


Employee Benefits

2024

US ANESTHESIA PARTNERS

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Working together is what makes US Anesthesia Partners a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This benefits guide offers details on your 2024 benefit options. Contact the Human Resources department with any questions.

See page 54 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to U.S. Anesthesia Partners. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

Dear USAP employee,

Your health and well-being matter to us. For this reason, we offer comprehensive benefit options for you and your family, including medical, dental, vision, life and disability, and additional benefits coverage. We are committed to excellence in our work and in our offerings for 2024.

This guide includes:

- An overview of your 2024 benefits options
- Explanations of each offering to help you make the best decisions for you and your family
- Contact information for all benefits vendors
- Costs associated with your benefits

What's NEW in 2024

- NEW FERTILITY benefits through BCBSTX with a lifetime maximum benefit of $75,000.
- NEW DENTAL CARRIER – USAP is moving from Cigna Dental to Delta Dental of Texas. Your current dental elections will roll over to 2024. It will have the same plan, same rates, with expanded population of in-network providers.
- New Directions EAP Visits – We are increasing face-to-face visits from 3 to 8 visits per year, per family member, per issue.
- MDLive – Enhancing MDLive virtual visits now include behavioral health counseling visits.
- During 2024 open enrollment, New York Life is not requiring Evidence of Insurability (EOI) for any new or updated elections to Supplemental Life (under $300,000 Guaranteed Issue Amount) or Disability (STD/LTD) elections.

Enrollment Reminders: Healthcare and Dependent Care Flexible Spending MUST be re-enrolled each calendar year, per IRS requirements. Health Savings Account (HSA) will roll over and allow you to keep the MaxSaver, or you can make contribution changes at anytime of the year.

What's CHANGING in 2024

- Medical – Slight deductible and max out of pocket increase and rate increase.
- New York Life – Supplemental Spouse Life and age reduction will be based on "Spouse/Domestic Partner" age instead of employee age.
- MetLife Accident – Moving from two options to one plan. All plans are moving to an enhanced plan with lower premiums rates. Anyone currently enrolled in Accident will roll over to this new enhanced plan.
- Critical Illness – Benefit premium decrease.
- Hospital Indemnity – Slight premium increase.
- Flexible Spending Contribution Increased: $3,050
- Dependent Care FSA: $5,000 No Change
- Dependent Care – Highly Comp Employees are limited to $2,500 in annual contributions.
- HSA Contributions Increased:
  - Individual - $4,150
  - Family - $8,300

MOVING TO DIRECT BILL

(No USAP Payroll Deduction) Effective 01/01/2024

- Farmer's Insurance/MetLife Auto & Home
- Nationwide Pet Insurance

Any questions?

We're here to help. Contact Human Resources at 855-948-4238.

Eligibility and Enrollment

US Anesthesia Partners' benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of US Anesthesia Partners (USAP) who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in medical, dental, vision, life and disability plans, along with the Flexible Spending Accounts (FSAs), and additional voluntary benefits.

Coverage Dates

Your elections are effective on your date of hire. Benefits cannot be changed until the next enrollment period unless you experience a qualifying life event (QLE).

Dependents

Dependents eligible for coverage include:

- Your legal spouse/domestic partner (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse/domestic partner have legal guardianship).
- Dependent children 26 or older, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility may be required upon enrollment.

As part of federal tax reporting requirements, we must report to the Internal Revenue Service (IRS) the covered person's name, address, and Social Security number (SSN).

Passive Enrollment

November 1 – November 15

This year we are conducting a **"Passive Enrollment."** This means your benefits elections will automatically roll over to the 2024 plan year. You do not need to take any action unless you:

- Would like to change or decline your current benefits, including status changes of currently enrolled dependents.
- Would like to purchase additional voluntary life insurance for yourself, spouse, and/or child.

Any new elections you make or those that roll over will remain in place for the 2024 plan year unless you experience a qualifying life event.

If You Do Not Enroll

New Hires or Newly Eligible Employees must elect coverage within 14 days of the date of hire. Otherwise, only the defaulted company paid benefits will be in effect.

FSAs require re-enrollment annually.

If You Are a New Hire (Onboarding)

You will have received enrollment materials during your onboarding process through Workday. The Benefit Inbox Action Item in Workday is the last item that will appear after the I-9 is fully completed. If you need additional assistance, you can reach out to 855-464-USAP (8727), visit **USAPToday.com**, download the Now Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

Be sure to update your Tobacco/Nicotine status; otherwise, your premium will default to include the surcharge. Providing false statements regarding Tobacco/Nicotine usage is against company policy. Covering ineligible individuals on your benefit plans is considered fraudulent and theft. Claims will be reprocessed and become your financial responsibility. Anyone identified providing false statements will be subject to disciplinary actions up to including termination of employment.

Eligibility and Enrollment

Dependent Verification

When you enroll a dependent in a US Anesthesia Partners benefit plan, you are certifying that you understand that you have enrolled an eligible dependent based on the plan definition of dependent, as described on the prior page.

US Anesthesia Partners will perform audits periodically in which US Anesthesia Partners may ask you for supporting documentation to provide proof of valid dependent status.

You will be notified by the benefit team if the plan requires documentation.

Acceptable supporting documentation:

- Natural or Adopted Child(ren) — Birth Certificate
- Step-Child(ren) — Birth Certificate and Marriage Certificate connecting the relationship with the parent and employee
- Spouse — Marriage Certificate or recent IRS Tax Joint Filing
- Domestic Partner — Government document supporting marriage or civil union AND recent document supporting cohabitation such as a utility bill with both the domestic partner and employee's name. USAP Domestic Partner Affidavit Required.

Plan ahead — you will have 60 days to submit your documents when asked:

- Can you locate your children's birth certificates, marriage license, or civil union documents?
- Do you need to order another copy of your children's birth certificates?

QMSCO – Qualified Medical Support Court Orders

QMSCOs will be updated to reflect existing benefit plan elections. If no elections are present, the Value HDHP medical plan, Standard dental plan and VSP vision plans will be elected based on the court order.

Qualifying Life Events

TIME SENSITIVE — 31 DAY DEADLINE!

When one of the following events occurs, you have 31 days from the date of the event to request changes to your coverage via self-service in Workday.

Note: Documentation is required for a QLE change.

- Change in your legal marital status (marriage, divorce, or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse/domestic partner's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to 855-464-USAP (8727), visit **USAPToday.com**, download the Now Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse/domestic partner have benefits coverage available through another employer?
- Did you get married, divorced, or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this Guide.
- Are you a tobacco/nicotine user? Be sure to update your status appropriately as the premium defaults to the surcharge.

Domestic Partnerships

Information About Domestic Partnerships

To qualify, you must meet the requirements for at least 12 consecutive months and must provide at least two of the following required documents listed below.

- Joint housing lease, mortgage or deed (at least 12 months prior to the date of the affidavit)
- Joint checking or savings account
- Joint ownership of a motor vehicle
- Designation of your partner as a primary beneficiary of your life insurance, retirement benefits, or residual estate under a will
- Designation of your partner as holding a durable power of attorney for your healthcare decisions
- State-issued Certificate of Domestic Partnership or Common-Law Marriage

Special Tax Rules for Domestic Partners

Unless your domestic partner qualifies as your dependent for tax purposes, Internal Revenue Service (IRS) rules do not allow you to pay the cost of your domestic partner's benefits on a before-tax basis. In addition, under IRS rules:

- You cannot pay health or dependent care expenses for a domestic partner or his/her children with funds from a Flexible Spending Account.
- The fair market value (as defined by the IRS) of your domestic partner's benefit coverage is taxable to you as "imputed income" and is subject to ordinary federal, Social Security, state, local and any other applicable payroll taxes.
- The cost of domestic partner coverage is the same as a spouse (or family, if you enroll both your domestic partner and his/her children). However, because IRS rules do not allow you to reduce your taxable pay for the cost of domestic partner coverage, a portion of your pre-tax payroll deduction will be added back.

If you and your domestic partner get legally married, please remember to submit a qualifying life event within 31 days of the marriage, to change your domestic partner status to "SPOUSE" and to remove imputed income.

Making Changes During the Year

You can make changes to your benefits for the following reasons:

- Birth or adoption of a child (yours but not your domestic partner's)
- Covered child's loss of dependent status (yours but not your domestic partner's)
- You domestic partner dies
- Your domestic partner gains or loses eligibility for healthcare coverage
- Your domestic partnerships ends (with court documentation)

Note: To add the same or another domestic partner in the future, you must again meet all the requirements for at least 12 consecutive months.

Enrollment Tips

US Anesthesia Partners provides its employees the best coverage possible. As a committed partner in your health, US Anesthesia Partners will be absorbing a significant amount of the costs. Your share of the contributions for Medical, Dental, Vision, and FSA benefits is deducted on a pre-tax basis, which lessens your tax liability.

Employee contributions vary depending on the level of coverage you select. In general, the more coverage you have, the higher your employee contributions will be.

Keep in mind that you may select any combination of Medical, Dental, and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself. The only requirement is that you, as an eligible employee of US Anesthesia Partners, must elect coverage for yourself in the plan in order to elect any dependent coverage. You have the option to select coverage from the following categories:

- Employee Only
- Employee + Child(ren)
- Employee + Spouse/ Domestic Partner
- Employee + Family

Be sure to have the Social Security number(s) (SSN) and birthdate(s) for any eligible dependent(s) that you plan to enroll.

As part of federal tax reporting requirements, we must report to the Internal Revenue Service (IRS) the covered person's name, address, and Social Security number (SSN).

Note

SSN is required for Medicare information on all employees and dependents.

How to Enroll

Understand Your Choices

This Guide contains very useful reference material to help you prepare for Benefit Enrollment. Keep it handy so you can refer to it throughout the year or visit **USAPToday.com** for additional materials.

Review Your Options with Your Family

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

Visit Workday

- **USAPToday.com** and click the Workday link
- **Workday.usap.com**
- Workday mobile app (only during Open Enrollment)

Go to Your Workday Inbox

Enroll, Review, Confirm & Submit Your Benefits

Save Your Elections

You must click the "I agree" checkbox and then the "Submit" button or your elections will not be saved. Remember that you can always visit Workday to view your elections.

IMPORTANT: Please print and/or save your 2024 Benefit Statement for your records.

Enrollment: Add or Change Benefits

Navigating to Benefit Enrollment in Workday

Visit Workday

- Go to **USAPToday.com** and click the Workday link
- **Workday.usap.com**
- Workday mobile app (Only for Open Enrollment)

Go to your Workday Inbox

- You will see a notice in your inbox to initiate your Benefit Enrollment event
- New Hires (currently onboarding) will see the notice to initiate your Benefit Enrollment event only AFTER all the onboarding activities are completed through the I-9

Complete Benefit Elections

1. Complete your tobacco/nicotine attestation. Select "No" if you and your spouse/domestic partner, if enrolled, have been tobacco/nicotine free for the past three months. Click "Continue."
2. When the page reloads, click "Continue" again.
3. The next screen will display all of your benefit options, each with their own box. Click on the bottom of your desired benefits to make your elections — it will either say "Enroll" or "Manage."
4. To enroll dependents:
    - After you've clicked into the desired benefit and made your plan election, click "Confirm and Continue."
    - On the Dependents page, click on "Add New Dependent." Complete the information and click "OK." Enter all mandatory information and click "Save." If your dependent is already in the Workday system, they will be listed on the Dependents page, and you can select/unselect the box next to their name accordingly. Click "Save."
5. Make Health Savings Account Plan Dependencies elections by clicking on "Select" or "Waive" for the various HDHP offerings. Click "Confirm and Continue." If you elect coverage, provide required information in the Contribute section. Click "Save."
6. Make Spending Account Plan Dependencies elections by clicking on "Select" or "Waive" for the various PPO offerings. Click "Confirm and Continue." If you elect coverage, provide required information in the Contribute section. Click "Save."
7. Make Insurance Elections by selecting "Select or Waive" for the various offerings in the Insurance Plan Dependencies and Coverage Limitations section. Click "Continue."
8. Update your Beneficiary Designations (if applicable) within the appropriate benefits. Make your election and click "Confirm and Continue." Make your beneficiary entries or changes and click "Save."
9. Click "Review and Sign" to review your Elected Coverages, Waived Coverages, and Beneficiary Designations. Scroll down the page to Attach Dependent Documentation (if applicable) and click the "I Agree" checkbox to confirm your selections. Click "Submit" to save the transaction.
10. Scroll to the bottom of the screen and click the Print icon to print a paper copy of your elections for your personal record or click "Done" to complete the process.

Benefit Enrollment Checklist

- Review elections
- Review dependents are selected
- Confirm Tobacco/Nicotine status is correct
- If FSA is elected, is it Health or Dependent Care FSA?
- Click "I Agree to confirm"
- Click "Submit" to save your enrollment
- PRINT or SAVE your enrollment for your records

Note

You can always visit Workday to view your benefit elections.

IMPORTANT: Please print and/or save your 2024 Benefit Statement for your records.

Medical Benefits

Medical benefits are provided through Blue Cross Blue Shield of Texas (BCBSTX). Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing a medical plan for you and your family. Keep in mind your choice is effective for the entire 2024 plan year unless you have a qualifying life event.

How to Find a Provider

Visit **www.BCBSTX.com** or call Customer Care at 800-551-2227 for a list of Blue Cross Blue Shield of Texas (BCBSTX) network providers. Note: You will not receive new medical ID cards unless you change medical plans.

Medical Plan Summary

This chart summarizes the 2024 medical coverage provided by Blue Cross Blue Shield of Texas (BCBSTX). All covered services are subject to medical necessity as determined by the plan. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PPO		HDHP CORE		HDHP VALUE	
	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]
ANNUAL DEDUCTIBLE						
INDIVIDUAL[2]	$1,500	$3,000	$2,000	$4,000	$3,500	$7,000
FAMILY[3]	$3,000	$6,000	$4,000	$8,000	$7,000	$14,000
FAMILY DEDUCTIBLE TYPE	Embedded	Embedded	Aggregated	Aggregated	Aggregated	Aggregated
COINSURANCE (PLAN PAYS)	80%	60%	80%	60%	70%	50%
ANNUAL OUT-OF-POCKET MAXIMUM[4] (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,000	Unlimited	$4,500	Unlimited	$7,500	Unlimited
FAMILY[5]	$10,000	Unlimited	$9,000	Unlimited	$15,000	Unlimited
COPAYS/COINSURANCE						
PREVENTIVE CARE	100% Covered	40%*	100% Covered	40%*	100% Covered	50%*
PRIMARY CARE	$35 Copay	40%*	20%*	40%*	30%*	50%*
SPECIALIST SERVICES	$55 Copay	40%*	20%*	40%*	30%*	50%*
DIAGNOSTIC CARE	20%*	40%*	20%*	40%*	30%*	50%*
MENTAL HEALTH – INPATIENT	20%*	40%*	20%*	40%*	30%*	50%*
MENTAL HEALTH – OUTPATIENT	$35 Copay	40%*	20%*	40%*	30%*	50%*
URGENT CARE	$75 Copay	40%*	20%*	40%*	30%*	50%*
EMERGENCY ROOM	$250 Copay + 20%*		20%*		30%*	
VIRTUAL VISITS	$25 Copay	N/A	$48**	N/A	$48**	N/A

*After deductible
**After you meet the deductible, coinsurance applies.
Note: If you experience an emergency out-of-the-country, the plan will reimburse reasonable and customary rates.
[1]Out-of-network reimbursement is subject to allowable amounts.
[2]Individual deductible applies to an employee only election.
[3]Family deductible applies to any election other than employee only.
[4]In- and out-of-network out-of-pocket costs do not cross-apply to the deductible or out-of-pocket maximum.
[5]You have a $7,500 individual in-network out-of-pocket maximum within your total family out-of-pocket maximum.

How It Works – Deductibles

On the PPO Plan, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

The HDHP Core and HDHP Value Plans have an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan.

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them. Example: Office visits, prescriptions, etc.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Tips to Save You Money

- Ask your doctor for prescription drug samples.
- Ask your doctor to file a "pre-certification" claim BEFORE performing any services/procedures so you know what your estimated out-of-pocket expenses will be at the time of service.
- Always stay and use "in-network" to avoid higher cost claims. The question to ask is, "Are you in-network with BCBS of Texas when making appointments?"
- Don't delay any preventive care visits to the doctor!

Medical Plan Options

You and your family have unique needs, which is why US Anesthesia Partners offers a variety of benefit plans from which you may choose. Consider your spouse/domestic partner's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Medical Premiums

Medical premium contributions will be deducted from your paycheck on a pre-tax basis. Your coverage level will determine your monthly contributions. Premiums can be found in Workday, during enrollment.

Virtual Visits and Finding Providers

Contact BlueCross BlueShield to utilize MDLive virtual visits, Nurseline, or to find a physician or facility/lab. MDLive is available 24 hours a day, 7 days a week to access a board-certified doctor. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center. You can access MDLive on the BlueCross BlueShield of Texas app, via online video, or by telephone by calling 888-680-8646.

Preferred Provider Organization Plan (PPO)

With the PPO plan, you have the freedom to receive care from any licensed provider. Keep in mind that you will generally pay less when you receive care from doctors, hospitals, and other healthcare facilities that participate in the network.

For most routine and office services, you pay a copay (refer to page 9 for additional information).

For other in-network medical care and services, you pay coinsurance after you meet the deductible.

NEW 2024 – Fertility Benefits Through BCBSTX

Fertility benefits have a $75,000 lifetime maximum benefit per employee. Call 800-521-2227 for specific details on fertility benefits.

High Deductible Health Plan (HDHP)

The HDHP is a high deductible plan with a Health Savings Account (HSA). This plan gives you the opportunity to lower your monthly premiums while allowing you the opportunity to set aside pre-tax dollars to pay for current or future eligible healthcare expenses. You can use your HSA dollars to pay for healthcare expenses even after you retire.

Similar to the PPO plan, the HDHP includes comprehensive medical and prescription coverage. In-network preventive care is covered at 100% to help you and your family stay as healthy as possible. You have the freedom to receive care from any licensed provider. However, you can save money when you use in-network providers.

The HDHP is different from the PPO in that for most services you'll have to meet a deductible before the HDHP pays its share of the benefit. In addition to the deductible, another key difference is that services provided under a HDHP are subject to coinsurance instead of a copay. In exchange for the deductible amount, the monthly premiums for these plans are lower.

In general, you'll pay the network cost of each service until you reach the deductible, then you will pay a percentage of the cost for each service (coinsurance) until you reach your annual out-of-pocket maximum.

Deductibles are included in the Out-of-Pocket Maximum. Always make sure you are staying "in-network" to get the best cost savings for your medical plan.

The HDHP Core and HDHP Value Plans have an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan.

Find a Doctor or Hospital

You don't have to be enrolled in a US Anesthesia Partners medical plan in order to verify if your preferred physician or facility is considered in-network. To do so, follow the below steps.

How to Search

1. **Navigate to www.BCBSTX.com, 800-521-2227**
   BlueCross BlueShield of Texas is the medical carrier for those living in and out of Texas.
2. **Locate "Find a Doctor or Hospital"**
   You can find it in the blue search bar near the top of the page. Click there.
3. **Click "Search as Guest"**
   Even if you are not yet a member, you can search the BlueCross BlueShield of Texas database.
4. **At this point, you can select "Find an In-Network Provider" or "Search All Providers"**
   - If you select "Find an In-Network Provider," you will then indicate that you get your insurance through your employer. Next, you will indicate whether you are a member or you are shopping for a plan. Select that you are looking for medical care, your state, and finally select the appropriate plan/network — see opposite list.
   - If you select "Search All Providers," you will move on to step 5 immediately.
5. Enter the location where you would like to search for care
6. Use the next page to refine your search
   - If you selected "Search All Providers," then you can use this webpage to refine the plan/network. Keep in mind that if you do not, these search results may show providers who are not considered in-network and whose services from those providers may not be covered by your plan. Be sure to confirm those details before seeking care.
   - You can use this webpage to refine your search by any of the filters on the left-hand side of the webpage.

Note: If traveling outside the U.S., review page 44 for Travel Assistance information. Traveling outside the U.S. will require you to pay upfront costs and then file claims for reimbursement with BCBSTX.

US Anesthesia Partner Networks

Your medical plan network depends on your group number. Please see the below chart for your state network. Your group number can be found on your BCBSTX ID card.

STATE	NETWORK
Colorado	BlueChoice PPO
Indiana	
Kentucky	
Nevada	
Tennessee	
Texas	
Washington	
District of Columbia	BlueChoice Advantage Open Access
Maryland	
Montana	
Florida	Network Blue
Ohio	

Medical benefits are through BlueCross BlueShield of Texas.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Wellness visits, physicals, and standard immunizations

If you discuss any diagnostic medical symptoms, your visit is no longer preventive and subject to copay, deductible, or coinsurance depending on your medical plan.

Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Preventive Care Services include routine mammogram, colonoscopy (Prep cost under Rx), prostate PSA test, pap smears, annual physical, well-baby exam and flu shots. Age and frequency limitations may apply.

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Iron supplements (for children ages 6 to 12 months at risk for anemia)

Important Tip: When scheduling your preventive care visit, make sure the scheduler notes that the visit is preventive so the doctor codes the visit as such and you pay $0 for the visit. However, if you have a "history of" (i.e. a previous diagnosis), your visit will not be considered preventive.

Don't miss out on these covered services. Remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What about the COVID-19 vaccine?

The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be covered at no cost.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're under the weather, there's no place like home. When you're constantly on the go, scheduling a doctor's appointment can easily move down your priority list. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

We provide a virtual medicine benefit through MDLive for you and your dependents. MDLive offers on-demand access to board-certified doctors through online video, telephone, or secure email. General health issues can be addressed at home for a copay of $25 per consultation on the PPO plan or for $48* on the HDHP plans. Virtual medicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Virtual visits aren't good for conditions requiring exams or tests, complex or chronic problems, or emergencies like sprains or broken bones.

MDLive doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine.

MDLive: 888-860-8646

Note

A virtual visit or Facetime directly with your primary care physician (vs. MDLive) might also be an option — and typically costs the same as an office visit.

MDLive doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/ urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomach ache
- Sinus problems
- NEW: Behavioral Health Services through MDLive Virtual Visits

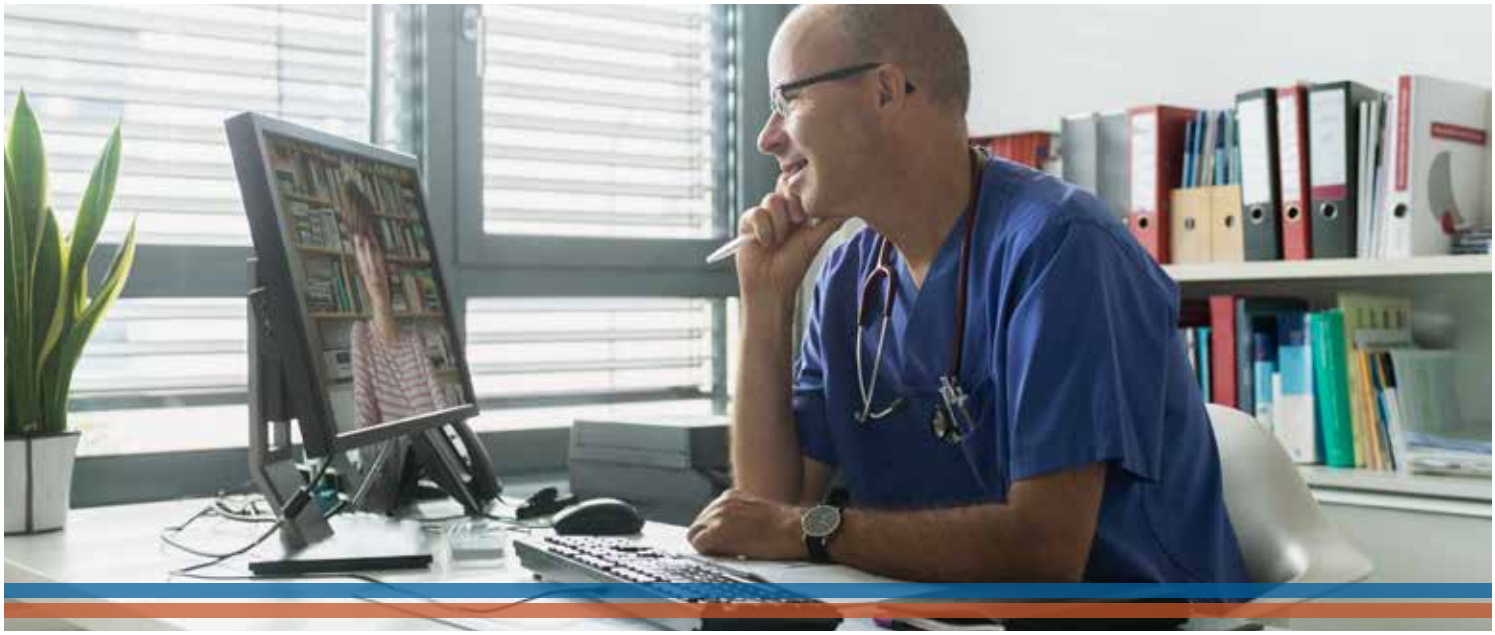
Access Virtual Visits

You can access MDLive on the BlueCross BlueShield of Texas app, via online video, or by telephone by calling 888-680-8646. After you register and request an appointment, you'll pay your portion of the service costs and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

VIRTUAL VISITS		
PPO	HDHP CORE	HDHP VALUE
$25 copay	$48* (Ded. Applies)	$48* (Ded. Applies)

*After the deductible is met, coinsurance applies.

Virtual Visit costs are Healthcare FSA and HSA eligible.



Employee Assistance Program

Employee Assistance Program (EAP)

US Anesthesia Partners cares about you and your family's total health management — mental, emotional, and physical. For that reason, we provide an Employee Assistance Program (EAP) at no cost to you through New Directions.

This service connects you with mental health and counseling services. Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. All services provided are confidential and will not be shared with US Anesthesia Partners. You may also access information, benefits, educational materials, and more either by phone at 800-624-5544, online at **eap.ndbh.com,** Passcode: USAP.

The New Directions program provides referrals to help with:

- Emotional Health and Well-Being
- Work Life Balance
- Alcohol or Drug Dependency
- Stress, Anxiety, Depression
- Grief and Loss
- Child/Elder Care
- Daily Living
- Career and Work
- Family Resources
- Financial Resources
- Emergency Resources

Online Therapy

Online Therapy is the most convenient way to connect with a licensed therapist using personal devices and mobile phones. You can send them texts, pictures, or audio/video messages, and they will respond daily up to five times a week. It is flexible to meet your needs and lifestyle and provides you with high-quality care at your fingertips 24 hours a day, 7 days a week.

How Online Therapy Works

1. On your web browser, enter **eap.ndbh.com**.
2. Enter the company code: usap.
3. Click "Request Counseling" — you'll see that you have a variety of options like face-to-face, online, telephonic, or in-the-moment.
4. Select Online — You will then see "Welcome to BetterHelp."
5. Select "Get Started."
6. Complete your basic information, enter the organization name as "US Anesthesia Partners" and then click "Next."
7. Once registration is completed, you can begin texting your therapist as much as you want. Over a period of time, you can write your thoughts and concerns and send it when you are ready for your therapist to review.
8. Keep in mind that this online chat will consist of you sending over as many messages as you have the time and thoughts. This is considered asynchronous text therapy, meaning you won't have immediate reaction to your texts, your therapist will respond a couple of times a day 5 days a week, which is equivalent to a 45-minute session.
9. When downloading the New Directions mobile app, you won't notice the difference between texting your friend or texting your therapist. Everything is secure and confidential.

FREE Phone Calls
8 FREE Face-to-Face Visits

Make sure to download the NEW DIRECTIONS mobile app.

NEW DIRECTIONS
Available 365/7, Completely Confidential
800-624-5544
eap.ndbh.com (Passcode: USAP)

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. Your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Mental Health and Your Medical Plan

When your covered EAP services run out, your medical plan covers behavioral and mental health services at the plan specified benefit level. Coverage includes virtual therapy from **MDLive**. Via video or telephone, you can receive confidential 1-on-1 counseling from the privacy and convenience of your home. Your licensed virtual therapist may provide a diagnosis, treatment, and medication if needed. You can see the same therapist with each appointment and establish an ongoing relationship. See plan documents for specifics on coverage for inpatient and outpatient services.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

1

Practice mindfulness.

Practice deep breathing, enjoy a stroll, and stay present in each moment.

2

Strengthen social connections.

Reach out to a friend or family member daily — even if it's just a video call or text.

3

Get quality sleep.

Keep a consistent sleep schedule and limit electronic use before bed.

4

Improve your outlook.

Treat people with kindness, including yourself.

5

Deal with your stress.

Think positively, exercise regularly, and set priorities.

BCBSTX Mental Health Services

Headway

It's the easiest way to get quality in-network mental health care.

We'll connect you with a licensed therapist or psychiatrist to support you in your mental health journey.

Whether you know what you're looking for or aren't sure where to start, we make it easy for you to find and schedule an appointment with the right mental health provider for you — covered by BCBSTX.

How it Works

- Find the right fit in seconds on **Headway.co**. Share your preferences and insurance details. Our personalized matching process will find the right providers for your unique needs within seconds — and calculate the exact cost for your session.
- Schedule your appointment immediately in one-click.

Book directly on Headway, and we'll take it from there.

Learn to Live

See how much better life can feel with digital mental health programs from Learn to Live.

Get a mental health tune-up — online.

- **Learn to adjust unhelpful thoughts and control your moods**. Explore quick and easy lessons whenever it fits your schedule. A little homework between sessions helps you keep up your progress. Activities are based on therapy techniques with a track record of helping people get better.
- **An expert coach can guide you.** If you need one-on-one support to reach your goals, connect with a coach by phone, text, or email. They'll lift you up, cheer you on, and help you master your new skills.
- **Your personal details are private.** Just like with face-to-face therapy, your personal results, program progress, and messages with your coach will not be shared with your employer.

Check out the programs included at no added cost through your BCBSTX plan:

- Log in at **bcbstx.com**.
- Click Wellness.
- Choose Digital Mental Health.

Or tap Digital Mental Health in the BCBSTX App.

Other Mental Health Resources

Other Mental Health Resources

No matter your situation, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

Whether it is life issues or work-related bad patient outcomes, help is just a call away. Resources are available at any time of need.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HELLO" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families can call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

According to the **American Psychological Association**, 61% of adults say they could have used more emotional support in 2020.

Health Savings Account (HSA)

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a Medical HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse/domestic partner, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Some eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on **www.irs.gov** for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse/domestic partner's non-HDHP.
- Your spouse/domestic partner does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)
- Domestic partners are not considered qualified dependents under IRS regulations and are therefore not eligible to use HSA funds.

Tax-free Interest

Employer Contributions
(pre-tax)

Voluntary Contributions

HSA

Tax-free Payments
(for qualified medical expenses)

Note

Not sure how much to contribute? Think about how much you may need in order to cover any anticipated or emergency medical services this year. Consider contributing the amount of your plan's in-network deductible so you know you're covered.

Health Savings Account

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in US Anesthesia Partners' HSA, you must elect the HDHP Core or HDHP Value plan in Workday and choose the amount to contribute on a pre-tax basis. US Anesthesia Partners will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Max Saver Plan

To ensure you are automatically contributing the maximum amount each year, enroll in the Max Saver Plan which will automatically enroll you at the IRS maximum with deductions split evenly over 24 pay periods. It is flexible in that if you want to reduce your contributions, you can move to the standard HSA plan at any time.

Medicare Reminder: 6 months before you enroll in Medicare, you must stop all HSA contributions. See Medicare details on page 46.

Frequency of HSA Contributions

Elections will be calculated and deducted based on 24 pay periods (1st and 2nd paycheck of each month). We encourage you to review your per pay period amount elections to ensure that it meets your financial objectives.

You can update your HSA at anytime during the year by completing a change in Workday at Benefits > Change Benefits > HSA Contribution Change. However, if you wish to frontload your HSA with a one-time only deduction to reach the IRS limit call, 855-464-USAP (8727), visit **USAPToday.com**, download the **Now** Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2024, contributions are limited to the following:

HSA FUNDING LIMITS	
INDIVIDUAL	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits ($4,150 for individual coverage and $8,300 for family coverage for 2024) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The US Anesthesia Partners HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit **www.hsabank.com**.

Flexible Spending Accounts (FSA)

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Flexible Spending Accounts are USE it or LOSE it accounts. Keep that in mind when determining contribution amounts.

Healthcare Flexible Spending Account (HCFSA)

Eligible with PPO plan

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Limited Purpose Flexible Spending Account (LPFSA)

Eligible with HDHP plans

A Limited Purpose Flexible Spending Account (LPFSA) works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses only. The contribution limit is $3,050.

Due to IRS Guidelines, highly compensated employees (HCEs) earning more than $155,000 will only be allowed to elect up to $2,500 for the Dependent Care FSA.

Dependent Care Flexible Spending Account (DCFSA)

Child & Elder Care Only

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse/domestic partner or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse/domestic partner to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Flexible Spending Accounts

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact TaxSaver Plan with reimbursement questions. If you need to submit a receipt, TaxSaver Plan will notify you. Always save receipts for your records.

FSA Claim Substantiation, IRS Requirement

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $155,000 or more last year) may have different FSA contribution limits. Visit **www.irs.gov** for more info.

FSA accounts are "use it or lose it" — any unused funds will be forfeited.

Eligible Healthcare FSA Expenses

Visit **TaxSaverPlan.com** for a list of eligible expenses.

Please note: Due to the CARES ACT, over-the-counter (OTC) drugs are considered eligible reimbursement items from Healthcare FSAs without the need for a physician's prescription. For a list of additional over-the-counter eligible items, please visit: **https://www.taxsaverplan.com/resources/list-of-eligible-items/over-the-counter/**.

Grace Period

- FSA participants may have an additional 2½-month grace period to incur expenses after the plan year ends (12/31/2024).
- If an expense occurs between 12/31/2024 and 3/15/2025, AND is submitted for reimbursement on or before 3/31/2025, any remaining balance in the previous plan year that ended 3/31/2025 will be paid out from the claim, even though the service was provided in the NEW plan year.
- The grace period only applies to the Healthcare FSA. The grace period does not apply to the Dependent Care FSA.

Note

You can use your FSA funds to pay for deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, and more.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for eligible healthcare costs. Which one is best for you?

	FLEXIBLE SPENDING ACCOUNTS		HEALTH SAVINGS ACCOUNT
	HC FSA	**DC FSA**	**HSA**
ELIGIBILITY	Eligible with the PPO Medical Plan Only.	Eligible with dependent children under age 13.	Eligible with the HDHP Medical Plans Only.
OWNERSHIP	USAP owns your Healthcare FSA. If you leave USAP, you lose access to the account unless you have a COBRA right.	USAP owns your dependent care FSA. If you leave USAP, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a FSA and an HSA.	You can elect a Dependent Care FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	1. You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse/domestic partner's non-High Deductible plan or a spouse/domestic partner's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	Contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free when used for qualified expenses.
CONTRIBUTIONS	The contribution limit for the Healthcare FSA for 2024 is $3,050.	The contribution limit for the Dependent Care FSA for 2024 is $5,000. Note: Highly compensated employees earning more than $155,000 a year will have a limit of $2,500 per calendar year.	The contribution limit for 2024 is $4,150 for individuals and $8,300 for families. This includes the employer contribution. If you are 55 or older, you may make an annual "catch-up" contribution of $1,000.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal, or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or you may use another account to pay for services and save the money in your HSA for future expenses or retirement.
GRACE PERIOD	A Healthcare FSA may include a 2.5-month grace period after the end of the Plan Year for expenses to be incurred and reimbursed. Any unclaimed funds at the end of the run out are lost and returned to your employer.	There is no grace period for Dependent Care FSA	HSA funds roll over from year to year. Money is always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at **www.irs.gov**.	Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care.	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at **www.irs.gov**.
OTHER TYPES	Limited Purpose FSA (LPFSA) – Only covers eligible dental and vision expenses. LPFSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Healthcare FSA and an HSA.	Dependent Care FSA is a type of FSA.	There is only one type of HSA.

Pharmacy Benefits (Specialty Rx PrudentRx)

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is offered through CVS Caremark. You may find information on your benefits coverage and search for network pharmacies by logging on to **www.caremark.com** or by calling the Customer Care number 888-963-7290. Your cost is determined by the tier assigned to the prescription drug product. The prescription tiers are Generic, Preferred, Non-Preferred, or Specialty (through **PrudentRx**).

	PPO		HDHP CORE		HDHP VALUE	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)						
GENERIC	$15 Copay	20%*	20%*	20%*	30%*	30%*
PREFERRED	$40 Copay	20%*	20%*	20%*	30%*	30%*
NON-PREFERRED	$80 Copay	20%*	20%*	20%*	30%*	30%*
SPECIALTY RX – PRUDENTRX	$0 Copay or 30% Coinsurance	N/A	$0 Copay or 30% Coinsurance	N/A	$0 Copay or 30% Coinsurance	N/A
MAIL ORDER RX (90-DAY SUPPLY)						
GENERIC	$38 Copay	20%*	20%*	20%*	30%*	30%*
PREFERRED	$100 Copay	20%*	20%*	20%*	30%*	30%*
NON-PREFERRED	$200 Copay	20%*	20%*	20%*	30%*	30%*
SPECIALTY RX – PRUDENTRX	$0 Copay or 30% Coinsurance	N/A	$0 Copay or 30% Coinsurance	N/A	$0 Copay or 30% Coinsurance	N/A

*After deductible

CVS Caremark

One of the easiest ways to access CVS Caremark is digitally by registering at **Caremark.com** or downloading the CVS Caremark mobile app. These tools make it easy to:

- View and manage your medications
- Check drug costs and coverage
- Find a network pharmacy
- Start a new order, transfer a current prescription, or request a refill
- Set up mail order prescriptions

IMPORTANT NOTE: You can go to any in-network pharmacy. Even though we have prescriptions through CVS Caremark, doesn't mean you must go to CVS for your prescriptions.

Pharmacy Benefits

In-Network Pharmacies and Mail Order

Network pharmacies are included in your prescription plan to help keep costs low. In-network pharmacies include most large pharmacies such as Walgreens, Sam's Club, Costco, RiteAide, Grocery Store Chain pharmacies, and CVS pharmacies (including those inside Target stores).

90-Day Supplies and Mail Service Pharmacy

If there are medications you take regularly, you can save on the cost by filling them in 90-day supplies. One 90-day supply through mail order typically costs less than three 30-day supplies. You can elect to pick the prescription up at a pharmacy or have it delivered to you with no-cost shipping. CVS Caremark will alert you 10 days before a refill in case you need to change the delivery date or location. You can visit **Caremark.com/mailservice** or call the number on your member ID card for assistance.

Any prescriptions paid out of pocket (Ex: GoodRx), without using USAP medical/Rx insurance, will not be applied towards any copays, deductibles, out-of-pocket maximum, or coinsurance on your medical plan.

Have a Specialty Medication?

US Anesthesia Partners offers a special program through **PrudentRx** to save you money on specialty medications. See page 28 to thoroughly review how the **PrudentRx** program works so you can ensure you choose the right plan for you and your family's needs.

Note

- Out-of-network reimbursement is subject to allowable amounts.
- Manufacture Rx Discount Cards are not applied to the deductible or out-of-pocket maximum.
- For the PPO plan, if a member purchases preferred/non-preferred brand name drugs when a generic equivalent exists, he or she will be required to pay the difference between the cost of the generic and preferred/non-preferred brand name drug, plus the preferred brand name copayment amount.
- If you purchase a prescription drug product from a non-network pharmacy, you are responsible for any difference between what the non-network pharmacy charges and the amount CVS Caremark would have paid for the same prescription drug product dispensed by a network pharmacy.

Q&A Generic Drugs

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit **www.fda.gov**.

NOTE: Apps and prescription discount programs such as GoodRx, Amazon Prime Rx Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

How do they work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription will not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRx is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80%. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by InsideRx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.

IMPORTANT NOTE:

- You do not need to fill your prescriptions through CVS Caremark.
- You can go to any in-network pharmacy.
- Filling your prescriptions using discount options may be at a lower cost than our USAP prescription drug plan.
- Any prescriptions paid out of pocket (Ex: GoodRx), without using USAP medical/Rx insurance, will not be applied toward any copays, deductibles, out-of-pocket maximum, or coinsurance, etc.

Specialty Drug Program

PrudentRx – PPO Plan

- The PrudentRx solution applies to the vast majority of specialty medications and allows members to pay $0 when enrolled.
  - Ex: Bob gets his specialty medication every month and is enrolled in PrudentRx. He pays $0 for his specialty medication. Copay assistance pays 30% of the price, and the plan pays the remainder of the medication costs. If there isn't copay assistance for a medication, Bob still pays $0, and the plan would pay for the totality of the claim. However, this is a very rare situation as most specialty drugs have some form of copay coupon.
- Copay assistance dollars do not apply towards deductibles or Maximum Out of Pocket MOOP.
- If the members are using copay assistance coupons/ dollars towards non-specialty medications, those dollars will NO LONGER APPLY towards their deductible or MOOP.
  - You may still be able to cover your copay on those particular medications with copay assistance (obtained on your own), but it will NOT count towards your deductible. You may have $0 Out-of-Pocket (OOP) expense until the copay assistance is exhausted but is not guaranteed.

PrudentRx – High Deductible Health Plan

- Participating members enrolled in high-deductible health plans (HDHPs) with health savings accounts (HSAs) must fully satisfy their deductibles before they are eligible for a $0 cost share using PrudentRx.
  - Ex: Bob receives his specialty medication every month. His medication costs $1,000 per fill. Per Bob's Healthcare plan, he is responsible for the cost of his medication until he meets his deductible. Once it is met, Bob will pay $0 for being enrolled in PrudentRx, and the plan will pay the remainder of the drug cost after any available coupons are applied.
- $0 OOP expense only occurs once the deductible is met. If the deductible is not met in a calendar year, the member will be responsible for the 100% of the price each time the medication is picked up.
- Because of limitations that exist within various external pharmacy systems, implementing the PrudentRx solution on HDHPs with HSAs will be limited to only those medications included on the specialty drug list and dispensed by CVS Specialty Pharmacy.

Applies to all PrudentRx Plans

Q: Is it required to be a part of the PrudentRx Program?

A: No. You do not need to participate in a copay card program. However, it is strongly encouraged to help reduce your final OOP cost. If you opt out of using assistance or enrolling in the PrudentRx Program, then you are responsible for the 30% copay.

Q: Will I be asked to participate in the PrudentRx Program?

A: Yes. If you are currently utilizing a specialty medication, PrudentRx will contact you about joining the program. You will not be contacted or asked to join unless you are taking a specialty medication.

Q: What happens if a drug does not have a specialty copay card or the annual manufacturer assistance has been exhausted?

A: If you are enrolled in the PrudentRx Program, your final OOP cost is $0 regardless. The plan will cover 100% of costs for a few medications that do not have PrudentRx coupons.

A: If you are enrolled in the HDHP PrudentRx Program, you must meet your deductible before receiving $0 OOP cost. Under the HDHP, PrudentRx coupons will only be applied after the deductible has been met and will mainly serve as a cost savings mechanism for the plan.

If you do not enroll in PrudentRx Specialty drug plan:

- If you have a specialty drug and do not enroll in PrudentRx, you will be responsible for at least 30% of the specialty drug and will not receive any of the PrudentRx Specialty Drug Plan discounts.

Q: How does the PrudentRx Program handle drug classes like HIV and LDDs (limited distribution drugs) not available at CVS Specialty?

A: Drug classes like HIV: these drugs will be included in the program if the plan included them as Exclusive Specialty. If they are open network or excluded as specialty products, they will be excluded from the PrudentRx program, and the plan will be responsible for the 30% copay.

A: LDDs not available at CVS Specialty: select high-cost specialty LDDs will continue to be dispensed via the established authorized pharmacies; however, PrudentRx has coordinated communications with those pharmacies to ensure members enrolled in the program receive these medications for a final $0 OOP. LDDs not included on the PrudentRx Drug List will remain excluded from the program but may still be covered under the plan as they are today with the standard member cost share.

Q: What is the difference between EHB (Essential Health Benefit) and non-EHB drugs?

A: Under the ACA (Affordable Care Act), non-grandfathered, self-funded plans (this plan) are not required to cover EHB; however, they are subject to annual MOOP limits. Covered benefits that fall outside the authorized definition are deemed non-EHB and need not be counted toward a member's MOOP limit. In the PrudentRx Program, non-EHB medications may still be covered by the plan; however, the 30% copay will not apply toward the MOOP.

Q: What if I start a different specialty medication?

A: If you start a new specialty medication, PrudentRx will contact you to start any copay assistance available for the new medication.

Q: Does my plan's exclusive Specialty Drug list change?

A: Yes. The exclusive Specialty Drug list may be updated periodically. Copayments for these medications, whether made by your plan or a manufacturer's copay assistance program, will NOT count toward your plan deductible or MOOP.

Q: What happens when I enroll in a copay assistance program such as PrudentRx?

A: You will continue to fill prescriptions as usual. The pharmacy or PrudentRx enters the copay assistance details when submitting the claim, and the copay assistance is applied toward the member cost share by the pharmacy. On a PPO plan, member cost share will be $0 OOP. On a HDHP plan, members may have cost sharing responsibilities if their deductible has not been met yet for the year.

Q: Why will copay assistance through a program like PrudentRx no longer contribute towards accumulator totals (i.e., deductible and MOOP)?

A: Deductibles are established as a means of cost sharing between the member and the plan sponsor, while a MOOP is the most the member will pay during a policy period. The help members get from a copay card is provided by the copay card sponsor and does NOT reflect any actual OOP cost the member pays. Given that deductibles and MOOPs are intended to capture true member costs only and not third-party assistance through a copay card (not including monthly premium payments), the update to accumulators are made to reflect only the amount a member actually pays.

Q: What if I elect to opt out of the PrudentRx Program?

A: If you elect to opt out of the program, you will be responsible for the full 30% coinsurance even after the deductible has been satisfied. If a drug is listed as a non-EHB, member payments toward the 30% coinsurance will not count toward the MOOP, and you will be responsible for the 30% coinsurance for non-EHB drugs even after the MOOP is met, unless otherwise required by law.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. US Anesthesia Partners offers affordable plan options from Delta Dental of Texas for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Delta Dental at **www.deltadentalins.com**. No ID cards will be provided. Providers will verify coverage with your Social Security number.

Dental Plan Summary

This chart summarizes the dental coverage provided by Delta Dental of Texas for 2024.

	STANDARD PPO		PREMIER PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$50	$50	$25	$25
FAMILY	$150	$150	$75	$75
ANNUAL MAXIMUM				
PER PERSON	$1,500	$1,500	$2,500	$2,500
COVERED SERVICES				
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100% Covered	100% Covered	100% Covered	100% Covered
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	You Pay 20%*	You Pay 20%*	You Pay 20%*	You Pay 20%*
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	You Pay 50%*	You Pay 50%*	You Pay 50%*	You Pay 50%*
ORTHODONTICS Dependent Child(ren) Only, Up to age 19	Not Covered		You Pay 50%*	
ORTHODONTIC LIFETIME MAXIMUM	Not Covered		$2,500	

*After deductible

Chronic conditions and the medications used to treat them can impact your oral health. If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer, or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings.

Delta Dental offers SmileWay® Wellness Benefits. To opt in to additional benefits available, visit **www1.deltadentalins.com/smileway**.

Note

Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Helpful Tips: Before having dental services, other than preventive care, it is recommended that your dentist conduct a "pre-certification" for dental expenses so you know the expected out-of-pocket costs. This will also assist the dentist in providing additional documentation when filing the dental claim if required by your dental carrier.

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through VSP.

Vision Plan Summary

This chart summarizes the vision coverage provided by VSP for 2024. Vision Plan benefits are available to you on a voluntary basis. The vision plan provides a benefit for exams and materials on a yearly basis. You have the freedom to see any vision provider you choose, but the plan generally pays better benefits when you receive care from in-network providers. In-network copayments are paid directly to the provider.

Out-of-network services are subject to Reasonable and Customary (R&C) limitations. Out-of-network services will be reimbursed up to the scheduled amounts below.

Note: VSP does not provide insurance ID cards. Your provider will use your SSN to verify coverage.

	VISION		
	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT	FREQUENCY
EXAMS			
COPAY	$10	Up to $45	Every Calendar Year
LENSES			
SINGLE VISION	$25 Copay	Up to $30	Every Calendar Year
BIFOCAL	$25 Copay	Up to $50	
TRIFOCAL	$25 Copay	Up to $65	
STANDARD PROGRESSIVE	$55 Copay	Up to $50	
PREMIUM PROGRESSIVE	$95 – $105	Up to $50	
CUSTOM PROGRESSIVE	$150 – $175	Up to $50	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION*	$60 Copay	Not Covered	Every Calendar Year
ELECTIVE	$130 Allowance	Up to $105	
MEDICALLY NECESSARY	$130 Allowance	Up to $210	
FRAMES			
COPAY	$25 Copay	Up to $70	Every Other Calendar Year
ALLOWANCE	$130	Up to $70	
OTHER SERVICES			
DIABETIC EYECARE PLUS PROGRAM**	$20 Copay	Contact VSP	As needed (Limitations may apply)

*Fitting and Evaluation fee applied to contact lens allowance.
**Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations may apply.

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

Supplemental Health Benefits

US Anesthesia Partners offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through MetLife, provides benefits for you and your covered family members if you have expenses related to an accident. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$8.16
EMPLOYEE + SPOUSE	$12.14
EMPLOYEE + CHILD(REN)	$15.47
EMPLOYEE + FAMILY	$19.93

ACCIDENT COVERAGE

SUMMARY OF BENEFITS*	
HOSPITAL ADMISSION	$1,500
ICU SUPPLEMENTAL ADMISSION (PAID IN ADDITION TO ADMISSION)	$1,500
HOSPITAL CONFINEMENT	$300 per day
ICU SUPPLEMENTAL CONFINEMENT (PAID IN ADDITION TO CONFINEMENT)	$300 per day
AMBULANCE	Air $1,250 / Ground $400
EMERGENCY CARE BENEFIT - EMERGENCY ROOM/PHYSICIAN'S OFFICE/URGENT CARE	$200
MEDICAL TESTING (X-RAYS, MRI/MR, ULTRASOUND, NCV, CT/CAT, EEG)	$200
PHYSICIAN FOLLOW UP VISIT	$100
PHYSICAL THERAPY/CHIROPRACTIC THERAPY/SPEECH THERAPY	$50
MEDICAL APPLIANCE BENEFIT	Up to $1,000
BLOOD/PLASMA/PLATELETS	$500
FRACTURES	Up to $10,000
DISLOCATIONS	Up to $10,000
BURNS	Up to $15,000
CONCUSSION	$500
COMA	$10,000
SURGICAL REPAIR – THORACIC CAVITY OR ABDOMINAL PELVIC CAVITY	$2,000
SURGICAL REPAIR – TORN TENDON/ LIGAMENT/ROTATOR CUFF	Up to $2,000
SURGICAL REPAIR – RUPTURED DISC	$1,500

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

To File a Claim: Contact MetLife

800-438-6388 / Group #: 160878
www.metlife.com/mybenefits
Plan Name: U.S. Anesthesia Partners

Supplemental Health Benefits

Critical Illness Coverage

Critical Illness coverage through MetLife pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis. Illnesses or occurrences prior to the effective date of coverage will not be payable events
- Wellness Benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test (once per year per covered person) $15,000 ($50) $30,000 ($100)

Coverage Amounts:

- Employee: $15,000 or $30,000
- Spouse: 100% of employee benefit
- Children: 100% of employee benefit

$15,000 COVERAGE (MONTHLY CONTRIBUTION)				
AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE AND CHILD(REN)
<25	$3.45	$7.05	$8.70	$12.30
25–29	$3.75	$7.65	$8.70	$12.75
30–34	$5.10	$10.50	$10.20	$15.60
35–39	$7.20	$15.15	$12.30	$20.25
40–44	$10.95	$22.95	$15.90	$27.90
45–49	$16.35	$34.50	$21.45	$39.60
50–54	$23.70	$50.10	$28.65	$55.20
55–59	$32.85	$71.10	$38.10	$76.20
60–64	$47.40	$103.05	$52.50	$108.15
65–69	$71.55	$155.85	$76.50	$160.95
70+	$109.20	$235.05	$114.30	$240.15

$30,000 COVERAGE (MONTHLY CONTRIBUTION)				
AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE AND CHILD(REN)
<25	$6.90	$14.10	$17.40	$24.60
25–29	$7.50	$15.30	$17.40	$25.50
30–34	$10.20	$21.00	$20.40	$31.20
35–39	$14.40	$30.30	$24.60	$40.50
40–44	$21.90	$45.90	$31.80	$55.80
45–49	$32.70	$69.00	$42.90	$79.20
50–54	$47.40	$100.20	$57.30	$110.40
55–59	$65.70	$142.20	$76.20	$152.40
60–64	$94.80	$206.10	$105.00	$216.30
65–69	$143.10	$311.70	$153.00	$321.90
70+	$218.40	$470.10	$228.60	$480.30

Age is based on the date of enrollment effective date.

Example: your hire date of January 1 of the next calendar year if you elected during an open enrollment period.

CRITICAL ILLNESS COVERAGE

COVERED CONDITIONS*	INITIAL BENEFIT	RECURRENCE BENEFIT
BENIGN TUMOR CATEGORY		
BENIGN BRAIN TUMOR	100%	100%
CANCER CATEGORY		
INVASIVE CANCER	100%	100%
NON-INVASIVE CANCER	25%	25%
SKIN CANCER	5%	None
CARDIOVASCULAR DISEASE CATEGORY		
CORONARY ARTERY BYPASS GRAFT (CABG)	100%	100%
CHILDHOOD DISEASE CATEGORY		
CEREBRAL PALSY, CLEFT LIP OR CLEFT PALATE, CYSTIC FIBROSIS, DIABETES (TYPE 1), DOWN SYNDROME, SICKLE CELL ANEMIA, SPINA BIFIDA	100%	None
FUNCTIONAL LOSS CATEGORY		
COMA	100%	100%
LOSS OF: ABILITY TO SPEAK; HEARING; OR SIGHT	100%	NONE
HEART ATTACK CATEGORY		
HEART ATTACK	100%	100%
SUDDEN CARDIAC ARREST	50%	None
INFECTIOUS DISEASE CATEGORY**		
BACTERIAL CEREBROSPINAL MENINGITIS, COVID-19, DIPHTHERIA, ENCEPHALITIS, LEGIONNAIRE'S DISEASE, MALARIA, NECROTIZING FASCIITIS, OSTEOMYELITIS, RABIES, TETANUS, TUBERCULOSIS	25%	None
KIDNEY FAILURE CATEGORY		
KIDNEY FAILURE	100%	None
MAJOR ORGAN TRANSPLANT CATEGORY		
MAJOR ORGAN TRANSPLANT FOR BONE MARROW, HEART, LUNG, PANCREAS, AND LIVER	100%	None
PROGRESSIVE DISEASE CATEGORY		
ALS, ALZHEIMER'S DISEASE, MUSCULAR DYSTROPHY, PARKINSON'S DISEASE (ADVANCED), SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)	100%	None
SEVERE BURN CATEGORY		
SEVERE BURN	100%	100%
STROKE CATEGORY		
STROKE	100%	100%

*A Pre-Existing Condition Limitation is not included. Benefits are payable for a covered condition, so long as it occurs on or after the coverage effective date, even if it results from a pre-existing condition. "Pre-existing condition" refers to a sickness or injury for which medical advice or care was sought prior to the coverage effective date.

**For a benefit to be payable, the covered person must have been treated for the disease in a hospital for 5 consecutive days.

Initial benefit means the benefit that is payable for a covered condition the first time that it occurs while coverage is in effect. The initial benefit amount is expressed as a percentage of the elected benefit amount.

Recurrence benefit means the benefit that is payable for another occurrence of the same covered condition for which MetLife has already paid a benefit. The recurrence benefit amount is expressed as a percentage of the initial benefit amount.

Supplemental Health Benefits

Hospital Indemnity Coverage

Hospital indemnity insurance coverage through MetLife, provides you with payments when you are admitted and when you are confined to a hospital due to an accident or illness, and the policy and certificate requirements are met. Typically, a flat amount is paid for admission, and a daily amount is paid for each day of a hospital stay. It also pays extra benefits for admission to or confinement in an Intensive Care Unit (ICU), and for other benefits and services.

Payments are made directly to you to use as you see fit. They can be used to help pay for medical plan deductibles and copays, for out-of-network stays, for your family's everyday living expenses, or for whatever else you need while recuperating from an illness or accident.

Keep in mind, even quality medical plans like those we offer can leave you with unexpected expenses to pay when you are hospitalized. Many people aren't financially prepared to handle these extra costs. Having extra financial support if the time comes may mean less worry for you and your family and it will give you the ability to protect your savings and focus on your recovery. For plan costs, visit **workday.usap.com**. For more plan information, please call MetLife at 800-GET-MET8 (800-438-6388).

How to File a Claim:

1. Visit **mybenefits.metlife.com** or download the MetLife Mobile App to view your certificate of insurance and to initiate your claim or call 866-626-3705 to obtain a claim form.
2. Answer some questions about your claim and upload your medical documentation to support your claim. The whole process takes just minutes!
3. Visit MyBenefits or your MetLife Mobile App frequently to check claim status, letters, and benefit payments.

SUMMARY OF BENEFITS*

	LOW PLAN	HIGH PLAN
INITIAL HOSPITAL CONFINEMENT	$500	$1,000
DAILY HOSPITAL CONFINEMENT	$100 (365 days)	$200 (365 days)
HOSPITAL INTENSIVE CARE	$100 (30 days)	$200 (30 days)
HEALTH SCREENING BENEFIT (1X PER YEAR, PER PERSON)	$50	$100

*This is a summary. Please refer to plan documents for details.

MONTHLY CONTRIBUTIONS

	LOW PLAN	HIGH PLAN
EMPLOYEE ONLY	$9.71	$19.83
EMPLOYEE + SPOUSE	$19.44	$39.68
EMPLOYEE + CHILD(REN)	$15.49	$31.67
EMPLOYEE + FAMILY	$25.22	$51.53

Survivor Benefits (Life Insurance)

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

US Anesthesia Partners provides you with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through New York Life (NYL), which guarantees that your spouse/domestic partner or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is your prior year's gross earnings, up to $500,000. If you have not been benefits eligible for a full year, your benefit is your salary as of the day you become benefits eligible. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

If you are a full-time physician, you have an alternative option available to you. Your Basic Life and AD&D insurance benefit will default into the one times your salary coverage, or you can choose to enroll in the $50,000 coverage option.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the New York Life (NYL) insurance.

It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. If there is no named beneficiary or surviving beneficiary, death benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the estate.

You will designate your beneficiary(ies) during your enrollment process on **workday.usap.com**. You can add beneficiaries at any time during the year by logging into Workday, clicking on the Benefits icon, and then clicking on Beneficiaries in the Change column. From there, you can edit, add, and delete beneficiaries. To assign the beneficiaries to a benefit, you must then initiate and submit the Beneficiary Change Benefit Event by clicking on Benefits in the Change column. If you need additional assistance, please reach out to 855-464-USAP (8727), visit **USAPToday.com**, download the Now Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

Covered Earnings Definition – Life and Disability

Covered Earnings means an Employee's gross total earnings received from the Employer in the prior calendar year prior to the date Disability begins. If the Employee was not employed and eligible by the Employer for the full prior calendar year, Covered Earnings will mean the greater of the Employee's internally determined Benefit Annual Rate (BAR) in effect as of October 1st or the date of Full-time eligibility just prior to Disability, or the Employee's gross total earnings received in the prior calendar year. Prior year gross total earnings will not be annualized when less than a complete calendar year. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on each subsequent October 1st following. Covered Earnings include pre-tax contributions made by the Employee, if any, for that year.

Accelerated Life Benefit — Terminal Diagnosis

If you are diagnosed with a terminal illness, within 12 months, you may be eligible for a life insurance payout of 90% basic and voluntary life. Max payout is $450,000 each. This also includes spouse voluntary life.

Terminated employees who may have qualified must have converted or ported their life insurance policies and inquired about benefit options.

Survivor Benefits

Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	One time your salary or $50,000 (full-time physicians)
WHO PAYS	US Anesthesia Partners
BENEFITS PAYABLE	Upon death or dismemberment
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death or dismemberment
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Over $300,000
VOLUNTARY SPOUSE/DOMESTIC PARTNER LIFE/AD&D	
COVERAGE AMOUNT (RATE BASED ON SPOUSE AGE)	Increments of $5,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death or dismemberment
MAXIMUM BENEFIT	$500,000. The benefit cannot be more than 100% of the Employee Voluntary Life/AD&D coverage.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Over $50,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$5,000 or $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon death or dismemberment
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No EOI required

AGE BENEFIT REDUCTION

AGE	BENEFIT AMOUNT
> 65	100%
65	65%
70	50%

NOTE: An EOI is only required if electing more than the GI amount ($300,000).

Voluntary Life and AD&D Insurance Rates

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:				
$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Below are some examples of cost, based on age and coverage amount.

	AGE BAND	EMPLOYEE LIFE RATE PER $1,000	COST WITH $100,000 COVERAGE	COST WITH $75,000 COVERAGE	COST WITH $25,000 COVERAGE
EMPLOYEE	>20	$0.05	$7.10	$5.33	$1.78
	20-24	$0.05	$7.10	$5.33	$1.78
	25-29	$0.06	$8.00	$6.00	$2.00
	30-34	$0.08	$10.00	$7.50	$2.50
	35-39	$0.10	$12.30	$9.23	$3.08
	40-44	$0.15	$16.70	$12.53	$4.18
	45-49	$0.24	$25.50	$19.13	$6.38
	50-54	$0.37	$39.40	$29.55	$9.85
	55-59	$0.58	$59.50	$44.63	$14.88
	60-64	$0.90	$91.70	$68.78	$22.93
	65-69	$1.56	$157.80	$118.35	$39.45
	70-74	$2.78	$279.90	$209.93	$69.98
	75+	$5.45	$546.60	$409.95	$136.65

	AGE BAND	SPOUSE/ DOMESTIC PARTNER LIFE RATE PER $1,000	COST WITH $100,000 COVERAGE	COST WITH $75,000 COVERAGE	COST WITH $25,000 COVERAGE
SPOUSE/DOMESTIC PARTNER	>20	$0.04	$5.70	$4.28	$1.43
	20-24	$0.05	$7.00	$5.25	$1.75
	25-29	$0.06	$8.00	$6.00	$2.00
	30-34	$0.08	$10.00	$7.50	$2.50
	35-39	$0.09	$11.00	$8.25	$2.75
	40-44	$0.11	$13.20	$9.90	$3.30
	45-49	$0.18	$19.50	$14.63	$4.88
	50-54	$0.27	$29.30	$21.98	$7.33
	55-59	$0.43	$45.00	$33.75	$11.25
	60-64	$0.71	$73.40	$55.05	$18.35
	65-69	$1.27	$129.00	$96.75	$32.25
	70-74	$2.18	$219.40	$164.55	$54.85
	75+	$4.36	$437.30	$327.98	$109.33

	CHILD(REN) LIFE COVERAGE AMOUNT	COST PER MONTH
CHILD(REN)	$5,000	$2.13
	$10,000	$4.25

Child(ren) Life Coverage up to age 26

Income Protection (Disability)

You and your loved ones depend on your regular income. That's why US Anesthesia Partners offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Short Term Disability (STD) Insurance — New York Life

Short Term Disability (STD) insurance protects a portion of your income if you become partially or totally disabled for a short period of time. If enrolled and approved for medical disability leave, STD benefits replace 60% of your weekly income, up to maximum of $2,500 per week after a 7-day elimination period. With STD, the benefit won't necessarily replace a true 60% of your weekly income, depending on what your yearly earnings are. For example, if 60% of your weekly earnings is more than $1,250, then you will be capped at the $1,250 coverage amount in the STD 1250 Plan. If 60% of your weekly earnings is more than $2,500, then you will be capped at the $2,500 coverage amount in the STD 2500 Plan. See chart for examples. STD payments will last as long as you are medically disabled up to 90 days. Monthly premiums are determined by age and coverage amount. Certain provisions and exclusions may apply. See the summary plan description for more information. Completing an Evidence of Insurability form (EOI) may be required to finalize your enrollment in disability or supplemental life benefits. If EOI is required, you will be notified.

Covered Earnings means an Employee's gross total earnings received from the Employer in the prior calendar year prior to the date Disability begins. If the Employee was not employed and eligible by the Employer for the full prior calendar year, Covered Earnings will mean the greater of the Employee's internally determined Benefit Annual Rate (BAR) in effect as of October 1st or the date of Full-time eligibility just prior to Disability, or the Employee's gross total earnings received in the prior calendar year. Prior year gross total earnings will not be annualized when less than a complete calendar year. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on each subsequent October 1st following. Covered Earnings include pre-tax contributions made by the Employee, if any, for that year.

After enrollment is submitted, your benefit will display as pending in Workday and if approved by underwriting, USAP Benefits will update your benefits accordingly.

YEARLY EARNINGS	COVERAGE AMOUNT WITH STD 1250 PLAN	COVERAGE AMOUNT WITH STD 2500 PLAN	COVERAGE AMOUNT WITH EMPLOYER PAID 1250 PLAN AND 1250 BUY-UP
$50,000	$577	N/A	$577, no buy-up
$100,000	$1,154	N/A	$1,154, no buy-up
$200,000	$1,250	$2,308	$1,250 and a buy-up of $1,058
$300,000	$1,250	$2,500	$1,250 and a buy-up of $1,250
$400,000	$1,250	$2,500	buy-up of $1,250

Disability Premium Calculation

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60%	$	x Rate	$	÷ $10	$
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium

AGE	RATE PER $10	$1,250 COVERAGE MONTHLY RATE	$2,500 COVERAGE MONTHLY RATE
Through Age 59	$0.853	$106.63	$213.25
Age 60+	$1.145	$143.13	$286.25

Income Protection

Long Term Disability (LTD) Insurance — New York Life

Long Term Disability (LTD) insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. If medically disabled, LTD benefits replace 60% of your income, up to a maximum of $10,000 or $15,000 (see LTD chart) per month after a 90-day elimination period.

The 90-day elimination period is defined as a period of continuous disability which must be satisfied before you are eligible to receive benefit payments from New York Life.

You are considered disabled when New York Life determines that, due to your sickness or injury:

- You are unable to perform the material and substantial duties of your regular occupation, or you have 20% or more loss in your monthly earnings; and
- You are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

LTD payments will last for as long as you are medically disabled or until you reach your Social Security Normal Retirement Age. If you become disabled at age 65 or later, your maximum period of benefits may differ. No premiums are required for your coverage while you are receiving payments under this plan.

Certain provisions, exclusions, along with any pre-existing condition limitations, may apply. See the summary plan description for more information.

Covered Earnings means an Employee's gross total earnings received from the Employer in the prior calendar year prior to the date Disability begins. If the Employee was not employed and eligible by the Employer for the full prior calendar year, Covered Earnings will mean the greater of the Employee's internally determined Benefit Annual Rate (BAR) in effect as of October 1st or the date of Full-time eligibility just prior to Disability, or the Employee's gross total earnings received in the prior calendar year. Prior year gross total earnings will not be annualized when less than a complete calendar year. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on each subsequent October 1st following. Covered Earnings include pre-tax contributions made by the Employee, if any, for that year.

LTD MAXIMUM BENEFIT PERIOD SCHEDULE

AGE WHEN DISABILITY BEGINS*	MAXIMUM BENEFIT PERIOD
Age 60 or under	Your 65th birthday or the date the 60th monthly benefit is payable, if later
Age 61	The date the 48th monthly benefit is payable.
Age 62	The date the 42nd monthly benefit is payable.
Age 63	The date the 36th monthly benefit is payable.
Age 64	The date the 30th monthly benefit is payable.
Age 65	The date the 24th monthly benefit is payable.
Age 66	The date the 21st monthly benefit is payable.
Age 67	The date the 18th monthly benefit is payable.
Age 68	The date the 15th monthly benefit is payable.
Age 69 or older	The date the 12th monthly benefit is payable.

*Based on the age the employee is when they become disabled.

Disability Premium Calculation

TO CALCULATE HOW MUCH YOUR LTD COVERAGE WILL COST:

$	÷ 12 =	$	x Rate	$	÷ $100	$
Annual Salary		Monthly Covered Payroll		Amount		Monthly Premium

JOB GROUP	LTD MONTHLY COVERAGE MAXIMUM	DEFINITION OF DISABILITY
Physicians	$15,000	Specialty Occupation for Anesthesia Physicians
Clinical	$10,000	Regular Occupation
MSO/RCM/ Corporate Directors & Executives	$10,000	Regular Occupation
MSO/RCM/ Corporate	$10,000	Regular Occupation for 36 months, then any Occupation

Leave of Absence – How to File

New York Life Group Benefit Solutions (NYLGBS)
888-842-4462 or www.myNYLGBS.com

Leave of Absence

For various reasons, employees may need extended time away from work. USAP provides a variety of leave options that comply with federal and state laws. Additional information regarding leave policies and eligibility requirements can be found in the employer guidebook.

4 Types of Leave

- Personal Leave of Absence
- Family and Medical Leave (FML)
- Military Leave of Absence
- Reasonable Accommodation Medical Leave of Absence

An employee must be placed on an approved leave of absence for benefits-based coverages to remain eligible for benefits in case of injury or death.

How to File a Leave and Disability Claim

If you are absent from work for 4 days or more for a FMLA qualifying reason, please contact **New York Life Group Benefit Solutions (NYLGBS) at 888-842-4462 or www.myNYLGBS.com** to file a claim. We partner with New York Life, our leave of absence administrator, to assist with managing employee leave of absences. Employees are responsible for ensuring the necessary documentation is provided to New York Life in a timely manner for a decision to be made on their claim.

For Personal Leaves and Military Leaves, please contact the Leave Coordinators at **leaves@usap.com**.

Benefits While on Leave

Your current benefit coverage(s) will continue if you are on an approved leave. If you receive pay through USAP while on leave, your deductions will continue to be taken with each check. If you do not receive a check through USAP, your benefit contributions will accrue in Workday, and you will be required to pay the premiums once you return from leave. The system will double your deductions until they are paid in full once you return.

If you have any benefits questions during your absence, please visit ServiceNow at support.usap.com to open a ticket for assistance or call 855-464-8727.

REMINDER: It is the employees' responsibility to ensure all documentation is provided to New York Life for a decision to be made on their leave claim. Additionally, it is important that physicians are reminded that they will need to complete the necessary paperwork to substantiate an employee's leave timeframe.

Leave of Absence — Did You Know?

Employee Not Actively Working: An employee must be placed on an approved Personal Leave of Absence for benefits-based coverages to remain eligible for benefits in case of injury or death. Must be "Actively at Work" under the Continuation of Insurance provision with New York Life. Ex: Employee not working due to traveling for an extended period of time. Employee should be placed on a Personal Leave of Absence (PLOA) and coded as such within Workday. Additionally, a PLOA Letter must be sent to the employee with an approval for their PLOA.

If any employee has used all their PTO and/or no longer receives pay, it is time to place out on Personal Leave of Absence.

Please contact **leaves@usap.com** for questions regarding a leave of absence.

Retirement Planning

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Automatic Enrollment

For your convenience, US Anesthesia Partners will automatically enroll eligible participants in the plan and deduct 3% from your pay on a pre-tax basis and invest your contributions in the Vanguard Target Retirement Fund with the target date closest to the year in which you will reach age 65.

If you want to enroll at a different rate, you can contribute from 0% to 100% of your pay on a pre-tax or Roth 401(k) after-tax basis, or a combination of both. You may be eligible to contribute on a post-tax basis as well. Please note, post-tax is in addition to the pre-tax/Roth after-tax IRS annual limit and this contribution is not eligible for employer match.

If you are age 50 or older, or will turn 50 by year's end, and you contribute the maximum allowed, you may make catchup contributions.

If you do not want to be enrolled, want to change your deferral percentage, or investments, you must contact Vanguard Participant Services at 800-523-1188 or access your account online at **vanguard.com/retirementplans**.

Employer Match

If you are a full-time employee, for every $1 you contribute up to 6% of your pay, US Anesthesia Partners will contribute $0.67 to your account. In order to receive the full 4% employer match, you must contribute 6%. You are immediately eligible to receive company matching contributions when you begin contributing.

Discretionary Profit Sharing

If you are a full-time employee, US Anesthesia Partners may make a discretionary profit-sharing contribution to your account. You do not have to contribute to receive profit sharing contributions. If you are eligible, after one year of service, you will begin receiving employer profit sharing contributions at the next quarterly plan entry date after you have become eligible. Quarterly plan entry dates occur on the first day of the month in January, April, July, and October.

Vesting

Vesting refers to your right of ownership to the money in your account. You are always 100% vested in your own contributions and their earnings. You become vested in any employer matching contributions and profit-sharing contributions after three years of service.

Plan Fee

Each plan participant will pay an annual flat fee of $37 ($9.25 quarterly) for record keeping services and other general plan administrative expenses.

Loans

Although the plan is designed for long-term savings, you can borrow from your account having a maximum of two outstanding loans at a time. Your loan amount can be $1,000 up to $50,000.

Connect with Vanguard

- Log on to your account at **vanguard.com/retirementplans** for 24-hour access to information about your account, your investments, and Vanguard's advice services.
- On your mobile device. Go to **vanguard.com/bemobile** to download the Vanguard app so you can access your account on the go.
- By phone. Call 800-523-1188 to reach Vanguard's 24-hour interactive VOICE® Network or speak with a Vanguard Participant Services employee Monday through Friday from 8:30 a.m. to 9 p.m. ET.

Vanguard®

Additional Benefits

US Anesthesia Partners wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Identity Theft Protection

Identity theft protection services from Allstate help assess your risk, deter theft attempts, detect fraud, and manage the restoration process in the event of an identity theft. Your identity will be monitored to uncover fraud at its inception. You will be offered an annual credit report, monthly credit scores, and monitoring of your TransUnion credit file.

Allstate offers privacy advocates that are certified and trained in identity restoration. If they detect suspicious activity, a privacy advocate can act as a dedicated case manager on your behalf and resolve the issue.

Allstate Provides:

- **Identity Monitoring:** Monitor identities to uncover identity fraud at the source.
- **Credit Monitoring:** offers an annual credit report, monthly credit scores, and monitoring of your TransUnion credit file for an additional charge.
- **Social Media Reputation Monitoring:** Monitor your Facebook, LinkedIn, Twitter, and Instagram profiles to give actionable alerts of reputational damage including racist, violent, derogatory, vulgar, or inappropriate comments.
- **Full-service Case Management and Resolution:** Allstate will fully manage your restoration case, helping you save time, money, and stress.
- **$1 Million Identity Theft Insurance Policy:** Protect consumers from the financial damages of identity theft with our $1 Million Identity Theft Insurance Policy for associated costs, legal defense expenses, and lost wages.
- **Solicitation Reduction:** Reduce the root cause of up to 20% of identity theft by decreasing junk mail, stopping pre-approved credit offers, and ending telemarketing calls.
- **Internet Surveillance:** Detect information misuse and compromised credentials in the Underground Internet and alert consumers with unparalleled accuracy.
- **Lost Wallet Protection:** Easily store, access, and replace wallet contents. The secure vault holds important information from credit cards, credentials, and documents.

Legal Benefits

The MetLife® Hyatt Legal Assistance Plan offers you and your family access to professional legal representation through a panel of network attorneys for issues ranging from consumer protection to family law to wills and estate planning. The nationwide network includes over 13,000 experienced attorneys. You also have the flexibility to use a non-plan attorney and get reimbursed for covered services according to a set fee schedule.

Legal advice will be just a phone call away. A knowledgeable client service representative can help you locate a plan attorney in your area. You'll also have convenient online access to resources that will assist with court appearances, document review and preparation, or real estate matters.

Examples of covered services include:

- Wills and estate planning: wills, codicils, trusts, living wills, and powers of attorney
- Real estate matters: eviction, tenant negotiations, security deposit assistance, refinancing, home equity loans, purchasing and selling your home
- Consumer protection matters: consumer protection and small claims assistance
- Financial matters: identity theft, debt collection defense, personal bankruptcy, and tax audit representation
- Family law: adoption, guardianship, name change, and premarital agreements
- Defense of civil lawsuits: administrative hearings, civil litigation defense, and incompetency defense
- Traffic matters: traffic defense and restoration of driving privileges
- Juvenile court defense
- Document preparation and review

For more information about the Legal Plan, visit **www.legalplans.com**.

Additional Benefits

Discount Tickets

TicketsatWork is a cost-free benefit that provides you access to thousands of exclusive travel and entertainment discounts.

To become a member:

- Visit **ticketsatwork.com** and click "Become a Member."
- Use USAP's company code USAPFUN or work email to create an account.

Becoming a member will give you access to discounts on things like:

- Hotels
- Theme Parks
- Concerts
- Sporting Events
- Vegas Shows
- Movie Tickets
- Rental Cars
- Gift Cards
- Broadway Shows

For more information, call 800-331-6483 or email **customerservice@ticketsatwork.com**.

Travel Assistance

You have access to the New York Life Group Benefit Solutions (NYL GBS) Secure Travel program. This service offers you and your dependents medical and travel assistance services, 24 hours a day, 365 days a year for business or pleasure travel.

Participants have access to assistance services when faced with an emergency while traveling internationally or domestically when more than 100 miles away from home.

To receive services, call NYL GBS Secure Travel at 888-226-4567 (in the US) or 202-331-7635 (outside the US). You can also email **ops@us.generaliglobalassistance.com**.

The NYL GBS Secure Travel plan provides three area of assistance:

Pre-Trip Planning

- Immunization requirements
- Visa and passport requirements
- Embassy/consular referrals
- Foreign exchange rates
- Travel advisories and weather conditions
- Cultural information

Traveling Assistance

- 24-hour multilingual assistance and referral to interpretation and translation services
- Referrals to physicians, dentists, medical facilities, and legal assistance providers
- Arrangements for payment of medical expenses up to $10,000 if required prior to treatment**
- Assistance with lost or stolen items, including luggage and prescription replacement services**
- Emergency cash advances, up to $1,500**
- Advancement of bail*

Emergency Assistance

- Emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility***
- Travel arrangements for the return of a travel companion or children under age 18 who are left unattended due to the covered person's medical emergency
- Cover round-trip transportation as well as accommodations, up to $150 per day for up to seven days, for a family member or friend to visit a covered person who is hospitalized more than 100 miles away from home for more than seven days
- Arrange and cover the costs associated with returning a deceased covered person's remains to his or her place of residence for burial
- Emergency message relay, toll-free Assistance with making emergency travel arrangements**

*Emergency Assistance services may be insured under a group or blanket insurance policy issued by Life Insurance Company of North America. All other NYL GBS Secure Travel services are NOT insurance and do not provide reimbursement of expenses or financial losses. Expenses for medical care are not covered.

**Covered person is responsible for any advances, payments, travel-related or replacement costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.

***Initial transport by ambulance following a covered medical emergency is excluded.

Discount Plans–2024 Auto/Home/Pet

USAP will no longer have payroll deductions for Farmer's Insurance Auto & Home or Nationwide Pet Insurance. However, you still have access to policy discounts but they will no longer be deducted via USAP payroll deductions.

Farmer's Insurance Home/Auto Insurance (Direct Bill Discount)

Homeowners insurance includes coverage for your house, condo, or rental property. This benefit is not offered in Florida.

Additional residency restrictions may apply.

Auto insurance includes coverage for your automobile (including classic and antique cars), boat, motor home, or recreational vehicle.

Call 800-438-6381 or visit **www.farmers.com/groupselect** to sign up today. Discount Code: DFF

Nationwide Pet Insurance (Direct Bill Discount)

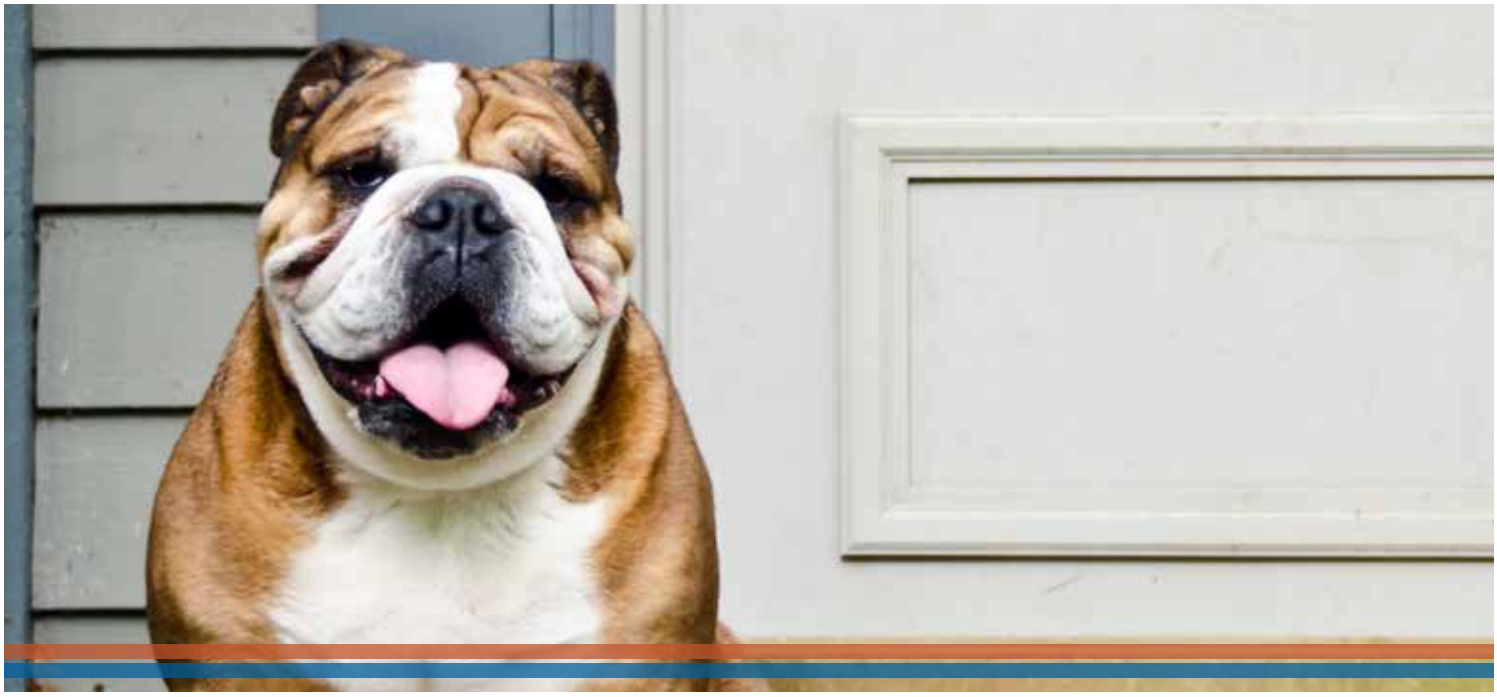
This insurance covers everything from preventive care to accidents or illness, including costs of X-rays, office visits, medications, surgeries, and hospital stays. You have the option of choosing your own vet or using a licensed in-network vet. Cost depends on your pet's age, species, and coverage level selected.

For pet owners, the cost of providing unexpected veterinary care if medical issues arise could add up to hundreds or even thousands of dollars. Nationwide Veterinary Pet Insurance (VPI) is a cost-effective way to protect you from the risk of these expenses and provide medical care for your pet with peace of mind.

Generally, care is covered after you meet your deductible and submit a claim for reimbursement of medical expenses for your pet.

VPI offers several policy options to meet a variety of needs and budgets. To enroll in the Nationwide-VPI plan, please go to **www.petinsurance.com/USAP**, 800-540-2016.

New Enrollment/Inquiries: 877-738-7874



Over 65 Considerations (Medicare)

When you are approaching age 65 or older than age 65 and become eligible for Medicare, some eligibility criteria may change. Use this section of the guide to determine what action you might need to consider to be sure you are meeting eligibility requirements for US Anesthesia benefit plans as well as meeting IRS guidelines.

Medicare.gov / 800-MEDICARE (800-633-4227)

Medicare Eligible Considerations

US Anesthesia Partners does not offer Medicare Gap Plans; however, you and your spouse can remain on the US Anesthesia Partners plan.

You and your spouse have a 31-day special enrollment right to enroll in Medicare when you retire (after you are no longer eligible for the active US Anesthesia Partners employer plan).

This special enrollment applies to both the employee and spouse currently enrolled in the US Anesthesia Partners Plan. The special enrollment period does not include COBRA.

HSA Considerations

If you enroll in any part of Medicare, you are no longer eligible to contribute to your HSA. If you are not enrolled, but your spouse is enrolled in any part of Medicare, you must contribute at the individual amount. This will not be monitored by US Anesthesia Partners. It is recommended that you should stop all HSA contributions 6 months prior to collecting Social Security. You may continue your HSA contributions if you do not elect any part of Medicare and are not collecting Social Security.

Visit **Medicare.gov** for more information.

Medicare and Over 65 FAQs

Q: I enrolled in Medicare, can I cancel my US Anesthesia Partners medical plan?

A: Yes, within 31 days you can submit a life event transaction in Workday to stop your US Anesthesia Partners medical plan. However, if you have dependents on your plan, they will be terminated and your dependents will be offered COBRA coverage. If you wish to leave your dependents on your plan, you must remain on the plan. Medicare will be considered secondary insurance except for a few exceptions.

Medicare Reminder: 6 months before you enroll in Medicare, you must stop all HSA contributions.

Q: I am about to turn 65, am I required to enroll in Medicare?

A: Only if you or your spouse commence Social Security benefits will you automatically be enrolled in Medicare Part A.

If you are a full-time eligible employee, and your spouse (if any), with active group health insurance, you are not required to enroll in Medicare.

When you retire or leave the company and are otherwise no longer eligible for group coverage, then you will have a special enrollment period to enroll in Medicare.

If you enroll during the special enrollment period when you retire or leave the company or otherwise are no longer eligible, then you will NOT be penalized if you enroll during this special enrollment period.

Visit **medicare.gov** for more information.

Q: What will happen to my HSA when I turn 65?

A: You will receive notices from Workday prior to turning 65. You should plan to stop HSA deductions six months prior to drawing Social Security benefits.

If you plan to enroll in any part of Medicare, it is recommended that you complete a Benefit Change in Workday to stop the Health Savings Account contributions.

If you decide to enroll in Medicare, you can continue to use your funds tax-free to pay for out-of-pocket eligible expenses, including Medicare premiums (excludes Medigap policies), deductibles, copayments and coinsurance. Any amount used for non-eligible expenses will be taxable income.

Q: Where can I find the annual Medicare Part D notice?

A: It is located in this guide on page 54.

Q: Why did my life insurance coverage amount decrease?

A: The life policy requires a reduction of coverage at age 65 and 70. Please see the summary plan description for more details.

USAP's medical plan will always be PRIMARY when enrolled in multiple coverages.

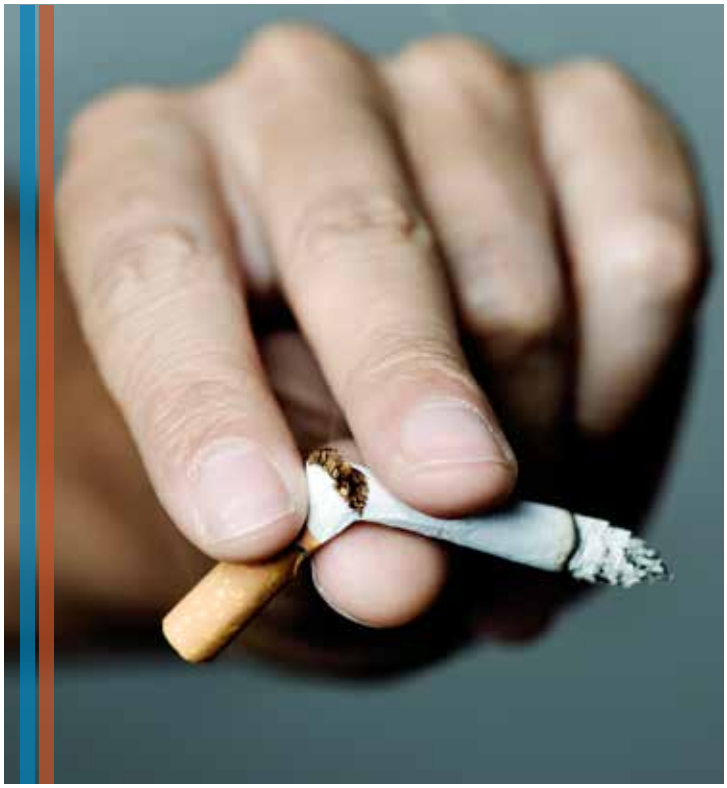
Wellness Information (Tobacco Cessation Program)

USAP is committed to maintaining a safe, courteous, and caring workplace. USAP empowers its team members to take personal responsibility for their health and to protect and promote a healthy working environment. USAP offers many health plans and options to care for yourself and your family.

Programs such as Medical, Dental, Vision, and Employee Assistance Program, all offer no-cost or inexpensive preventive resources to care for you and your loved ones who are eligible and enrolled. If an issue arises, there is a comprehensive plan available to support an illness or issue when you need help from a healthcare professional.

We know that healthcare benefits are important not only to you and your family's health but also to your financial health. Studies show that when plan participants are tobacco/nicotine free and fully vaccinated to protect against COVID-19 they spend less healthcare dollars; keeping the costs as low as possible for all participants.

As such, we hope that you take advantage of the wellness features of the plans focusing on not using tobacco/nicotine products and keeping your eligible family members COVID-19 vaccinated per current CDC guidelines.



Tobacco/Nicotine Surcharge

As part of our commitment to the health of our employees, US Anesthesia Partners maintains a tobacco/nicotine free environment. We recognize the challenges associated with nicotine addiction and have a variety of resources available to assist tobacco/nicotine users who wish to quit. However, we also recognize the cost impact tobacco/nicotine has on our medical plan and the plan does not subsidize tobacco/nicotine use.

US Anesthesia Partners will add a tobacco/nicotine surcharge to the medical premium for employees enrolled in a US Anesthesia Partners medical plan who, during enrollment, do not certify that in the immediate prior three months, they are tobacco/nicotine-free. If a spouse/partner is enrolled in a US Anesthesia Partners medical plan, the employee must certify that the spouse/partner is also tobacco/nicotine-free in order to waive the surcharge.

US Anesthesia Partners defines a tobacco/nicotine user as a person who has used tobacco/nicotine in the past three months. Tobacco/nicotine includes any form of tobacco/nicotine products, which includes but is not limited to cigarettes, cigars, snuff, chewing tobacco, pipes, e-cigarettes or similar tobacco/nicotine-related product.

The tobacco/nicotine surcharge is $50 per month; up to $600 annually.

If you have questions regarding the surcharges, see the FAQ on **USAPToday.com** > Benefits for more information or call 855-464-USAP (8727), visit **USAPToday.com**, download the Now Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

Well onTarget℠

The BCBSTX tobacco cessation programs through Well onTarget® can help you quit tobacco and stay tobacco free.

You can sign for the Tobacco Cessation Programs in the Well onTarget Portal at **wellontarget.com** or for more information, call 877-806-9380.

Frequently Asked Questions

Tobacco/Nicotine FAQs

Q: How do I waive the tobacco/nicotine surcharge?

A: If you are not a tobacco/nicotine user, you must go through the enrollment process to waive your tobacco/ nicotine surcharge.

Q: What products are included in the tobacco/ nicotine surcharge?

A: Tobacco/nicotine includes any form of tobacco/ nicotine products, which includes but is not limited to cigarettes, cigars, snuff, chewing tobacco, pipes, e-cigarettes or similar tobacco/nicotine-related products.

Q: How does US Anesthesia Partners define someone as a tobacco/nicotine user?

A: US Anesthesia Partners defines a tobacco/nicotine users as anyone who has used tobacco/nicotine in the last 3 months.

Q: Does the tobacco/nicotine surcharge only apply if I use tobacco/nicotine?

A: The surcharge is effective if you and/or your spouse/ partner are tobacco/nicotine users and participate in the US Anesthesia Partners plans.

Q: How much is the tobacco/nicotine surcharge?

A: It is $50 per month or up to $600 annually.

Q: What if I or my spouse have been tobacco/ nicotine free for 3 or more months?

A: You can login to Workday and submit the Change Tobacco/Nicotine Use Status Benefit Event. Subsequent changes to your medical premium will not occur until the Benefit Event is approved by the benefits administrator and the designated effective date is reached.

Q: What if I or my spouse/partner have been tobacco/ nicotine free for 2 months at the time of enrollment and plan to be tobacco/ nicotine free when my benefits begin, how should I respond to the certification question during enrollment regarding being tobacco/ nicotine for 3 months?

A: You should respond that you and/or your spouse/ partner have not been tobacco/nicotine free for the last 3 months. When both you and your spouse/ partner are tobacco/ nicotine free for 3 months, go to Workday and complete a life event certifying that you and your spouse/partner have been tobacco/nicotine free for 3 months. You can update your status to waive the tobacco/nicotine surcharge.

Q: What if I quit using tobacco/nicotine and restart?

A: You can login to Workday and submit the Change Tobacco/Nicotine Use Status Benefit Event. Subsequent changes to your medical premium will not occur until the Benefit Event is approved by the benefits administrator and the designated effective date is reached.

Q: What if I am a social tobacco/nicotine user?

A: Any use of tobacco/nicotine products during the prior 3 months, social or as a regular user, for you and/or your spouse, qualifies you for the surcharge.

Q: How do I update my designation?

A: You can login to Workday anytime and submit the Change Tobacco/Nicotine Use Status Benefit Event. You can access the related Job Aid by going to **USAPToday.com**. If you need additional assistance, call 855-464-USAP (8727), visit **USAPToday.com**, download the Now Mobile App, visit ServiceNow at **support.usap.com** and open a ticket.

Q: How can I quit smoking?

A: Here are several resources to assist you:

- Visit with your doctor
- The US Anesthesia Partners health plan covers certain products to help you quit; contact your health plan for more information
- Obtain a prescription from your doctor to help, such as Chantix
- Obtain Nicotine Replacement Therapy products such as gum, lozenges, patches, etc.
- Visit **smokefree.gov** to find online and local resources to help.

Note

If you have any questions about the Tobacco/Nicotine Surcharge, please reach out to 855-464-USAP(8727), visit **USAPToday.com**, download the Now Mobile App, or visit ServiceNow at **support.usap.com** and open a ticket.

Frequently Asked Questions

Pharmacy FAQs

Q: How do I manage my new prescriptions?

A: You should contact CVS Caremark for your member services pharmacy needs. You can call 888-963-7290 — 24 hours a day for assistance.

Retail Pharmacy

- Your BCBSTX ID card will contain both medical and pharmacy information.
- Present your ID card to your pharmacy. The pharmacy will need to update your profile with the new information.
- If you are a new hire or newly eligible for benefits, typically you will receive your ID card within 7-14 business days after your enrollment is finalized.

Mail Service Pharmacy

- CVS Caremark's Mail Service Pharmacy is not required, except for specialty medications.
- If you have used a Mail Order benefit from your previous plan, ask your physician to send an electronic prescription to the CVS Caremark Mail Service Pharmacy.
- Please make sure you have at least a two-week supply on hand.

Specialty Medications Through PrudentRx

If you have a specialty medication*, you will need to:

- Ask your physician to send an electronic prescription to the CVS Caremark Mail Service Pharmacy.
- CVS Specialty is the point of contact for you to receive your specialty medication. Please return phone calls and remain in contact with CVS Specialty to coordinate delivery or arrange pickup at a local CVS store. You can reach CVS Specialty at this number 800-237-2767.
- Call CVS Specialty at any point in the process should you need customer service assistance.

*Specialty medications must be obtained through CVS Specialty, the CVS Caremark specialty pharmacy. Specialty medications may need extra care from you and your doctor to coordinate delivery.

Benefit Plan FAQs

Q: What if I forgot to drop my ex-spouse/partner during open enrollment or within 31 days of my divorce?

A: Contact HR Operations as soon as possible. Due to IRS taxation rules, you may not receive a refund. However, adding or keeping an ineligible dependent on a US Anesthesia Partners benefit plan can be treated as fraud or misrepresentation of material fact. Some acts that will be treated as misrepresentation of material fact:

- Falsifying dependent information
- Falsely certifying ineligible persons as eligible
- Falsifying dependent documentation
- Falsely enrolling ineligible persons in coverage

Q: Why do I need to provide the social security numbers for my dependents?

A: As part of federal tax reporting requirements, we must report to the Internal Revenue Service (IRS) the covered person's name, address, and Social Security number (SSN). To ensure proper reporting of your minimum essential health insurance coverage to the IRS and to avoid paying an IRS penalty, please be sure your dependents, if any, have a valid SSN entered in the enrollment system.

Frequently Asked Questions

ACA and COBRA-Related FAQs

Q: If I have medical coverage from US Anesthesia Partners, will I meet the requirements of the Affordable Care Act (ACA or healthcare reform)?

A: Yes. If you enroll for coverage from US Anesthesia Partners, you do not have to worry; you will meet the ACA requirements. That's because US Anesthesia Partners medical coverage meets the criteria required for minimum essential coverage.

Q: Can I get help paying for medical coverage, such as a federal subsidy, through the health insurance marketplace?

A: Even though you are eligible for the US Anesthesia Partners medical plan, you may be eligible to get help paying for medical coverage through a public exchange. US Anesthesia Partners offers a medical plan that meets the ACA minimum plan requirements and is affordable based on the employee pay. In some circumstances you may still qualify based on your family income for a subsidy. Visit **healthcare.gov** for more information.

Q: When am I eligible to continue coverage under COBRA?

A: An employee and/or their dependents are eligible to continue group healthcare under COBRA if coverage is lost under the following scenarios:

- Employee is no longer employed at US Anesthesia Partners for any reason other than "gross misconduct"
- Employee's work hours are reduced
- Employee dies (dependents are eligible for coverage in this event)
- Employee becomes entitled to and enrolls in Medicare, prior to electing COBRA
- Employee gets divorced
- Dependent loses dependent status

Q: My child is turning 26, when does US Anesthesia Partners health coverage end?

A: Medical, Dental, and Vision coverage ends at the end of the month in which a child turns 26. COBRA is offered for up to 36 months. All other US Anesthesia Partners benefit plans will also end at the end of the month in which a child turns 26, however, COBRA is only offered for Medical, Dental, and Vision.

Q: My child is turning 26, what do I need to do to get COBRA paperwork?

A: Coverage will automatically end at the end of the month in which a child turns 26, unless previously deemed disabled. The COBRA notification is automatically sent out after the coverage ends. Your only action would be to review and decide to enroll and pay for the COBRA coverage or go to **www.healthcare.gov** to shop for new coverage.

Frequently Asked Questions

FSA and HSA FAQs

Q: How long can I use my FSA funds after the plan year ends?

A: Below are important submission dates to remember.

- For 2023, the plan year ends December 31, 2023, but you have until March 31, 2024, to submit claims for reimbursement.
- Healthcare FSA (ONLY)
  - Participants have an additional 2 1/2-month grace period of time to incur expenses after the Plan Year ends (December 31).
  - If an expense is incurred between December 31, 2023, and March 15, 2024, and submitted for reimbursement on or before March 31, 2024, any remaining balance, in the previous Plan Year that ended December 31, 2023, is eligible for reimbursement, even though the service was provided in the new Plan Year.

Q: Can I use money in my HSA to pay for medical care for a family member?

A: Yes. You are allowed to use the funds to pay for qualified expenses for yourself, your spouse or a dependent without paying taxes on the amount.

Q: Can I pay my health insurance premiums with HSA funds?

A: You cannot use your HSA funds to pay your health insurance premiums unless you're collecting federal or state unemployment, have COBRA or are paying for Medicare premiums.

Q: Can I change my FSA or HSA annual election?

A: You cannot change your FSA annual election unless you experience a Qualifying Life Event. You can change your HSA annual election at any time throughout the year. You complete a change in Workday > Benefits > Change Benefits > HSA Contribution Change.

Q: Can I deduct a lump sum or one-time only FSA amount?

A: You cannot change the frequency or amount of the FSA deduction.

Q: How can I be reimbursed from my FSA account?

A: You can use your debit card at the point of sale for eligible expenses or you can submit a claim directly to TaxSaver Plan for reimbursement.

Q: Can I deduct a lump sum or one-time only HSA amount?

A: You cannot set up a one-time only deduction for HSA in Workday, but you can make a request by opening a ticket:

- Visit **USAPToday.com**
- Download the Now Mobile App OR
- Visit ServiceNow at **support.usap.com**

Q: Why would I pay for some benefits with pre-tax money?

A: Paying for certain optional benefits with pre-tax money lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

Q: What is a Limited Purpose FSA (LPFSA)?

A: The LPFSA is for those participants with the US Anesthesia Partners HDHP Core and Value plans. It can be used for only dental and vision expenses.

Q: How do I substantiate a claim?

A: TaxSaver Plan will coordinate with US Anesthesia Partners medical, dental and vision plans to reduce, or in some cases, eliminate substantiation of receipts for US Anesthesia Partners plans.

Be sure to keep your receipts for expenses that may not be substantiated through US Anesthesia Partners reporting and for your personal tax records. If you still have unsubstantiated claims, you will need to submit documentation of other eligible expenses.

You should also be sure to keep receipts for expenses on your HSA debit card for your personal tax records.

Q: How do I determine whether a FSA or a HSA is right for me?

A: Both plans allow employees to set aside pre-tax dollars for eligible health care expenses. If enrolled in a high deductible medical plan, you can contribute to both the Limited Purpose FSA and the HSA. If enrolled in a PPO medical plan, then you can only participate in the Healthcare FSA. You do not have to be enrolled in a US Anesthesia Partners medical plan to enroll in the Healthcare FSA. You must be enrolled in a US Anesthesia Partners medical plan to participate in the US Anesthesia Partners HSA plan. See page 24 for the FSA vs. HSA plan comparison.

Glossary

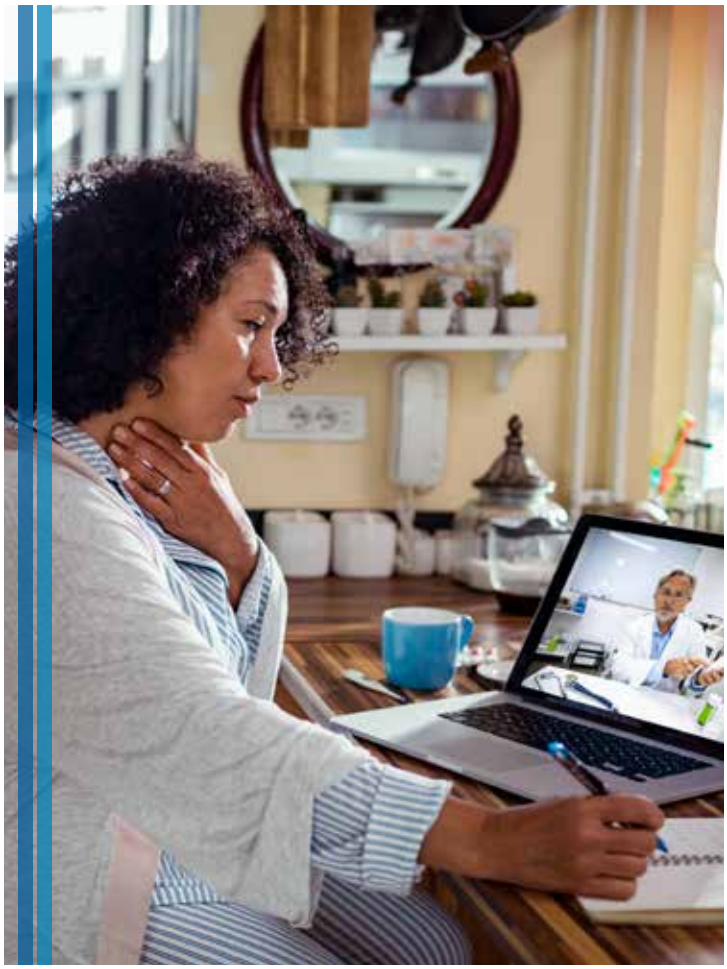
Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Evidence of Insurability – EOI is an application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.



Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Purpose FSA –** Designed to complement a Health Savings Account, a Limited Purpose FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Glossary

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from U.S. Anesthesia Partners About Your Prescription Drug Coverage and Medicare under the BlueCross BlueShield PPO, HDHP Core, and HDHP Value Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with U.S. Anesthesia Partners and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. U.S. Anesthesia Partners has determined that the prescription drug coverage offered by the BlueCross BlueShield PPO, HDHP Core, and HDHP Value plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current U.S. Anesthesia Partners coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with U.S. Anesthesia Partners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through U.S. Anesthesia Partners changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	U.S. Anesthesia Partners
Contact—Position/Office:	Human Resources
Address:	12222 Merit Drive, Suite 600 Dallas, TX 75251
Phone Number:	855-948-4238

Women's Health and Cancer Rights Act

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 (WHCRA). 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 855-948-4238.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 855-948-4238.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 855-948-4238.

GENERAL NOTICE OF YOUR RIGHTS GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

This notice contains important information about your associate benefits plan(s). Please read the entire notice.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer associates and their families (qualified beneficiaries) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the US Anesthesia Partners group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the US Anesthesia Partners Plan Administrator at (855) 464-8727. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

QUALIFYING EVENTS

If you are an associate of US Anesthesia Partners covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an associate covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

- The death of your spouse;
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with US Anesthesia Partners;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an associate covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

- The death of the associate;
- A termination of the associate's employment (for reasons other than gross misconduct) or reduction in the associate's hours of employment with US Anesthesia Partners;
- The associate's divorce or legal separation;
- The associate became entitled to Medicare prior to his/her qualifying event; or
- The dependent child ceases to be a dependent child under the Group Health Plan.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to US Anesthesia Partners and that bankruptcy results in the loss of coverage of any retired associate under the Group Health Plan, the retired associate will become a qualified beneficiary with respect to the bankruptcy. The retired associate's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOU WHEN YOU LOSE GROUP 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 30-day 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.

COVERAGE PROVIDED

Under COBRA, the associate or a family member has the responsibility to inform the US Anesthesia Partners Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. You must provide this notice to: US Anesthesia Partners, 12222 Merit Drive, Suite 700 Dallas, TX 75251, by logging on to Workday and completing a life event notice (within 31 days), or please contact (855) 464-USAP (8727), visit USAPToday.com, download the Now Mobile App, or visit ServiceNow at support.usap.com and open a ticket to receive further instruction. To be eligible for a change in benefits, you must notify within 31 days. To be eligible for a COBRA event, you must notify within 60 days. No premium refund will be allowed if you notify after 31 days.

US Anesthesia Partners has the responsibility to notify the administrator of the associate's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the US Anesthesia Partners Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, US Anesthesia Partners is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated associates or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

PERIOD OF COVERAGE

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.

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months. Also, if you or your spouse gives birth to or adopts a child while on COBRA, you will be allowed to change your coverage status to include the child. The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, a qualified beneficiary must notify the US Anesthesia Partners Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the US Anesthesia Partners Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

PERIOD OF COVERAGE CONTINUED

If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:

- Divorce or legal separation
- Death
- Medicare entitlement
- Dependent child ceasing to be a dependent

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the US Anesthesia Partners Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA.

HEALTH FSA INFORMATION

COBRA coverage under the US Anesthesia Partners Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered associate, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the US Anesthesia Partners Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the US Anesthesia Partners Health FSA coverage in force at the time of the qualifying event. The “use it or lose it” rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the US Anesthesia Partners Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact TaxSaver Plan at (888) 602-6272 during business hours for more information.

ALTERNATE RECIPIENTS UNDER QMCSOS

A child of the covered associate who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by US Anesthesia Partners during the covered associate's period of employment with US Anesthesia Partners is entitled to the same rights to elect COBRA as an eligible dependent child of the covered associate.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTUNUATION COVERAGE?

Yes. 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 www.healthcare.gov.

PLAN CONTACT INFORMATION

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 www.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 www.HealthCare.gov.

To ensure that all covered individuals receive information properly and timely, it is important that you notify the TaxSaver Plan Customer Service Department at (888) 602-6272 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

If you have any questions about COBRA, please contact the TaxSaver Customer Service Department at (888) 602-6272 during business hours.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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) after delivery. 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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 (WHCRA). 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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact (855) 464-USAP(8727), visit USAPToday.com, download the Now Mobile App, or visit ServiceNow at support.usap.com and open a ticket.

HIPAA SPECIAL ENROLLMENT EVENTS

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact (855) 464-USAP(8727), visit USAPToday.com, download the Now Mobile App, or visit ServiceNow at support.usap.com and open a ticket.

GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your health information only for each of the following purposes: treatment, payment, health care operations and certain special situations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, health plan budgeting, carrier bidding, and customer service. An example would be an internal quality assessment review or to a business associate of the health plan.
- Special Situations include disclosures for your safety or for the safety of the general public; to individuals involved in your care or payment for your care (unless you specifically object to such disclosures); for instances of national security; for worker's compensation; for organ donation programs (if you are an organ donor); to military command (if you are a member of the armed services); to coroners, medical examiners or funeral directors; or as otherwise required by law.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may communicate with you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you, however, if we are receiving compensation for these communications, we must first obtain written authorization from you.

We may not use or disclose your genetic information for underwriting purposes. We may also not sell your health information without your express written authorization, unless the sale is part of a merger, transfer, sale or consolidation of the health plan to another health plan.

We will not use your protected health information for employment purposes or another benefit plan without your written authorization.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to inspect and copy your protected health information, either electronically or on paper, and obtain this copy within 30 days or within 60 days if we are unable to provide the information within 30 days and notify you of the delay within the first 30 days.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction, unless the request is made to restrict disclosure to an insurer or health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for which you have paid out of pocket in full. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request an amendment of your protected health information. We are not required to agree to the requested amendment of your information, but will consider your request.

The right to receive an accounting of certain non-routine disclosures of protected health information that were not disclosed for treatment, payment or health care operations.

We have the obligation to provide and you have the right to obtain notice from us in the event that the privacy or security of your protected health information has been breached.

You have the right to opt out of any communications that may be construed as fundraising or marketing for the health plan.

We have the obligation to let you know about the availability of this notice every three years. You have the right to receive a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October, 2017 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a copy of the revised notice within 60 days of the change.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid

WEBSITE	http://myalhipp.com/
PHONE	1-855-692-5447

ALASKA – Medicaid

	The AK Health Insurance Premium Payment Program
WEBSITE	http://myakhipp.com/
PHONE	1-866-251-4861
EMAIL	CustomerService@MyAKHIPP.com
MEDICAID ELIGIBILITY	https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

WEBSITE	http://myarhipp.com/
PHONE	1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

	Health Insurance Premium Payment (HIPP) Program
WEBSITE	http://dhcs.ca.gov/hipp
PHONE	916-445-8322 / (fax) 916-440-5676
EMAIL:	hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

WEBSITE	Health First Colorado Website: https://www.healthfirstcolorado.com/
PHONE	Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+ WEBSITE	https://hcpf.colorado.gov/child-health-plan-plus
CHP+ PHONE	Customer Service: 1-800-359-1991 / State Relay 711
WEBSITE	Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
PHONE	HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

WEBSITE	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
PHONE	1-877-357-3268

GEORGIA – Medicaid

GA HIPP WEBSITE	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
PHONE	678-564-1162, Press 1
GA CHIPRA WEBSITE	https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
PHONE	678-564-1162, Press 2

INDIANA – Medicaid

	Healthy Indiana Plan for low-income adults 19-64
WEBSITE	http://www.in.gov/fssa/hip/
PHONE	1-877-438-4479
	All other Medicaid
WEBSITE	https://www.in.gov/medicaid/
PHONE	1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

MEDICAID WEBSITE	https://dhs.iowa.gov/ime/members
MEDICAID PHONE	1-800-338-8366
HAWKI WEBSITE	http://dhs.iowa.gov/Hawki
HAWKI PHONE	1-800-257-8563
HIPP WEBSITE	https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP PHONE	1-888-346-9562

KANSAS – Medicaid

WEBSITE	https://www.kancare.ks.gov/
PHONE	1-800-792-4884
HIPP PHONE	1-800-967-4660

KENTUCKY – Medicaid

	Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program
WEBSITE	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
PHONE	1-855-459-6328
EMAIL	KIHIPP.PROGRAM@ky.gov
KCHIP WEBSITE	https://kidshealth.ky.gov/Pages/index.aspx
KCHIP PHONE	1-877-524-4718
MEDICAID WEBSITE	https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

WEBSITE	www.medicaid.la.gov or www.ldh.la.gov/lahipp
PHONE	1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

ENROLLMENT WEBSITE	https://www.mymaineconnection.gov/benefits/s/?language=en_US
PHONE	1-800-442-6003 TTY: Maine relay 711
WEBSITE	Private Health Insurance Premium https://www.maine.gov/dhhs/ofi/applications-forms
PHONE	1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

WEBSITE	https://www.mass.gov/masshealth/pa
PHONE	1-800-862-4840 TTY: 711
EMAIL	masspremassistance@accenture.com

MINNESOTA – Medicaid

WEBSITE	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
PHONE	1-800-657-3739

MISSOURI – Medicaid

WEBSITE	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
PHONE	573-751-2005

MONTANA – Medicaid

WEBSITE	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
PHONE	1-800-694-3084
EMAIL	HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

WEBSITE	http://www.ACCESSNebraska.ne.gov
PHONE	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid

MEDICAID WEBSITE	http://dhcfp.nv.gov
MEDICAID PHONE	1-800-992-0900

NEW HAMPSHIRE – Medicaid

WEBSITE	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
PHONE	603-271-5218
TOLL FREE FOR HIPP PROGRAM	1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

MEDICAID WEBSITE	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
MEDICAID PHONE	609-631-2392
CHIP WEBSITE	http://www.njfamilycare.org/index.html
CHIP PHONE	1-800-701-0710

NEW YORK – Medicaid

WEBSITE	https://www.health.ny.gov/health_care/medicaid/
PHONE	1-800-541-2831

NORTH CAROLINA – Medicaid

WEBSITE	https://medicaid.ncdhhs.gov/
PHONE	919-855-4100

NORTH DAKOTA – Medicaid

WEBSITE	https://www.hhs.nd.gov/healthcare
PHONE	1-844-854-4825

OKLAHOMA – Medicaid and CHIP

WEBSITE	http://www.insureoklahoma.org
PHONE	1-888-365-3742

OREGON – Medicaid

WEBSITE	http://healthcare.oregon.gov/Pages/index.aspx
PHONE	1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

WEBSITE	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
PHONE	1-800-692-7462
CHIP WEBSITE	https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP PHONE	1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

WEBSITE	http://www.eohhs.ri.gov/
PHONE	1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

WEBSITE	https://www.scdhhs.gov
PHONE	1-888-549-0820

SOUTH DAKOTA - Medicaid

WEBSITE	http://dss.sd.gov
PHONE	1-888-828-0059

TEXAS – Medicaid

WEBSITE	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
PHONE	1-800-440-0493

UTAH – Medicaid and CHIP

MEDICAID WEBSITE	https://medicaid.utah.gov/
CHIP WEBSITE	http://health.utah.gov/chip
PHONE	1-877-543-7669

VERMONT– Medicaid

WEBSITE	https://dvha.vermont.gov/members/medicaid/hipp-program
PHONE	1-800-250-8427

VIRGINIA – Medicaid and CHIP

WEBSITE	https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
MEDICAID AND CHIP PHONE	1-800-432-5924

WASHINGTON – Medicaid

WEBSITE	https://www.hca.wa.gov/
PHONE	1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

WEBSITE	http://dhhr.wv.gov/bms http://mywvhipp.com
MEDICAID PHONE	304-558-1700
CHIP TOLL-FREE	1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

WEBSITE	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
PHONE	1-800-362-3002

WYOMING – Medicaid

WEBSITE	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
PHONE	1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits
Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare
& Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is November 1 - December 15 annually.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56%, in 2018, of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer offered coverage. Also, this employer contribution, as well as your associate contribution to employer offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact (855) 464-USAP (8727), visit USAPToday.com, download the Now Mobile App, or find the service portal at usap.service-now.com and open a ticket.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Contacts

Medical & Virtual Visits
Blue Cross Blue Shield of Texas (BCBSTX)
800-551-2227
www.BCBSTX.com
See table below for group number

Pharmacy
CVS Caremark
888-963-7290
www.caremark.com
RXBIN #: 004336
ISSUER (80840) #: 9151014609
RXGRP #: RX20CR

Dental
Delta Dental
800-521-2651
www.deltadentalins.com
Group #: 22585

Vision
VSP
800-877-7195
www.vsp.com
Group #: 30052381

Health Savings Account
Debit Card Issued, use to expiration date
HSA Bank
800-357-6246
www.hsabank.com

Flexible Spending Accounts & COBRA
Debit Card Issued, use to expiration date
TaxSaver Plan
800-328-4337
www.taxsaverplan.com
csr@taxsaverplan.com

Accident, Critical Illness, Hospital Indemnity
MetLife
800-435-6388
www.metlife.com/mybenefits
Group #: 160878

Employee Assistance Program
New Directions
800-624-5544
eap.ndbh.com
Passcode: USAP

Life and AD&D & Disability
New York Life (NYL)
Evidence of Insurability (EOI):
866-607-2360
Email:
bethlehemmail@newyorklife.com
www.newyorklife.com
Policy #: FLX 969844

Disability and Family Medical Leave
New York Life (NYL)
800-238-2125 (To File a Claim)
Fax: 800-642-8553
Nyl.com/customer-forms
Email scanned documents to:
DallasFCO.Intake2@newyorklife.com
STD Policy #: LK 752818
LTD Policy #: LK 966572

Travel Assistance
NYL GBS Secure Travel
202-331-7635 (Outside the U.S.)
888-226-4567 (Within the U.S.)
ops@us.generaliglobalassistance.com
Policy #: OK971285
Group #: 57

Legal Coverage
MetLife Legal Plans
800-821-6400
www.legalplans.com
Group #: 160878

Identity Theft
Allstate Identity Protection
800-789-2720
www.myAIP.com
clientservices@infoarmor.com

Retirement
Vanguard
800-523-1188
www.vanguard.com/retirementplans
Policy #: 097382

Discount Tickets
Tickets at Work
800-331-6483
www.ticketsatwork.com
Company Code: USAPFUN

Important Contacts – Continued

Verification of Employment & Income

The Work Number
800-367-5690
www.theworknumber.com
Company Code: 16163

US Anesthesia Partners Human Resources

12222 Merit Drive, Suite 700
Dallas, TX 75251
855-948-4238

Benefit Discount Programs

Home/Auto (Direct Bill Plan)

Farmers Insurance
800-438-6381
www.farmers.com/groupselect
Code: DFF

Pet Insurance (Direct Bill Plan)

Nationwide-VPI
800-540-2016
www.petinsurance.com/USAP
New Enrollment/Inquiries: 877-738-7874

Medicare

www.MEDICARE.gov
1-800-MEDICARE (800-633-4227)

Enrollment in Workday

1. Visit Workday
   - **USAPToday.com** and click the Workday link
   - **Workday.usap.com** OR
   - Workday mobile app
2. Go to your Workday Inbox to find your benefit event
3. Review, update, and submit your Enrollment elections within 14 days from your date of eligibility (date of hire) or November 15, 11:59 PM during Open Enrollment

Questions?

855-464-USAP (8727) Option 3
Monday-Friday 8 a.m. to 6 p.m. CT

To access additional information and for IT, Payroll, HR Ops Help:

- Visit **USAPToday.com**
- Download the Now Mobile App OR
- Visit ServiceNow at **support.usap.com**

Notes



US ANESTHESIA PARTNERS