the Go mobile app from the iTunes Store or Google Play
- Open the TRI-AD mobile app: you will complete a one-time registration separately for the mobile app and the website (the client ID to register on the mobile app is: TIDCEDARS)
- Select Claims > Add Claim
- Fill in the online form
- Take a photo of your receipt and upload.

Reimbursements are usually paid within a week of submitting claim forms and supporting documentation.

For faster reimbursement, set up direct deposit with TRI-AD at: **tri-ad.com**

Fax or Mail

- Collect your itemized receipts and documentation
- Complete a TRI-AD claim form; to get the form, sign into tri-ad.com with your username and password and go to resources or call TRI-AD at 855-460-6971.
- Fax the claim form and documentation to TRI-AD at fax number 844-791-8318. There is no need to follow up with a hard copy in the mail (If you log on to your online account, you can see the scanned images of your documentation shortly afterward.) Remember to keep the original claim form and supporting documents for your records.

  OR

- Mail your form and documentation to:
  TRI-AD Reimbursement Plans Department
  221 West Crest Street, Suite 300
  Escondido, CA 92025-1737.

Appealing a Denied Claim

If you (or a covered family member) have a disagreement about whether a healthcare expense is eligible or the amount reimbursed or paid, call TRI-AD at 855-460-6971. If you believe TRI-AD's decision is incorrect, in whole or in part, it is considered a denied benefit (or an adverse benefit determination) and you may ask to have the decision re-examined, using the appeal procedures in the Benefit Claims and Appeals section starting on page 60.

When you submit a claim for reimbursement from your child/adult care FSA, TRI-AD (the FSA administrator) will make a determination as to eligibility and the amount of benefit payable, if any. The FSA administrator's decision is final.

TAXES ON BENEFITS

Healthcare and the FSAs

The IRS sets the rules for who is eligible for pretax benefits. When you enroll in a medical plan, dental plan or the voluntary vision plan (except as described in the next paragraph), you are automatically enrolled in the healthcare premium payment program (part of the Flex Plan) so that you pay your share of medical, dental and voluntary vision premiums on a pretax basis. This means your contributions are deducted from your paycheck before your taxes are calculated, which reduces the amount of income tax and FICA (Social Security and Medicare) taxes you owe.

You aren't taxed on the cost of the medical and dental benefits Cedars-Sinai pays for you, and under federal law, the medical, dental and voluntary vision coverage for your eligible spouse, children under age 26 (and any tax dependent) has the same tax treatment.

Premiums for Domestic Partners (DPs) and Their Children

If you cover your DP (and their eligible children who are not legally your children or your tax dependents), the premiums that you and Cedars-Sinai pay for their coverage is considered taxable and is automatically added to your paycheck as imputed income—which means federal income taxes are imposed as though you received that amount of pay.

Imputed income is calculated by taking the total premium (what you and Cedars-Sinai pays combined) for your level

of coverage (for example, employee plus DP) minus the total premium for employee-only coverage.

Under California law, healthcare provided to certain DPs is not taxable for state income tax purposes. If you have questions, contact the Payroll Department.

Imputed income is added to your paycheck for determining your federal and state income and Social Security and Medicare (FICA taxes). It does not show as a line item on your paycheck; you'll see only the increase in your Social Security and Medicare withholding. Cedars-Sinai is required to collect FICA tax and withholds FICA taxes on imputed income. The usual Social Security tax rate is 6.2% of pay (up to the Social Security wage base of $142,800 for 2021 or $147,200 for 2022). The Medicare tax rate is 1.45% of all wages. Plus, individuals with earned income of more than $200,000 ($250,000 for married couples filing jointly, $125,000 for married couples filing separately, and $200,000 for filing single) pay an additional 0.9% in Medicare taxes. For withholding tax purposes, covered wages above $200,000 are taxed at a rate of 2.35% (1.45% + 0.9%), regardless of filing status.

Imputed income is not automatically withheld for federal or state income taxes. You may want to have Cedars-Sinai withhold extra money for the additional federal and state income taxes you'll owe. You must complete federal and state tax forms to change your tax withholding amounts.

Obtain tax forms from the:

- Cedar-Sinai intranet:
  ADMINISTRATIVE > HUMAN RESOURCES > MYPROFILE
- Payroll Satellite Office (in the medical center)
  Ray Charles Cafeteria, Suite 1631C
  Phone: 310-423-3734
  Hours: Monday–Friday 8 a.m.–4:30 p.m.,
  Closed noon–1 p.m.

Submit completed forms to the Payroll Satellite Office or fax them to 323-866-8883.

Exception for Tax Dependents

You may not owe imputed income taxes on coverage for your DP (and their children)* if they are your tax dependents or if such coverage is not taxable under applicable state law. It's your responsibility to determine if they are your tax dependents and eligible for tax-favored healthcare coverage; see IRS Publication 501 or consult a tax professional. If so, contact the MBC HR Employee Benefits Help Desk (888-302-3941 or MBC.cshs@milliman.com) for a Declaration of Domestic Partner Tax Status form.

* Keep in mind that being a tax dependent does not make a family member eligible for coverage. A family member must meet the qualifications listed in Family Member Eligibility starting on page 25 to be covered under Cedars-Sinai benefit plans.

Life and AD&D

Usually life insurance and accidental death & dismemberment (AD&D) insurance benefits are paid in a lump sum and are not taxable to the beneficiary. If life insurance or AD&D benefits are paid in installments, you may have to pay taxes on any amount over the coverage amount (for example, interest earned).

If you have more than $50,000 in employer-paid life insurance, you owe income taxes on the imputed value of the coverage amount above $50,000 (as valued in the IRS table). Taxes on the imputed income are withheld from your paycheck.

Long Term Disability

When an employer pays LTD premiums, any LTD benefit payments are taxable as income. When an employee pays LTD premiums with after-tax income, any LTD payments are not taxable. Therefore, if you're a Cedars-Sinai non-management employee, any benefits paid under supplemental LTD insurance are not taxable, but any benefits paid under the Cedars-Sinai-paid basic LTD are taxable as income.

Any benefit payments from employer-paid basic LTD plan are taxable as income.

CHOOSING YOUR BENEFICIARIES

The following Cedars-Sinai insurance plans provide a benefit to survivors:

- Basic life insurance
- Basic AD&D insurance
- Supplemental life insurance (employee, spouse and/or child, if enrolled)
- Supplemental AD&D insurance (if enrolled).

In some situations, basic long term disability (LTD) insurance may pay a benefit to your survivor(s) if you die while receiving disability benefit payments. LTD beneficiaries are named when you apply for LTD benefits.

Although this SPD describes only the procedures for naming your life insurance and AD&D insurance beneficiaries, your survivors might be entitled to survivor benefits from:

- Social Security
- DB Plan (Defined Benefit Plan), if you participate
- DC Plan (Defined Contribution Plan), if you participate
- 403(b) Plan, if you participate.

You can find out more about retirement plan beneficiaries:

- Social Security at ssa.gov
- DB Plan at Cedars-Sinai-MyRetirement.com
- DC Plan and/or 403(b) Plan at Cedars-Sinai.BeReady2Retire.com

Life and AD&D Insurance

You can designate anyone as your beneficiary for the following benefits:

- Basic life insurance (Cedars-Sinai paid)
- Basic AD&D insurance (Cedars-Sinai paid)
- Supplemental life insurance
- Supplemental AD&D insurance.

If you're married, you don't have to designate your spouse—you can choose your children or anyone else; however, a beneficiary who is a minor at the time of your death must have a guardian to receive the benefit.

And you can also:

- Choose multiple beneficiaries to share the benefit
- Choose primary beneficiaries, who are the initial people to receive the benefits, and contingent beneficiaries, who receive the benefit if any primary beneficiary is no longer living at the time of your death.

Changing/Updating Beneficiaries

The most efficient approach is updating them online at Cedars-Sinai.MyBenefitChoice.com. If you don't have access to a computer, contact the MBC HR Employee Benefits Help Desk at 888-302-3941 for assistance designating beneficiaries.

When no beneficiary is designated

If you don't have a living beneficiary on file at the time of your death, the benefit is paid according to the terms of each plan's contract. For employees, life insurance and AD&D plan proceeds are paid to your (in order):

1. Spouse or domestic partner
2. Biological and adopted children
3. Parents
4. Spouse or domestic partner
5. Biological and adopted children

Spouse (or Domestic Partner) and Child Life Insurance

The employee is automatically the beneficiary of supplemental spouse (or domestic partner) life insurance and supplemental child life insurance proceeds. The insurer contract does not allow any other person or trust to be named as beneficiary. If you die together, the benefit would be paid to the employee's estate.

BENEFIT CLAIMS AND APPEALS

If you (or a family member) are told you are not enrolled in a benefit plan or the benefit plan won't pay for a service or expense because it's not covered and you believe that is incorrect, you have the right to ask to have that decision reviewed. Your request to have the benefit paid is considered a "claim"; your request to have the decision not to pay the claim reviewed is considered an "appeal."

Who you file the appeal with depends on the reason the claim wasn't paid:

- If you are told the benefit or service is not covered by the plan, you should file an appeal with the insurer/claims administrator listed in the table beginning on page 7. Insurer/claims administrator contact information is listed under resources in the front of the booklet and in the insurance company's booklet (the attachments).
- If you are told you are not enrolled in the plan, follow the Eligibility and Enrollment Claims and Appeals in the next section of this document.
- If a wellness incentive contribution/HRA account or healthcare flexible spending account benefit is not paid, see the Claims and Appeal Procedures for the Wellness Incentive Program/HRA and Healthcare FSA starting on page 60 of this SPD.

Deadlines Apply! If you fail to appeal a denied claim by the deadline described in this SPD or in the applicable insurer/claims administrator booklet (attached), you permanently waive your right to appeal.

In the appeal procedures in this SPD, "you" means either you or a family member you believe is eligible to be covered under the healthcare or insurance plans or an authorized representative acting on your behalf.

Claims and Appeals Deadlines Extended During the Coronavirus Pandemic

During the COVID-19 national emergency that began March 1, 2020, the deadlines for making certain benefit claims and appeals were extended. The new deadline was one year from the date of the original deadline (or, if earlier, 60 days after the federal government announced the end of the national emergency).

Contact the specific claims administrator outlined in this section for details. Note: The extended deadlines do not apply to the child/adult care flexible spending account.

AUTHORIZED REPRESENTATIVE

An authorized representative may act on your behalf under these claims procedures. When you receive a benefit denial letter or notice, either you or your authorized representative may ask for an appeal. If you are appointing an authorized representative, you must notify the claims administrator. Send your notification to:

For Eligibility and Enrollment

Cedars-Sinai
c/o MBC HR Employee Benefits Help Desk
P.O. Box 600610
Dallas, TX 75360-0610
Fax: 206-299-3158
Scan/email: MBC.cshs@milliman.com

For the Wellness Incentive Contribution or HRA and Healthcare FSA

Cedars-Sinai
c/o TRI-AD Reimbursement Plans Department
221 West Crest Street, Suite 300
Escondido, CA 92025-1737
Fax: 866-233-4741 (for the wellness incentive)
844-791-8318 (for HRA and healthcare FSA)

WELLNESS INCENTIVE CLAIMS AND APPEALS

In general, all employees may participate in the Employee Wellness Program sponsored by Cedars-Sinai. For most program activities, there are no employee payments or claim reimbursements.

One component of the Employee Wellness Program, however, the wellness incentive contribution, is a health reimbursement arrangement (HRA). You must be a benefits-eligible employee enrolled in a Cedars-Sinai-sponsored medical plan to receive a wellness incentive contribution and have an HRA account. Because HRAs are subject to ERISA, claims procedures are outlined in Claims and Appeal Procedures for the Wellness Incentive and Healthcare FSA starting on page 60.

CLAIMS AND APPEAL PROCEDURES: ELIGIBILITY AND ENROLLMENT

Initial Claims Review Procedures

Cedars-Sinai (as plan administrator) has delegated responsibility for determining initial eligibility and enrollment for healthcare (medical, prescription drug, dental and vision), insurance (basic life and AD&D, supplemental life and AD&D and disability) and the HRA and FSA spending accounts to the MBC HR Employee Benefits Help Desk.

When you enroll in or change your benefits, you'll receive a confirmation statement mailed to your home the week after the close of your enrollment period. At other times check your current benefit elections on your Summary of Current Benefits page on Cedars-Sinai.MyBenefitChoice.com.

Contact the MBC HR Employee Benefits Help Desk if you don't receive a confirmation statement or your confirmation statement or Summary of Current Benefits indicates you (or a family member) aren't covered for benefits that you thought you enrolled in.

In some cases, you will need to submit valid documentation showing family member eligibility. If the documentation you provide isn't valid or isn't received within 45 days after the benefits start date, your enrollment or benefit change will not become effective and a denial letter will be sent to your home.

Eligibility or Enrollment Denial

If you have a healthcare, insurance or spending account issue regarding eligibility or enrollment similar to those listed in the table below, call the MBC HR Employee Benefits Help Desk. Many of these kinds of issues can be resolved by talking with a representative.

If after speaking with a representative, your issue cannot be resolved, it will be considered a denied benefit and you will receive a denial letter from the MBC HR Employee Benefits Help Desk by the initial denial letter deadline below.

Examples of Eligibility and Enrollment Claim Situations	Initial Denial Letter Deadline
• You believe you enrolled or changed benefits but didn't receive a confirmation statement • Your confirmation statement indicates you (or a family member) aren't enrolled for benefits and you thought you had enrolled • Your Summary of Current Benefits on Cedars-Sinai.MyBenefitChoice.com indicates you (or a family member) aren't enrolled for benefits and you thought you had enrolled • You receive a denial letter from the MBC HR Employee Benefits Help Desk • You have a life insurance or AD&D insurance claim denied because the insurer says you are not enrolled • You seek medical, dental or vision treatment and your doctor's office or the insurance company says you are not enrolled • You have a healthcare FSA or HRA claim denied because TRI-AD says you are not enrolled • You have a disability claim denied because insurer says you are not enrolled	90 days May be extended up to 90 days, if you're notified within the original 90-day period (180 days total)

Different deadlines for non-enrollment or eligibility claims

Generally, if you make a claim for benefits under one of the plans other than for eligibility or enrollment issues, your claim will be reviewed under different time frames as outlined by the claims administrator for that particular benefit plan.

If Your Claim Is Denied

The denial letter will contain:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial was based
- A description of any additional material or information you must provide to process your claim
- A description of the plan's review procedures and time limits including applicable time limits
- A statement of your right to bring a civil action under section 502 of ERISA following a denial on review
- A description of any internal rule or guideline upon which the denial is based, or a statement about your right to request a copy of the rule or guideline free of charge.

Filing an Appeal for Eligibility and Enrollment

You may file an appeal if you:

- Receive a denial letter from the MBC HR Employee Benefits Help Desk
- Contact the MBC HR Employee Benefits Help Desk about an eligibility or enrollment issue and you don't receive a denial letter or response by the applicable deadline.

To appeal the denied claim, send an appeal letter or email by the appeal deadline (outlined below), to:

Address: Cedars-Sinai Medical Center
c/o MBC HR Employee Benefits Help Desk
P.O. Box 600610
Dallas, TX 75360-0610

Email: MBC.cshs@milliman.com

Fax: 206-299-3158

Your appeal letter must include:

- Your full name
- Your signature
- Employee ID number
- Proof of dependent eligibility (if applicable to your claim)
- Benefit plan(s) involved
- Name of the person you think is eligible or should be enrolled and their relationship to you
- Concise statement of facts or theories supporting your claim.
- During the appeal, you 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 review will not give deference to the initial determination and will be conducted by an appropriately named fiduciary of the plan who is neither the individual who made the adverse determination nor his or her subordinate.

Notice of Decision

Cedars-Sinai will make a decision within 60 days after receiving your written appeal. If special circumstances warrant extra time, you will be notified of the special circumstances and the date you can expect a decision. Expedited deadlines may apply to certain healthcare and disability claims (for instance, 45 days for a disability claim).

If your appeal is denied, the MBC HR Employee Benefits Help Desk (for Cedars-Sinai) will send you a written notice including:

- Specific reasons for the denial
- Reference to specific plan provisions on which the denial is based
- A statement describing your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim. A document, record or other information is considered relevant to a claim if it:
  - Was relied upon in making the claim determination
  - Was submitted, considered or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination
  - Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim
- A statement of your right to bring a civil action under ERISA Section 502(a), if applicable.
- If you have a disability claim, reference to any internal rule, guideline or protocol upon which the decision is based (or your right to a free copy of that rule); and if the determination is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination (or your right to obtain a free copy of that explanation).

Please note: benefit denials based on eligibility are not eligible for an external review process.

CLAIMS AND APPEAL PROCEDURES FOR THE WELLNESS INCENTIVE/HRA AND HEALTHCARE FSA

Initial Claims Review Procedures

Cedars-Sinai (as plan administrator) has delegated responsibility for approving or denying initial wellness incentive/HRA or FSA benefit claims to TRI-AD. Reimbursement procedures are described starting on page 52. If you submit a wellness incentive/HRA or healthcare FSA claim for reimbursement and the claim is denied, or if you are paid but you believe the payment is incorrect, that is considered a denied benefit. Follow the procedures in this section if you want to appeal the denial.

If you submit a claim for reimbursement and are notified that you're not eligible or not enrolled, contact the MBC HR Employee Benefits Help Desk or follow the appeal procedures outlined above in Eligibility and Enrollment Claims and Appeals.

In general, for all claims

A document, record or other information is considered relevant to a claim if it:

- Was relied upon in making the claim determination
- Was submitted, considered or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with plan documents and plan provisions have been applied consistently with respect to all claimants
- For disability claims, constituted a statement of policy or guidance with respect to the plan concerning the denied claim.

If Your Claim Is Denied

If TRI-AD, the claims administrator, notifies you that the expense is not an eligible healthcare expense or eligible for reimbursement from your account and you believe the claims administrator was incorrect in denying your benefit, you may request that the administrator reconsider the decision by filing an appeal using TRI-ADs rules.

Please note: if your TRI-AD debit card purchase is declined, it's not a denied benefit because you can pay out-of-pocket and submit a claim for reimbursement from your account.

If additional information is needed to process your claim, within **five days** you'll be notified of the specific information necessary to process the claim. You have **45 days** to provide the information to the claims administrator.

If your benefit is denied, the claims administrator will notify you within **30 days**. If for reasons beyond the administrator's control, more time is needed to process the claim, the due date may be extended up to 15 days, if you're notified within the original 30-day period (45 days total). **The notice of benefit denial may be written or electronic and must contain:**

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial was based
- A description of any additional material or information you must provide to process your claim
- A description of the plan's review procedures and time limits including applicable time limits
- A statement of your right to bring a civil action under section 502 of ERISA following a denial on review.

How to File an Appeal

Within 180 days after denial, you may submit a written request for reconsideration of the denial to the claims administrator. You may submit written comments, documents, records and other information relating to the claim. At your request, you receive, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

Decision on Appeal

If your appeal is related to your employment status or enrollment in the plan, or if you have provided TRI-AD with a written release of private health information (PHI) for Cedars-Sinai to review your expense or other private information, Cedars-Sinai will review your appeal without giving deference to the initial claim decision within **60 days**.

If your appeal is denied, you will receive a notice from TRI-AD (on behalf of Cedars-Sinai), containing:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial was based
- A statement of your right to bring a civil action under section 502 of ERISA following a denial on review
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

The following benefits are not subject to the ERISA benefit claims and appeals rules; therefore:

- **Premium Only Plan:** If you have a disagreement about pretax premiums, Cedars-Sinai will make a decision and determine the necessary action. The decision is final.
- **Child/Adult Care FSA:** If you have properly filed a claim for reimbursement, the claims administrator (TRI-AD) will determine whether the expense is eligible and the amount of benefit payable. The claims administrator's decision is final.

CLAIMS ADMINISTRATORS

For benefit claims other than those related to eligibility and enrollment claims, contact the following claims administrators. Such administrators may have their own procedures for determining claims, which are incorporated into this SPD by this reference.

Claims Administrator		For Claims Procedures Refer To...
Medical and Prescription Drug Benefits		
Vivity HMO | Anthem: Medical and Prescription Drugs		
Phone:	844-659-6878	Attachment 1—Vivity HMO • Pages 132-140, "How to Make a Complaint" • Pages 183-186, "Claims Disclosure Notice Required By ERISA"
Write to:	Anthem Blue Cross Grievance and Appeal Management P.O. Box 4310 Woodland Hills, CA 91365	
Blue Cross HMO and Blue Cross PPO | Anthem: Medical		
Phone:	833-913-2238 (HMO in CA) 877-800-7339 (PPO in and out of CA)	Attachment 2—Blue Cross HMO • Pages 107-116, "How to Make a Complaint" • Pages 157-161, "Claims Disclosure Notice Required By ERISA" Attachment 3—Blue Cross PPO • Pages 127-132, "Your Right to Appeals • Pages 135-138, "Claims Disclosure Notice Required by ERISA"
Write to:	Anthem Blue Cross ATTN: Appeals P.O. Box 4310 Woodland Hills, CA 91365	
Blue Cross HMO and Blue Cross PPO | Prescription Drugs: MedImpact		
Phone:	800-788-2949	Attachment 4—MedImpact Rx • Pages 12–21, "Benefit Claims and Appeals"
Fax:	858-790-6060	
Write to	Attn: Claims Dept. 10680 Treena St., 5th Floor San Diego, CA 92131	

Claims Administrator		For Claims Procedures Refer To...
Dental		
DeltaCare USA		
Phone:	800-422-4234	Attachment 5—DeltaCare USA • Page 9, "Claims for Reimbursement" • Pages 11-13, "Enrollee Claims Complaint Procedure"
Write to:	Customer Service P.O. Box 1803 Alpharetta, GA 30023 Claim Forms P.O. Box 1810 Alpharetta, GA 30023	
Delta Dental PPO		
Phone:	888-335-8227	Attachment 6—Delta Dental PPO • Pages 17, "Grievance Procedure and Claims Appeal"
Website:	deltadentalins.com	
Write to	Attn: Customer Service Department P.O. Box 997330 Sacramento, CA 95899	
Vision		
Blue View Vision (Anthem)		
Phone:	866-723-0515	Attachment 7—Blue View Vision • Page 14, "How to Submit a Claim"
Website:	anthem.com/CA	
Write to:	Anthem Blue View Vision P.O. Box 8504 Mason, OH 45040	
Wellness Incentive/HRA and Healthcare FSA		
TRI-AD		
Phone:	855-460-6971	This SPD • Page 46
Website:	tri-ad.com	
Write to:	TRI-AD Reimbursement Plans Department 221 West Crest Street, Suite 300 Escondido, CA 92025-1737	

Claims Administrator		For Claims Procedures Refer To...
Basic and Supplemental Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance		
Verity Point (for Voya Life)		
Phone:	For death benefits: 844-893-2115 For accelerated death and AD&D benefits: 913-638-9866; molly.wymore@voya.com	Attachment 8—Basic and Supplemental Life Insurance (Voya Life) • Page 4 of Continuation of Insurance Rider • Page 15, "Denials and Appeals for Plans Subject to ERISA" • Continuation of Insurance Rider page 4, "Denials and Appeals for Plans Subject to ERISA – for Total Disability Claims Only" Attachment 9—Basic and Supplemental AD&D Insurance (Voya Life) • Page 14, "Claim Procedures"
Write to:	Voya Life Claims P.O. Box 1548 Minneapolis, MN 55440	
Overnight Address:	Voya Life Claims 20 Washington Ave. South, Minneapolis, MN 55401	
Disability Insurance		
Reliance Standard		
Phone:	To ask questions, call customer service: 800-351-7500 Monday–Friday 5 a.m.–4 p.m. (PT)	Attachment 10—Disability (Reliance Standard) • Pages 5.0-5.1 "Claims Provisions"
Web:	To submit claims online: reliancestandard.com/cedars-sinai	
Repatriation of Remains and Medical Evacuation Expense Benefit		
Anthem Blue Cross		
Phone:	Call the Customer Service number on your Anthem Blue Cross medical ID card.	Attachment 11—Repatriation of Remains and Medical Evacuation Expense (Anthem Blue Cross) • Page 6 "Claim Provisions"
Address:	Anthem Blue Cross Life and Health Insurance Company Group Services P.O. Box 70000 Van Nuys, California 91470	

Claims Administrator		For Claims Procedures Refer To...
Legal Plan		
MetLife		
Phone:	800-821-6400 Monday–Friday 5 a.m.–5 p.m. (PT)	Attachment 12—MetLife Legal Plans • Pages 5-6 "Denial of Benefits and Appeal Procedures"
Web:	members.legalplans.com	

TIME LIMITS ON LEGAL ACTIONS

- Unless a benefits booklet states a different limit, you or your beneficiary may not take legal action against the plans more than two years after the right to bring a legal action arose. For example, this might be two years from when an expense was incurred, or when you knew, or with reasonable diligence should have known, of the facts that allow you to make a claim.
- As described in How the Plan is Administered on page 68, the relevant claims administrator has full discretionary power and authority to interpret the plan and its rules and to determine questions of eligibility and claims for benefits. To the extent permitted by law, the decision of the claims administrator will be final and binding on all parties, except to the extent that a court of competent jurisdiction finds an abuse of discretion.

Any review of a final decision or action of the claims administrator will be based only on such evidence presented to or considered by the claims administrator at the time it made the decision that is the subject of the review. All participants in the Plan consent to actions of the applicable claims administrator made in its sole discretion and agree to the narrow standard of review described in this section.

LEGAL AND ERISA INFORMATION

Under the Employee Retirement Income Security Act of 1974, as amended (ERISA), you are entitled to certain information about your benefits. This section includes:

- A summary of your rights under ERISA
- Other information required by ERISA
- Additional legal information that affects your benefits and your rights to benefits.

Administrative Information

Plan Name	Type of Plan	Plan Year	Plan ID Number
Cedars-Sinai Medical Center Health and Welfare Plan (commonly referred to as "The Healthcare and Insurance Plan")	Welfare Benefit Plan Healthcare benefits, flexible spending accounts (healthcare and child/adult care), life and accidental death & dismemberment insurance, disability insurance and health reimbursement arrangement (wellness incentive contribution).	7/1–6/30	506

Plan Sponsor

The plan is sponsored by:

Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, CA 90048

310-423-5306

Cedars-Sinai Medical Center files required plan information with the Internal Revenue Service and the Department of Labor. If you write to either agency, you must refer to these numbers:

Employer Identification Number: 95-1644600

Health and Welfare Plan Number: 506

Participating Employers

In addition to Cedars-Sinai Medical Center (the plan sponsor), the following Cedars-Sinai-affiliated organization also participates in the plan:

Cedars-Sinai Medical Care Foundation
200 N. Robertson Blvd., Suite 107
Beverly Hills, CA 90211

Effective Dates

This Summary Plan Description (SPD) is effective July 1, 2021.

Named Fiduciaries

Cedars-Sinai Medical Center is the named fiduciary of all Cedars-Sinai benefit plans, with the authority to control and manage plan operation and administration, except that the insurers contracted with Cedars-Sinai for insured benefit programs are fiduciaries for the final determination of benefit claims as provided in their contracts.

The Cedars-Sinai HR Employee Benefits Department handles administrative tasks on a day-to-day basis, with the assistance of the MBC HR Employee Benefits Help Desk, TRI-AD (the COBRA administrator, and the FSA and HRA administrator) and the benefit plan claims administrators. No employee in these departments or these organizations is a fiduciary with regard to the plan benefits unless exercising Cedars-Sinai's discretionary powers as the plan administrator.

Plan Administrator

Cedars-Sinai Medical Center (also referred to as Cedars-Sinai in this section) is the plan administrator of the Cedars-Sinai employee benefit plans, within the meaning of ERISA section 3(16)(A).

You may contact the plan administrator at:

Plan Administrator
c/o HR Employee Benefits Department
Cedars-Sinai Medical Center
6500 Wilshire Blvd., 6th Floor
Los Angeles, CA 90048
GroupHRBenefits@cshs.org

Legal process may be served on the plan administrator.

Agent for Legal Service

To take legal action against any of the benefit plans, you may have legal process served on:

Plan Administrator
c/o HR Employee Benefits Department
Cedars-Sinai Medical Center
6500 Wilshire Blvd., 6th Floor
Los Angeles, CA 90048-1869

Financial Records of the Plan

Cedars-Sinai Medical Center keeps financial records on a July 1 through June 30 basis. The plan year is referred to as the "benefit year," "plan year" or "year" in this SPD. The financial records are kept in the Cedars-Sinai HR Employee Benefits Department.

Plan Funding

At this time, employee contributions are required for some benefits and others are paid by Cedars-Sinai, as outlined on this page and in the What's Inside section on page 7.

Discretionary Authority

In exercising discretionary powers under the plan, Cedars-Sinai, as the plan administrator, and it's designees (which include the insurers and claims administrators to whom Cedars-Sinai has delegated fiduciary responsibility), have the broadest discretion permissible under ERISA and any other applicable laws, and their decisions will constitute final review of claims. Benefits under these benefit programs are paid only if the plan administrator or insurer/claims administrator, as applicable, decides, in its discretion, that you are entitled to benefits or claim payment.

The relevant claims administrator has full discretionary power and authority to interpret the plan and its rules and to determine questions of eligibility and claims for benefits. To the extent permitted by law, the decision of the claims administrator will be final and binding on all

parties, except to the extent that a court of competent jurisdiction finds an abuse of discretion.

Any review of a final decision or action of the claims administrator will be based only on such evidence presented to or considered by the claims administrator at the time it made the decision that is the subject of the review. All participants in the plan consent to actions of the applicable claims administrator made in its sole discretion and agree to the narrow standard of review described in this section.

How the Plan Is Administered

As plan administrator, Cedars-Sinai Medical Center has the exclusive authority to control and manage plan operation and administration, except as delegated. Cedars-Sinai may designate others to carry out any duty or power that would otherwise be a plan responsibility of Cedars-Sinai. It may retain actuaries, accountants, consultants, third-party administration service providers, legal counsel or other specialists, as Cedars-Sinai may deem appropriate and necessary for plan administration. Cedars-Sinai also has further authority to allocate or delegate responsibilities.

Cedars-Sinai has the exclusive power, right and authority, in its discretion, to determine whether:

- You are eligible to be covered in any Cedars-Sinai-sponsored plan
- Any individual is an eligible family member you may cover under any Cedars-Sinai-sponsored plan.

Eligibility and enrollment are described in this SPD; eligibility and enrollment procedures described in the attached insurer/claims administrator benefit booklets may be incorrect and cannot be relied upon.

Cedars-Sinai has delegated claims administration to the claims administrators listed in the table above. The relevant claims administrator has the full power and sole discretionary authority to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable benefit booklet and has final responsibility for determining the amount of any benefits payable and providing the claims procedures to be followed and the claims forms to be used.

Amendment and Termination of the Plans

Cedars-Sinai Medical Center has the exclusive power, right and authority in its discretion to amend and/or terminate the plans in any and all respects at any time for any reason and may delegate the same to any individual(s) it chooses.

Distribution of Assets Upon Plan Termination

Upon termination of the plan, plan assets, if any, will be distributed as follows:

- First, to pay claims covered by the plan and incurred through the date of plan termination (provided the claims are submitted within six months of the date of plan termination)
- Second, to pay for reasonable administration expenses of the plan
- Third, to fund post-termination benefits and plan administration expenses as determined by Cedars-Sinai.

Insurance Company Authority for Insured Benefits

The benefits listed in the following table are insured, which means benefits are provided under a group insurance contract between Cedars-Sinai Medical Center and the insurer. The insurer (not Cedars-Sinai) is responsible for paying claims. See the attachments for a description of benefit and insurer procedures.

Insured Benefits	Funding
Medical Benefits — Vivity HMO — Blue Cross HMO Prescription Drug Benefits — Anthem (for Vivity HMO plan)	Shared between Cedars-Sinai and employee
Dental Benefits* — DeltaCare USA — Delta Dental PPO	Shared between Cedars-Sinai and employee
Voluntary Vision Insurance — Blue View Vision (Anthem)	Employee paid
Basic Life Insurance	Cedars-Sinai paid
Basic AD&D Insurance	Cedars-Sinai paid
Supplemental Life Insurance (employee, spouse and/or child)	Employee paid
Supplemental AD&D Insurance	Employee paid
Basic Long Term Disability Insurance	Cedars-Sinai paid
Supplemental Long Term Disability Insurance (Cedars-Sinai non-management employees only)	Employee paid
Basic Short Term Disability Insurance (physicians in training only)	Cedars-Sinai paid

*For retirees in the Silver Passport program, dental benefits are paid by Cedars-Sinai.

For insured benefits only, any refund, rebate, dividend, experience adjustment, or other similar payment under the group contracts will be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse the Cedars-Sinai for premiums that it has paid and administrative costs it has incurred in maintaining the Health and Welfare Plan.

Limitation of Rights

Neither the Health and Welfare Plan (or amendments to the plan) nor payment of any benefits give you any legal right against Cedars-Sinai or the plan administrator except as expressly provided in the plan document or as provided by applicable federal law.

No Guarantee of Employment

The Health and Welfare Plan is not intended to be (and may not be construed as constituting) a contract or other arrangement between you and Cedars-Sinai to the effect that you will be employed for any specific period of time.

No Vested Interest

Except for the right to receive any benefit payable under the plan, no person has any right, title or interest in or to the assets of Cedars-Sinai because of the Health and Welfare Plan.

Self-Insured Benefits

For self-insured benefits, the insurance companies do not serve as insurers but only as claims administrators. Claims for benefits are sent to the claims administrator. The claims administrator processes claims, requests and receives funds from Cedars-Sinai to pay the claims and then pays the claims to doctors, pharmacies and other providers. Benefits are paid directly out of the general assets of Cedars-Sinai. There is no special fund or trust or insurance from which benefits are paid. Cedars-Sinai is ultimately responsible for providing these self-insured benefits.

Self-Insured Benefits	Funding
Medical Benefits — Blue Cross PPO Prescription Drug Benefits — MedImpact (for Blue Cross HMO and PPO plans)	Shared between Cedars-Sinai and employee

Self-Funded Benefits	
Wellness Incentive Contribution/HRA Account	Cedars-Sinai paid
Healthcare FSA Account	Employee paid

Limitation on Assignment

Your rights and benefits under the Health and Welfare Plan cannot be used as collateral for loans or assigned, attached, encumbered or sold or transferred to your creditors or anyone else.

You and your eligible dependents' right to receive benefit payments, appeal a claim or bring a cause of action against the Health and Welfare Plan is personal to you or your eligible dependents. Any claim or rights under the Health and Welfare Plan, which includes but is not limited to any right to appeal a claim under the procedure set forth in the Health and Welfare Plan document, any right to bring a cause of action against the Health and Welfare Plan in any forum, or any right to receive benefits or benefit payments from the Health and Welfare Plan, is not assignable or transferrable in whole or in part to any other person, provider, or other entity at any time. Any assignment or transfer of a claim or other rights to receive benefit payments is void unless you or your eligible dependents receive written consent from the Plan Administrator. Nothing in this clause will prevent the Health and Welfare Plan from paying a provider or similar entity directly and any such payment shall not constitute a waiver of this anti-assignment clause. In addition, the Plan Administrator's consent or lack thereof to the assignment or transfer of benefits does not affect your or your eligible dependents' eligibility for benefits under the Health and Welfare Plan.

Loss of Benefits

You might lose benefits in certain circumstances, including, for example:

- Termination of the plans
- Coordination of benefits
- Leaving Cedars-Sinai employment; because these benefits are tied to your Cedars-Sinai employment, when you leave, you lose coverage (you may be able to temporarily continue healthcare benefits, and some insurance coverage is portable on a self-pay basis)
- If you have medical coverage through Silver Passport, you will lose medical coverage upon turning 65
- In most cases, if you are on a leave of absence lasting longer than one year, benefits coverage is cancelled
- If you have duplicate healthcare coverage (for instance, you are enrolled as an employee and as a dependent; both parents are employed by Cedars-Sinai and both cover the same children)
- Under the life insurance, AD&D insurance and disability insurance plans, you must be actively at work for your benefits to start; see the insurer booklets for details

- Disability insurance does not cover pre-existing conditions for your first year of coverage; see the insurer booklets for details
- Under the flexible spending accounts' "use it or lose it rule," you could forfeit funds not spent during the benefit year
- If you enroll someone who is not eligible (fraudulently misrepresenting their relationship to you), upon discovery, their coverage will be cancelled and you could have to pay any healthcare expenses incurred; coverage may also be cancelled for misuse of a plan ID card
- If you don't submit claims to the insurer/claims administrator by the deadline or don't follow the procedures as described in the insurer/claims administrator booklets (see the relevant attachments for details)
- By observing certain rules, Cedars-Sinai and qualifying participants receive tax savings and tax-free benefits; should the plan lose its tax-qualified status, you, in turn, could lose some or all of the tax-free benefits.

There are additional situations where you could lose benefits, as described in the insurer/claims administrator booklets (see the attachments for details).

Third-Party Liability

If you or your enrolled family members are injured, become ill, need medical care or prescription drugs or die because of an accident and someone else is legally liable for the medical, prescription drug or dental bills, your Cedars-Sinai benefits will cover the expenses as described in the insurer or claims administrator benefit booklets, but this benefit plan (or party paying the benefits) will have all the rights of recovery you have against the responsible party. This includes the right to recover payments directly from the responsible party or a third party, including the liability insurer of such party or any insurance coverage providing medical expense or liability coverage (for instance, uninsured/underinsured motorist coverage, personal umbrella coverage, medical payments coverage or workers' compensation coverage). By accepting benefits under the plan, you (and your covered spouse or dependents) agree to the special recovery rules in this section and as described in the benefit booklets, and you agree to assist Cedars-Sinai (or its designee) in the plan's recovery.

These rights apply when benefits are paid through this plan by Cedars-Sinai, Blue Cross (PPO medical plan benefits), MedImpact (prescription drug benefits under the HMO and PPO medical plans), Delta Dental PPO (dental plan) or any other self-insured benefit paid through this plan. The plan's insurers/claims administrators also have subrogation and recovery rights, which are described in their attachments.

Your Duties and Agreement

- You must notify the plan administrator (at the address on page 66) promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the plan administrator in the investigation, settlement and protection of the plan's rights.
- You must not do anything to disadvantage or harm the rights of the party paying benefits.
- You must send the plan administrator copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the plan administrator if you retain an attorney or if a lawsuit is filed on your behalf.
- You may be required to enter into a reimbursement agreement acknowledging and agreeing to your obligations.
- You agree that if the injured party, his spouse, dependents, attorney, beneficiary, estate or other third party distribute funds without regard to the plan's rights of subrogation or reimbursement, such

individual or individuals will be personally liable to the Plan for the amounts so distributed.

- You agree that any amounts recovered on behalf of a participant are plan assets and the participant is therefore a fiduciary of the Plan with respect to amounts recovered from third parties.
- You agree that if you fail to comply with the requirement s of this Third Party Liability section, your participation in the plan may be terminated and/or the plan may offset any such amounts against future claims.

See the insurer/claims administrator benefit booklets for a description of their subrogation rights.

Subrogation

The parties paying benefits (Cedars-Sinai, Anthem, MedImpact, Delta Dental, etc.) have the right to recover plan payments made on your behalf from *any* party responsible for reimbursing or paying damages to you for your injuries. The following apply:

- The party (or parties) paying benefits has the first priority for the full amount of benefits they have paid from any recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- If you get a settlement, judgment or otherwise receive payment or reimbursement from a third party or their guarantor, the party (or parties) paying benefits will automatically have a lien in the amount of the benefits paid by the plan.

  You and your legal representative must do whatever is necessary to enable the party paying benefits to exercise its rights and do nothing to dismiss, damage or otherwise affect the legal interest or demands of the party paying benefits.
- The party paying benefits has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the plan.
- To the extent that the total assets from which a recovery is available are insufficient to fully repay the party (parties) paying the benefit's subrogation claim and any claim still held by you, the party (or parties) paying the benefit's subrogation claim will be paid first—before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- The party paying benefits is not responsible for any attorney fees, other expenses or costs without its prior written consent. The party paying benefits further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire, regardless of whether funds recovered are used to repay benefits.
- The party paying benefits has a contractual claim that includes not only the expenses paid by the party, but also the costs and expenses, including attorney's fees, incurred by it with respect to any claim for reimbursement or subrogation.
- The party paying benefits may recover amounts regardless of whether the funds have been commingled with other assets and may recover from any available funds, without the need to trace the source of the funds.

Reimbursement

If you obtain a recovery and the party paying benefits has not been repaid for the benefits paid on your behalf, the party paying benefits has the right to be repaid from the recovery in the amount of the benefits paid on your behalf, and the following apply:

- You must reimburse the party paying benefits to the extent the plan paid on your behalf from any recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the party paying benefits has a right of recovery, in first priority, against any recovery.
- You and your legal representative must hold in trust for the party (or parties) paying benefits proceeds of the gross recovery (that is, the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the party paying benefits immediately upon your receipt of the recovery. You

must reimburse the party paying benefits, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire, regardless of whether funds recovered are used to repay benefits paid by the plan administrator. If you fail to repay the party paying benefits, the party paying benefits will be entitled to deduct any of the unsatisfied portion of the amount of benefits the party paying benefits has paid or the amount of your recovery, whichever is less, from any future benefit under the plan if:

  - The amount paid by the party paying benefits on your behalf is not repaid or otherwise recovered by the party paying benefits, or
  - You fail to cooperate.
- If you fail to disclose to the party paying benefits the amount of your settlement, the party paying benefits will be entitled to deduct the amount of their lien from any future benefits under the plan.
- The party paying benefits will also be entitled to recover any amount they have paid or the amount of your settlement, whichever is less, directly from the providers to whom the party paying benefits has made payments. In this situation, it may be your obligation to pay the provider the full billed amount, and the party paying benefits would not have any obligation to pay the provider.

The party paying benefits is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Recovery of Overpayment

If the party providing benefits under the plan (Cedars-Sinai, Anthem, MedImpact, Delta Dental or any other organization providing benefits) pays benefits that are more than they should have paid under the Third Party Liability provision, it may recover the extra amounts from any or all of the following:

- The persons to or for whom payments were made
- Insurers/claims administrators
- Other organizations.

Coordination of Benefits with Other Plans

If you are covered by more than one group medical plan (including prescription drug benefits) or dental plan, your benefits under the Cedars-Sinai plan will be coordinated with the benefits of those other plans. These coordination provisions apply separately to each enrolled family member, per calendar year, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as described in the benefits booklets.

No Double Coverage

Double coverage is not allowed in Cedars-Sinai sponsored plans. If you or a dependent is discovered to be double covered, Cedars-Sinai will cancel one of the coverages.

THE PRIVACY OF YOUR HEALTH INFORMATION IS PROTECTED

Cedars-Sinai (and the insurance companies) must follow federal HIPAA privacy and state laws that apply to health and other insurance benefits. Please refer to the notices on Cedars-Sinai's employee portal and/or mailed to you with your annual enrollment materials for information regarding your rights and our legal duties. Cedars-Sinai (and the benefit insurers and administrators) may collect, use and share your nonpublic personal information (PI) as described in the state notice of privacy practices.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, Cedars-Sinai (and insurers and administrators) take reasonable safety measures to protect your PI.

Each insurer's state notice is available upon request by calling the phone number on your benefit ID card.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- 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
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductibles and copays/coinsurance that apply to other Cedars-Sinai medical benefits.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or healthcare coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under an employer healthcare plan, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of QMCSOs from the Cedars-Sinai HR Employee Benefits Department.

NO SURPRISES ACT AND TRANSPARENCY IN COVERAGE

The No Surprises Act and the Transparency in Coverage Final Rule require certain group health plans to disclose information on a public website. The No Surprises Act billing information can be found at anthem.com/blog/health-insurance-basics/understanding-cost-transparency/. The Transparency in Coverage Final Rule requires disclosure of information regarding in-network provider negotiated rates, historical out-of-network allowed amounts and drug pricing information through separate machine-readable files (MRFs). The MRFs for the plans maintained by Cedars-Sinai may be accessed at anthem.com/blog/health-insurance-basics/understanding-cost-transparency/. Contact your Anthem Blue Cross medical plan for more information.

YOUR ERISA RIGHTS

As a plan participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Note that the Premium Only Plan and Child/Adult Care FSA are not covered by ERISA and this Statement of ERISA Rights does not apply to these programs. ERISA provides that all plan participants are entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual Form 5500. 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 have a right to continue medical, dental, and voluntary vision and, in some situations, the wellness incentive/HRA or healthcare flexible spending account, coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the medical, dental, vision or healthcare FSA benefits as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the plan and do not receive them within 30 days, you may file suit in a 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 after exhausting the plan's and/or insurer's claims and appeal procedures. (Please note, some insurers may require arbitration.) In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse 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 you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have general benefit questions or questions about eligibility or enrollment, contact the MBC HR Employee Benefits Help Desk.

If you have questions about plan benefits or claims payment/reimbursement, contact the insurer/claims administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from Cedars-Sinai, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave. NW
Washington, DC 20210If you are in Los Angeles, the regional office is:
Employee Benefits Security Administration
Los Angeles Regional Office
1055 East Colorado Blvd., Suite 200
Pasadena, CA 91106
Phone: 626-229-1000
Fax: 626-229-1098

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-EBSA (3272) or visiting Department of Labor EBSA's website.