El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

PHARMACY
BENEFIT PROGRAM

NOTE: THESE BENEFITS ARE PART OF THE
"EL CAMINO HOSPITAL GROUP INSURANCE PLAN" – PLAN# 502

EFFECTIVE: JANUARY 1, 2008
AMENDED AND RESTATED: JANUARY 1, 2019

Contract Administrator:
OptumRx, Inc.
PO Box 509075
San Diego, CA 92150-9075

TABLE OF CONTENTS

Page

OTHER IMPORTANT INFORMATION 1
INTRODUCTION 2
PRESCRIPTION BENEFIT SUMMARY 3
ELIGIBILITY, EFFECTIVE DATE, TERMINATION &COBRA 8
CLAIMS PROCEDURES 9
DEFINITIONS 14
GENERAL PLAN INFORMATION 16
STATEMENT OF RIGHTS 22

OTHER IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional information about coverage of a specific drug from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the General Plan Information section for the name, address and phone number of the Contract Administrator.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the Definitions section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

SOLICITUD DE INFORMACIONESENESPANOL

(Spanish Language Offer of Assistance)

Este folleto contiene un resumen en ingles de los derechos y beneficios de su Plan. En caso de tener alguna dificultad en entender cualquier parte de este folleto, comuniquese con Administrador del Plan en donde usted trabaja.

El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

El horario de la oficina es: las 8:30 de la manana hasta las 4:30 de la tarde, lunes a viernes. Usted tambien puede llamar a la oficina del administrador del plan de seguro a estos telefonos: (650) 940-7000 para pedir ayuda.

INTRODUCTION

This document describes the El Camino Hospital Prescription Benefit Program. No oral interpretations can change this program.

An Employee who enrolls in one of El Camino Hospital's medical benefit options will also have the prescription drug benefits that are described herein. The prescription drug program is provided through OptumRx with their network of participating pharmacies. Under the program, prescriptions are normally filled at a network pharmacy and the Covered Person is responsible for some share of the drug cost (e.g., a "Co-Pay"). There are no claim forms to fill out. A home delivery or "mail-order" option may also be included for maintenance medications.

Prescription drug coverage will take effect for an Employee and his Dependents when the Employee and such Dependents satisfy all of the eligibility and enrollment requirements. Failure to follow the eligibility or enrollment requirements may result in delay of coverage or no coverage at all.

Benefits are available only for expenses that are incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage terminates, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a drug is incurred on the date the prescription is filled.

The Plan Sponsor may make changes to the Plan or these benefits of the Plan. If the Plan or these Plan benefits are terminated or amended, the rights of Covered Persons are limited to Eligible Expenses incurred before such amendment or termination.

This document is divided into a number of separate sections. See the Table of Contents for the titles of those sections and their location.

PRESCRIPTION BENEFIT SUMMARY

The following is a summary of the Plan's prescription drug benefits. Although these benefits are self-funded by the Plan Sponsor, prescription benefits are provided through an arrangement with an independent prescription program vendor. Should there be any variance between the information in this summary and the terms of the agreements between the Plan Sponsor and the prescription vendor, the agreements will govern.

Prescription coverage includes a retail feature with participating pharmacies and a mail order option. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Plan participants. The mail order option allows a Plan participant to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs. A Covered Person can contact OptumRx at 844-265-1735 or by going to www.optumrx.com for detailed prescription benefit information.

Retail – Up to 30 Day Supply	
1st Tier – Generic	$5 Copay
2nd Tier – Formulary Brand Name	$20 Copay
3rd Tier – Non-Formulary Brand Name	Not Covered
Retail – Maintenance Medications after 2 fills – Preferred Home Delivery*	
1st Tier – Generic	$10 Copay
2nd Tier – Formulary Brand Name	$40 Copay
3rd Tier – Non-Formulary Brand Name	Not Covered
Home Delivery – Mail Order – UP to 90 Day Supply	
1st Tier – Generic	$10 Copay
2nd Tier – Preferred Brand Name	$40 Copay
3rd Tier – Non-Preferred Brand Name	Not Covered

***Preferred Home Delivery** - You may get 2 fills of your maintenance medications (prescription drugs used to treat long-term conditions) through your participating pharmacy. If you continue taking these medications, you should order these prescriptions through OptumRx's home delivery pharmacy. Otherwise, you will pay an increased amount at your participating pharmacy.

BriovaRx - If you are on a specialty medication, you may go through your local pharmacy or BriovaRx specialty pharmacy to obtain a 30 day prescription. BriovaRx specialty pharmacy has a dedicated team of nurses that will work directly with you and your doctor on your medication therapy. You also receive free supplies when you use BriovaRx. Please call 1-866-218-5445 to get started.

Generics Preferred - If you or your doctor chooses a brand drug when a generic drug is available, your copay will be subject to an additional charge.

Healthcare Reform (HCR) Preventative Services - Certain medications are subject to $0 copay through the Affordable Care Act Preventative Services program. These can be limited to age, gender, and risk assessment. These medications may include Aspirin, Bowel Preps, Contraceptives, Fluoride, Folic Acid, Immunizations, Iron, and Vitamin D. This list is subject to change.

OPTUMRX, PREMIUM STANDARD FORMULARY

Your prescription benefit uses the OptumRx Premium Standard Formulary. The formulary encourages patients to use clinically appropriate medications while helping to manage increasing costs. A formulary is a list of medications in different therapy classes. Therapeutic classes are used to categorize or group the drugs on the formulary. The classes group drugs which are considered similar by the disease they treat or by the effect they have on the body. There are three tiers, or levels:

- Tier 1: Generic drugs - a safe, effective drug approved by the U.S. Food and Drug Administration

(FDA) that also costs less – you'll pay the lowest copayment.

- Tier 2: Formulary (or preferred) brand name drugs.

- Tier 3: Non-formulary (or non-preferred) brand name drugs – Non Formulary drugs are not covered. Please talk with your doctor on alternatives that can be prescribed.

For a copy of the formulary, please call OptumRx at 844-265-1735 or visit www.optumrx.com to perform a coverage check.

PRIOR AUTHORIZATION

Prior authorization is needed for certain medications. If you have questions on a particular drug, please contact Customer Service or visit www.OptumRx.com to perform a coverage check. Please have your doctor call OptumRx at 800-711-4555, option 2, to go through a clinical review on your medication if it is subject to prior authorization.

Prior Authorization is a program that helps you get the prescription drugs you need **with safety, savings and-most importantly-your good health in mind**. It helps you get the most from your healthcare dollars with **prescription drugs that work well for you and that are covered by your pharmacy benefit**. It also helps control the rising cost of prescription drugs for everyone in your plan.

The program monitors certain prescription drugs to ensure that you are getting the appropriate drugs for your disease state. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed a certain medication, that drug may need a "prior authorization." ***It makes sure you're getting a cost-effective drug that works for you.*** For instance, prior authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

STEP THERAPY

Drugs in certain categories could be subject to Step Therapy. Step Therapy is a program in which certain drug classes are organized in a set of "steps" with generic drugs being the first step and brand name drugs being the second step. Please call OptumRx for any coverage checks or questions. Examples of categories include:

- ARB (Ace II Inhibitors): ie-Avapro, Cozaar, Diovan/HCT, Benicar/HCT, Micardis/HCT
- Antiviral: ie: Famcicolivr, Valacycolvir, Zovirax
- HtviG- Enhanced: ie -Lipitor, Zocor, Pravachol, Caduet, Vytorin, Crestor
- Proton Pump Inhibitors: ie -Aciphex, Nexium, Prevacid, Zegerid, Protonix

PREFERRED HOME DELIVERY

El Camino uses a Preferred Home Delivery Program for maintenance medications. Your Maintenance Medication Program provides you with an affordable way of obtaining maintenance medications. You can receive up to two refills of certain maintenance medications at your local pharmacy. You then have the choice to continue filling at the local pharmacy and paying an increased copayment, or to use Home Delivery with the OptumRx Pharmacy at your home delivery copayment.

Maintenance medications are prescription drugs that you need to take regularly. Medications that treat ongoing conditions like high blood pressure, high cholesterol and asthma are usually considered maintenance medications. After you fill a maintenance medication at a local pharmacy, you will receive a letter from OptumRx explaining the benefit, identifying the prescriptions under this program and explaining the benefits of Home Delivery with OptumRx. You will receive up to two letters per medication per year.

If you have any additional questions or would like to perform a coverage check on certain medication, please do not hesitate to contact OptumRx's Customer Service at 844-265-1735 or visit www.optumrx.com. OptumRx looks forward to providing you with your medications in a safe, convenient and affordable manner.

COVERED DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs which are prescribed by a Physician and which require a prescription either by federal or state law) and certain non-prescription items.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans but which are available through this program:

Contraceptives - All FDA-approved contraceptive methods for women are covered at l00 percent without charging a copayment, coinsurance or deductible, when filled at a network pharmacy.

Diabetic Supplies - Insulin and diabetic supplies including syringes, needles, insulin injectable devices, pump supplies, swabs, blood monitors and kits, blood test strips, blood glucose calibration solutions, urine tests, lancets, and lancet devices.

Estrogen Replacement Drugs

Hyperactivity (ADD, ADHD) Drugs - See the "Premium Standard Formulary" and the Retail Pharmacy Feature for special supply availability.

Impotence Drugs - Erectile dysfunction drugs (e.g., Viagra, Levitra, Cialis). Certain products are limited to 6 per 30-day period

Preventive Prescriptions

Vitamins, Etc.- Legend vitamins, including prenatal vitamins, and legend fluoride products.

EXPENSES NOT COVERED

Prescription drug coverage will not include:

Administration - Any charge for the administration of a drug.

Blood, Blood Plasma & Biological Sera

Cosmetic Products - Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

Dermatology Drugs - Depigmentation products used for skin conditions requiring a bleaching agent.

Diagnostic Testing & Imaging Supplies - Diagnostic testing or imaging supplies (e.g., Tubersol used for TB skin test, Radiopaque dye for outpatient testing).

Durable Equipment, Devices, Etc. - Equipment and devices of any type even though such items may require a prescription. These include but are not limited to:

- respiratory therapy supplies such as aerochambers, spacers or nebulizers; peak flow meters; and
- artificial appliances or braces.

Excess Refills - Refills which exceed the number specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

Experimental & Non-FDA Approved Drugs - Experimental drug and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration.

Fertility Agents

Hair Growth Products - such as Propecia and Vaniqa.

Homeopathic Drugs - Homeopathic drugs, legend or non-legend.

Immunization Agents - Serums, toxoids or vaccines, except that FluMist is covered and except as required under Preventive Care.

Injectable Allergens

Investigational Drugs - A drug or medicine labeled: "Caution -limited by federal law to investigational use."

Non-Home Use - Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs - A drug or medicine that is purchased without a written prescription. This does not apply to insulin.

Ostomy Supplies

OTC or OTC Equivalents – Products purchased "over-the-counter" (i.e., without a prescription) that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration, except as required as a preventive care service. Examples include: Hydrocortisone 1% cream, Ibuprofen 200mg, Dephenhydraminc 25mg, and Niacin 125mg & 250mg.

DISCLAIMER: THIS PRESCRIPTION INFORMATION IS ONLY A SUMMARY. IF THERE ARE ANY CONFLICTS BETWEEN THIS PRESCRIPTION INFORMATION AND THE TERMS OF AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND THE PRESCRIPTION PROGRAM VENDOR, THE TERMS OF THE AGREEMENT(S) WILL GOVERN.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION & COBRA

Eligibility Requirements - Employees, Retirees & Dependents

To participate in the Plan's prescription benefits as described herein an individual must be either:

- an Employee (i.e., an employee who is insured under the group medical coverage offered by the Employer);
- a Retiree (i.e., a former employee who has retired and who is insured under the Employer's group medical coverage); or
- an Employee's insured family member as defined under the employer's group medical coverage (i.e., an Employee's spouse, domestic partner or child, or a spouse of a retiree).

Effective Date of Coverage
Prescription coverage will be effective on the date the Employee or Retiree (and any individual family member) meets the eligibility requirements. Separate enrollment is not required for these prescription benefits. Enrollment for medical coverage will include these prescription benefits.

Termination of Coverage
An individual's coverage hereunder will terminate upon the earliest of the following:

- termination of the Plan or termination of these prescription benefits of the Plan;
- termination of the individual's coverage under the group medical coverage offered by the Employer.

COBRA Continuation Coverage
Except as noted, COBRA Continuation Coverage applies to these prescription benefits to the same extent it applies (or does not apply) to the Employer's group medical coverage. The COBRA terms as reflected in the group medical coverage, including the COBRA Notice Procedures as included in the medical coverage's Summary Plan Description, are incorporated by reference. Election of COBRA under the Employer's group medical coverage will be deemed to be election of COBRA for these prescription benefits unless expressly declined by the Qualified Beneficiary and allowed by the Plan Sponsor.
NOTE: These prescription benefits are not provided through insurance. These prescription benefits are employer-funded (self-funded) and are not subject to California's COBRA law (AB1401), commonly known as "Cal-COBRA."

CLAIMS PROCEDURES

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

SUBMITTING A CLAIM

If a Covered Person fills a prescription at a participating pharmacy without presenting his ID card, he may have to pay for the entire cost of the drug and then file a claim with OptumRx for reimbursement. The prescription drug claim must include the drug name, dosage, quantity, the patient's name and address, and the Employee's or Retiree's name and social security number. The Covered Person may obtain the OptumRx's claim form from El Camino Hospital. OptumRx will reimburse 100% of the cost of the drug, less the contracted rate and less the applicable Co-Pay as shown in the Prescription Benefit Summary.

Claims should be submitted to:

OptumRx
P.O. Box 509075
San Diego, CA 92150-9075

If a Covered Person fills a prescription at a non-participating pharmacy (i.e., a pharmacy that is not participating in the prescription vendor's network), he will not receive full reimbursement.

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (ClVIS) have three (3) years to submit claims when CMS has paid as the primary plan and these Plan benefits should have been primary

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

To the extent the Plan is established and maintained pursuant to a collective bargaining agreement and if the bargaining agreement sets forth or incorporates by reference: (1) provisions concerning the filing of claims and the initial disposition of claims, and (2) a grievance and arbitration procedure to which adverse benefit determinations are subject, then the terms of the bargaining agreement will apply to claims handlings. However, if the bargaining agreement includes only a grievance and arbitration procedure, then the provisions included herein concerning the filing and initial disposition of claims will apply but the appeal procedures will be superseded by the terms of the bargaining agreement.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals Plan Responds to Appeal	See "Appeals Procedures" subsection. Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- the specific reason(s) for the decision to reduce or deny benefits;
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

Effective July 1, 2011 or such later date pursuant to guidance issued by the Department of Labor, any notice of Adverse Benefit Determination will be provided in a culturally and linguistically appropriate manner and include:

- name of health care provider;
- upon the request of the claimant, the diagnosis code and its corresponding meaning if the treatment code and its corresponding meaning;
- the reason or reasons for the Adverse Benefit Determination or Pinal Internal Adverse Benefit Determination including the denial code and corresponding meaning;
- a description of the Plan's standard, if any, used in denying the claim and, with respect to a Final Internal Adverse Benefit Determination, a discussion of the decision;
- a description of available internal appeals and external review processes;
- disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with the Internal Claims and Appeals.

APPEAL PROCEDURES

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the decision;
- reference to the pertinent Plan provisions on which the decision is based;
- 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 claim;
- identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;
- a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

EXTERNAL REVIEW PROCEDURES

Filing an External Review
An individual may file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. The request is filed as described in the notice.

Preliminary Review
Within five (5) business days after the date of the receipt of the external review request, a preliminary review must be completed to determine whether:

- the Claimant is or was covered by the Plan at the time the health care service was requested;
- the Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- the Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeals process; and
- the Claimant has provided all of the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, a written notification must be issued to the Claimant. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefit Security Administration (EBSA).

If the request is not complete, the notification must describe the information needed to make the request complete, and the Plan must let a Claimant perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

External Review Process
The external review process is independent and without bias and may be assigned to and conducted by an independent review organization (an "IRO") that is accredited by a nationally recognized accrediting organization or may be conducted in another manner that ensures an independent and unbiased external review. If an IRO will be assigned to conduct the review, then at least three IROs must be under contract for assignments which must be rotated among them. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO shall notify the Claimant, in a timely manner, of its acceptance of the review and inform the Claimant of the deadlines for submissions of additional information which shall be no later than ten business days following receipt of this notice.

Within five business days of assignment of the external review to the IRO, the Plan shall provide to the IRO any documents and information it used in making its Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

Notice of Final Review Decision
The IRO must provide written notice of the Final External Review Decision within 45 days after receiving the request for the external review. The notice must be delivered to the Claimant and to the Plan.

Expedited External Review
External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize his or her ability to regain maximum function, an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility. For an expedited review, the IRO must provide notice of the Final External Review Decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice to the Claimant is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Benefit Document - A document that describes one (1) or more benefits of the Plan.

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)).

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Dependent - see the Eligibility, Effective Date, Termination and COBRA section

Eligible Expense(s) - Expense that is: (l) covered by the Benefit Document and (2) incurred while the person is covered.

Employee - sec the Eligibility, Effective Date, Termination and COBRA section

Employer(s) - The Employer or Employers participating in the Plan as stated in the General Plan Information section.

Fiduciary - Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

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

Participating Employer - An Employer who is participating in the coverages of the Plan. See General Plan Information section for the identity of the Participating Employer(s).

Preventive Prescription - A medicine, drug or supplement that is recommended by the U. S. Preventive Task Force and is required to be provided at no additional cost to a Covered Person as mandated under the Patient Protection and Affordable Care Act.

Physician - A Doctor of Medicine (MD), a Doctor of Osteopathy (DO), or any other licensed health care provider who is licensed to prescribe drugs.

NOTE: The term "Physician" will not include the Covered Person himself or his relatives.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the General Plan Information section.

Plan Administrator - see "Plan Sponsor"

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan.

Administrator - See General Plan Information section for the identity of the Plan Sponsor.

Retiree - See the Eligibility, Effective Date, Termination and COBRA section.

GENERAL PLAN INFORMATION

Name of Plan:	El Camino Hospital Group Insurance Plan
Plan Sponsor/Plan Administrator: Address: Business Phone Number:	El Camino Hospital 2500 Grant Road, Mountain View, CA 94040 (650) 940-7000
Participating Employer(s):	El Camino Hospital
Plan Sponsor ID Number (EIN):	94-3167314
Plan Number:	502
Original Effective Date of Plan:	January 1, 1966
Plan Year:	January 1 through December 31
Named Fiduciary: Address:	El Camino Hospital 2500 Grant Road, Mountain View, CA 94040

(See also definition of "Fiduciary")

Agent for Service of Legal Process: Address:	El Camino Hospital 2500 Grant Road, Mountain View, CA 94040

(Legal process may be served upon the Plan Administrator or a Fiduciary)

Type of Plan:	This is an employee welfare benefit plan providing group benefits
Plan Benefits Described Herein:	Self-Funded Prescription Drug Benefits
Type of Administration:	Contract Administration - see "Administrative Provisions" for additional information
Contract Administrator·:	OptumRx
Mailing Address:	P.O. Box 509075 San Diego, CA 92150-9075

FUNDING SOURCES AND USES

Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a Section 125 pre-tax premium plan.

See the COBRA Continuation Coverage section for more information.

ADMINISTRATIVE PROVISIONS

Administration (type of)
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan Sponsor fully intends to maintain these Plan benefits indefinitely. However, since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate retiree benefits under the Plan, if any; alter or postpone the method of payment of any benefit;
- amend any of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend to modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification to amendment shall divest an individual of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Plan participants will be provided with notice of the change within the time required by federal law.

Anticipation, Alienation, Sale or Transfer
No benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment will be made when the error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Collective Bargaining Agreement(s)
This Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor, and is available for examination by Covered Person and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

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

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

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan documents, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other

person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

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

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

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

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

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

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

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

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

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

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

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

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

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

Plan Administrator Duties & Compensation – The duties of the Plan Administrator are to:

- administer the Plan in accordance with its terms;
- interpret the Plan in its discretion, including the right to remedy possible ambiguities, inconsistencies or omissions;
- decide disputes which may arise relative to a Plan participant's rights; prescribe procedures for filing a claim for benefits and to review claim denials;
- keep and maintain the Plan documents and all other records pertaining to the Plan; appoint a Claims Administrator to pay claims;
- perform all necessary reporting as required by ERISA;
- establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609;
- delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

The Plan Administrator serves without compensation. However, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

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

Reimbursements

Plan's Right to Reimburse Another Party – Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then

the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

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

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

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

- the individual submits any claim that contains false or fraudulent elements under state or federal law;
- a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;
- an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law;
- an individual makes an intentional misrepresentation of a material fact.

Rescission requires thirty days advance notice, and any rescission of coverage is subject to the Claims and Appeals procedures.

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

STATEMENT OF RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

Receive Information About This Plan and Benefits. This includes the right to:

- 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) 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 a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and
- receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

- the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the "COBRA Continuation Coverage" information for additional details about these 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 a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.
If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Enforcement of Rights
Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if he requests materials from a Plan and docs not receive them within 30 days, he may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
If he has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal Court but only after exhausting the Plan's claims and appeals procedures. In addition, if he disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMSCO), he may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

Assistance With Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (l) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or 2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.