AGREEMENT FOR MEMBERSHIP: This Ground Ambulance Membership Plan Coverage Agreement ("Agreement") is entered into between Dignity Health St. Elizabeth Community Hospital, doing business as Dignity Health St. Elizabeth Community Hospital (referred to herein as "Dignity Health St. Elizabeth Community Hospital"), based at 2550 Sister Mary Columba Drive, Red Bluff, CA 96080

By signing the Application, I agree, on behalf of myself and the residents of my household listed on the Application, to abide by the terms of Dignity Health St. Elizabeth Community Hospital's Ambulance Membership Plan (the "Plan"), as set forth in this Agreement. Coverage will begin the day after Dignity Health St. Elizabeth Community Hospital receives my Application and payment, and will expire midnight on the last day of the month payment is received of the following year.

PERSONS COVERED: The Plan covers me and the household members listed in my Application, so long as they remain full-time residents of the specified household. New household members may be added, household members may be deleted or the household location may be changed by written notice to Dignity Health St. Elizabeth Community Hospital effective the day following receipt by Dignity Health St. Elizabeth Community Hospital of such notice. All persons covered by the Plan shall be referred to herein as "Plan Members" or "Members." References to "I" or "me" and similar references shall be construed as including all Members.

CONDITIONS OF MEMBERSHIP: As a condition of obtaining the benefits of membership and Plan coverage, I must submit a complete, accurate Application and pay Dignity Health St. Elizabeth Community Hospital a non-refundable membership fee in the amount specified in the Application. In the event of any change in the insurance coverage or status of any individual named in the Application, I agree to notify Dignity Health St. Elizabeth Community Hospital within ten (10) days and, if the change results in the affected individual owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from Dignity Health St. Elizabeth Community Hospital.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by Dignity Health St. Elizabeth Community Hospital, but that my membership in the Plan will assist me by discharging that part of my financial liability that is not covered by insurance for those Dignity Health St. Elizabeth Community Hospital services specified in this Agreement. This benefit is subject to certain limitations specified in this Agreement. As a condition of receiving this benefit, I hereby assign to Dignity Health St. Elizabeth Community Hospital all rights and benefits that I or the other Members in my household have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services covered by this Agreement. Such payment sources are collectively referred to in this Agreement as "Insurance." I authorize payment of all Insurance benefits or payments for ambulance services covered by this Agreement to Dignity Health St. Elizabeth Community Hospital.

I understand that Dignity Health St. Elizabeth Community Hospital will, whenever it deems it feasible, file claims for and directly collect the benefits payable from Insurance, up to the amount of Dignity Health St. Elizabeth Community Hospital 's charges for its services. When requested by Dignity Health St. Elizabeth Community Hospital , I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receive any Insurance or other third party payments for ambulance services provided by Dignity Health St. Elizabeth Community Hospital , I will promptly turn over those payments to Dignity Health St. Elizabeth Community Hospital . I agree to pay Dignity Health St. Elizabeth Community Hospital for any services it provides that are not covered by this Plan.

BENEFITS: Payment of the membership fee and compliance with the terms of this Agreement entitle Members to the following benefits within the Service Area as specified below:
a. Emergency ambulance services: Members who receive medically necessary emergency ambulance services from Dignity Health St. Elizabeth Community Hospital shall pay nothing out of pocket, except as specified herein.
b. Inter-facility ambulance services. Members who receive medically necessary inter-facility ambulance services from Dignity Health St. Elizabeth Community Hospital shall pay nothing out of pocket, except as specified herein.

LIMITATIONS and EXCLUSIONS: Membership benefits only extend to medically necessary ambulance services provided by Dignity Health St. Elizabeth Community Hospital provided in the Service Area as described below. Benefits are provided for ground ambulance services only.

BEYOND THE CALL: Any ambulance service which is denied coverage by a Member's primary Insurance shall be deemed not to be medically necessary and shall not be covered by this Plan. Subject to the foregoing, in determining whether any emergency or inter-facility ambulance service is "medically necessary," Dignity Health St. Elizabeth Community Hospital reserves the right to require a certificate of medical necessity from a qualified physician in determining medical necessity. As a condition of receiving the full benefit of membership with respect to any ambulance service provided by Dignity Health St. Elizabeth Community Hospital , the ambulance service must be covered by the Member's primary Insurance coverage. Some insurance programs require the insured person to obtain prior authorization before receiving ambulance services. Some plans require certain documentation from the insured within a specified time limit, or the plans deny or reduce coverage for ambulance services. Services outside the Service Area are or beyond the mileage limitations specified below are not covered. Dignity Health St. Elizabeth Community Hospital shall apply the standards of the Medicare program. Medi-Cal participants are not eligible for membership.

SERVICE AREA: The Service covers only the County of Tehama.

TERMINATION AND RENEWAL OF COVERAGE: Dignity Health St. Elizabeth Community Hospital may terminate this Agreement and the participation of any Membership in the Plan for failure to comply with the terms of this Agreement. Dignity Health St. Elizabeth Community Hospital reserves the right to discontinue its Ambulance Plan at any time upon notice to Members. In such event, Dignity Health St. Elizabeth Community Hospital shall return a pro rata portion of the membership fee. Dignity Health St. Elizabeth Community Hospital also reserves the right to unilaterally modify the terms of this Plan, including but not limited to the membership fee to be charged to Members who join or renew their membership after the effective date of such change. Subject to the foregoing, Dignity Health St. Elizabeth Community Hospital shall renew membership on an annual basis upon completion by a Member of an Application or Renewal Application and payment of the specified Membership Fee. Renewal contracts may include changes in coverage.

NOTICES REQUIRED BY THE DEPARTMENT OF MANAGED HEALTH CARE:
(A) BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

(B) WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call.

YOU MUST SIGN OR INITIAL THIS STATEMENT IN THE APPLICATION.

(C) COMPLAINTS: For complaints regarding this Ambulance Plan, or if you have questions regarding the Plan, first attempt to call Dignity Health St. Elizabeth Community Hospital at 530.529.8318. If Dignity Health St. Elizabeth Community Hospital fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1.800.400.0815. The Department's website is http://www.dmhc.ca.gov. You may obtain complaint forms and instructions online.

(D) OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 ct scq.).2 DLMR 281356.1 023.269805.1

Dignity Health™
St. Elizabeth Community Hospital

Dignity Health™
St. Elizabeth Community Hospital
A GROUND MEMBERSHIP PROGRAM

2550 Sister Mary Columba Drive
Red Bluff, CA 96080

Focusing on our citizens, in our community.

Dignity Health™
St. Elizabeth Community Hospital

Enroll online at **dignityhealth.org/stelizabethhospital/ambulance**
or call **530.529.8318**

Peace of mind in an emergency.

You are covered with Dignity Health Medical Transport Services.

Dignity Health™
St. Elizabeth Community Hospital

Membership Enrollment Form

STEP 1 Member Contact Information

First Name:_____ Last Name: _____

Physical Address:_____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____ County:_____

Date of Birth: _____/_____/_____ (M ☐ F ☐) Do you live within the city limits? Yes ☐ No ☐

Do you have medical insurance? Yes ☐ No ☐

STEP 2 List Persons In Household and Date of Birth (other than yourself)

First Name:_____ Last Name: _____

Date of Birth: _____/_____/_____ (M ☐ F ☐) Does member have medical insurance? Yes ☐ No ☐

First Name:_____ Last Name: _____

Date of Birth: _____/_____/_____ (M ☐ F ☐) Does member have medical insurance? Yes ☐ No ☐

First Name:_____ Last Name: _____

Date of Birth: _____/_____/_____ (M ☐ F ☐) Does member have medical insurance? Yes ☐ No ☐

STEP 3 Annual Membership Fees

☐ **$75** Per household with medical insurance

☐ **$100** Per household with no medical insurance

☐ Group Fees – Call for details

Membership Agreement

All information included in this application is correct to the best of my knowledge, including all health insurance information. If this insurance is not in place at the time medical services are rendered, my Dignity Health membership is considered null and void. Any changes in this information must be reported to the Dignity Health Membership Office within (5) days. Membership is valid for one (1) year, beginning (1) day after your completed application and your nonrefundable payment is received. My signature below indicates agreement to the stated terms and conditions of membership.

Signature X_____ Date_____

Payment Options

☐ **Check or Money Order.** Make payable to Dignity Health St. Elizabeth Community Hospital

Dignity Health Office Use Only

Base Code	Track Code

NOTICES REQUIRED BY THE DEPARTMENT OF MANAGED HEALTH CARE:

(A) BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

(B) WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next it the rotation to receive a call. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate time frame due to a mechanical or maintenance problem or being on another call.

SIGN or INITIAL HERE _____

(C) COMPLAINTS: For complaints regarding this Ambulance Plan, or if you have questions regarding the Plan, first attempt to call Dignity Health St. Elizabeth Community Hospital at 530.529.8318. If Dignity Health St. Elizabeth Community Hospital fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-800-400-0815. The Department's website is http://www.dmhc.ca.gov. You may obtain complaint forms and instructions online.

(D) OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.).

All membership applicants 19 years or older must sign

I hereby apple for membership in the Dignity Health St. Elizabeth Community Hospital Membership program. I have reviewed the Dignity Health St. Elizabeth Community Hospital Membership Plan Coverage Agreement and agree to abide by the terms thereof. I request payment of authorized Medicare or other insurance benefits to me or on my behalf to Dignity Health St. Elizabeth Community Hospital for any ambulance services and supplies furnished to me by Dignity Health St. Elizabeth Community Hospital. I authorize any holder of medical information about me or minors within my household to release that information to the Centers for Medicare and Medicaid Services, other providers, their agents and carriers, or Dignity Health St. Elizabeth Community Hospital, in order to determine benefits payable on my behalf, now and in future. This agreement and authorization is executed on my own behalf and on behalf of other members of my household, if they are minors or otherwise unable to sign. In the event of any change in the insurance coverage or status specified on this application, I agree to notify Dignity Health St. Elizabeth Community Hospital within ten (10) days and, if the change results in the affected member(s) owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from Dignity Health St. Elizabeth Community Hospital specifying the additional amount due. Failure to notify Dignity Health St. Elizabeth Community Hospital of any such change or to pay any additional amount due within thirty days of the invoice date shall result in the automatic termination of this Agreement without any notice to the affected member. By signing this application for Membership, I agree to all conditions of the "Dignity Health St. Elizabeth Community Hospital Ambulance Plan Coverage Agreement" as stated in said contract.

Dignity Health™
St. Elizabeth Community Hospital