BENEFITS GUIDE

2024

ApellaHealth

CONTACT INFORMATION

BENEFIT	COMPANY TO CONTACT	PHONE NUMBER	WEBSITE ADDRESS
401(k)	Fidelity Investments	1-800-835-5097	**netbenefits.com**
Accidental Death and Dismemberment Insurance	New York Life	1-800-238-2125	**newyorklife.com/group-benefit-solutions**
Accident Insurance	Sun Life	1-800-247-6875	**sunlife.com/us**
Adoption Benefits	Human Resources	1-864-560-6387	**Hub**
Cancer Policy Insurance	Sun Life	1-800-247-6875	**sunlife.com/us**
Company Provided Life Insurance	New York Life	1-800-238-2125	**newyorklife.com/group-benefit-solutions**
Critical Illness Insurance	Sun Life	1-800-247-6875	**sunlife.com/us**
Dental Insurance	Delta Dental	1-800-335-8266	**deltadentalsc.com**
Employee Assistance Program	AllOne Health	1-866-216-1996	**myassistanceprogram.com**
Employee Purchasing Program	Purchasing Power	1-866-670-3477	**spartanburg.purchasingpower.com**
Family Medical Leave	New York Life	1-888-842-4462	**newyorklife.com/group-benefit-solutions**
Flexible Spending	UMR	1-800-826-9781	**umr.com**
Health Savings Account	UMR	1-800-826-9781	**umr.com**
Hospital Indemnity	Sun Life	1-800-247-6875	**sunlife.com/us**
Long-Term Disability	New York Life	1-888-842-4462	**newyorklife.com/group-benefit-solutions**
Medical Insurance	UMR	1-800-967-6831	**umr.com**
Prescription Medications	SRHS Employee Pharmacy	1-864-560-9200	**SpartanburgRegional.com/Pharmacy**
Specialty Medication Prior Authorizations	SRHS Employee Pharmacy	1-864-560-9200	**SpartanburgRegional.com/Pharmacy**
All Other Medication Prior Authorizations	RxBenefits	1-800-334-8134	
Patient Engagement Center (Nurse on Call)		1-864-560-8477	
Short-Term Disability	New York Life	1-888-842-4462	**newyorklife.com/group-benefit-solutions**
Supplemental Life Insurance	New York Life	1-800-238-2125	**newyorklife.com/group-benefit-solutions**
Tuition Reimbursement	HR Apella Health	1-864-560-6387	**Hub**
Universal Life Insurance	TransAmerica	1-877-221-0423	**transamerica.com/insurance/universal-life-insurance**
Vision Insurance	EyeMed	1-866-939-3633	**eyemedvisioncare.com**

WHAT'S NEW FOR 2024?

We are excited to announce many improvements to our health benefits for 2024! Below you will find a high-level summary with details of these benefit changes throughout the guide. One change that will impact all health plan members is the cost of care for certain services at Spartanburg Regional hospitals. The cost of commonly used hospital-based outpatient services (i.e. labs, physical therapy, etc.) will be lower beginning Jan. 1, 2024. (See page **10** for more information.)

Pharmacy copays will be lower. (See page **17** for more information.) Value Health Plan members must meet their annual deductible before the copays apply, but there are low-cost maintenance medications available without first meeting the deductible. This list is on the Benefits Hub page. In addition, Value Plan Wellness participants who enroll in the Health Savings Account will have a financial contribution made by Apella Health. (See page **18** for more information.)

HEALTH PLAN CHANGES FOR 2024 INCLUDE:

- **Value Plan** – The deductible for those who cover their children or spouse will see a slight increase to comply with high-deductible health plan federal requirements. The coinsurance and out-of-pocket maximum will be lower. (See page **12** for more information.)

  The amount employees may defer (pre-tax) into the Value Plan's Health Savings Account has increased. (See page 18 for more information.)
- **Healthy Choice** – The deductible, out-of-pocket maximum and premiums will be lower. There will be additional copays available to all Healthy Choice plan members. (See page **13** for more information.)
- **New Voluntary Life Product** – A new life insurance plan will be available via the online enrollment tool this year. This plan will replace the existing Cincinnati Whole Life Insurance benefit. (See page **29** for more information.)

CONTENTS

Important Info

FROM YOUR HR DEPARTMENT

At Apella Health, we take pride in the health and wellness services we provide to our associates. We understand that the benefits you receive are important, and our goal is to help you through the benefits decision-making process. On page 51, you will find instructions for completing your enrollment online. We have included all the phone numbers and websites you'll need to answer any questions you might have on the facing page. Take the time to read this benefits guide. If there is something you don't understand or if you need further explanation, call the Human Resources Department at **864-560-6387**. Thank you for being a part of the Apella Family.

700 North Pine Street
Spartanburg, SC 29303
864-560-6387 • ApellaHealth.com

This guide is provided to help in making your 2024 benefits elections. You may find a complete plan document on the Hub or request the document from Human Resources.

EMPLOYER-PROVIDED BENEFITS

As an eligible associate, Apella Health automatically offers you and your covered dependents a variety of benefits, including tuition reimbursement; a free counseling program through a confidential outside provider; benefits covering infertility, adoption and autism; an associate discount program and much more. For the most current information, visit the Hub or **SpartanburgRegional.com/Employees**.

In addition to the above, you will find many benefits in which you may enroll on the following pages, including medical, dental, vision and more.

If you are reading or reviewing this document during our **Annual Enrollment** period, your enrollment is passive this year. In other words, all benefits, with the exception of medical flexible spending and dependent care flexible spending, will roll over to 2024 just as you have them in 2023. If you wish to make any changes to your elections or who you cover on your benefits, you must log into the enrollment system and make those desired changes during Annual Enrollment.

If you are **an associate who is newly hired or newly eligible for benefits**, you must make your benefit elections **within 31 days** of the date on which you were hired or became eligible for benefits.

Find the Affordable Care Act (ACA) Preventive Screening information on page 6.

IMPORTANT INFORMATION

2024 Wellness Plan Incentive Program:
Those associates who completed their biometrics, preventive exam and labs between Oct. 1, 2023 and Sept. 30, 2024 will have lower deductibles and out-of-pocket maximums during 2024. In addition, those in the Value Plan will receive a company contribution to their Health Savings Account (if enrolled). The amount of the contribution depends on the tier of coverage and can be found on page 12.

- Wellness Incentives for 2025 will be decided at a later date and will require that associates enrolled in the health plan complete biometrics and labs during your annual visit to Employee Health.

AND

- At least one of the below listed screenings must be completed **between Oct. 1, 2023, and Sept. 30, 2024**:
  - Pap smear
  - Mammogram
  - PSA screening
  - Colonoscopy screening
  - Affordable Healthcare Act-approved wellness screening
  - Dental screening through a dental office[i]
  - Vision screening through an optometrist or ophthalmologist[ii]
  - Virtual mental health evaluation

i Associate responsible for any charges not covered by their dental plan, if enrolled.

ii Associate responsible for any charges not covered by their vision plan, if enrolled.

If enrolled in an Apella Health health plan, completion of the required screening will be tracked by UMR Benefits. If enrolled in the Apella Health Dental or Vision plan, your participation will also be tracked by UMR. UMR will report to the wellness coordinator your completion date (only) to determine your eligibility for 2025 wellness incentives. If you are not enrolled in any of these plans, you may qualify for wellness incentives if you provide proof of your participation by Oct. 31, 2023 to the Employee Health wellness plan coordinator.

All wellness program requirements will be completed from Oct. to Sept. each year.

This means that labs and biometrics completed during your annual employee health visit from Oct. 2023 to Sept. 2024 will be considered towards satisfying the 2024 wellness program requirements.

MyHealth ReadySet

Employee Health has a personal health portal called MyHealth ReadySet. This personal health portal allows associates to:

- Self-schedule annual assessments and vaccine appointments, including COVID-19, tetanus, etc.
- Complete paperwork (surveys) online before scheduled Employee Health appointments.
- View vaccine records.
- Set up email appointment reminders.
- Upload documents such as vaccine records, work notes, etc.
- View messages from Employee Health.

ACA Preventive Screenings

What ACA preventive screenings are covered by your health plan at 100% for both men and women?

The following ACA preventive screenings are covered at 100% by your health plan for covered members:

- Abdominal aortic aneurysm (AAA)
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease
- Blood pressure screening
- Cholesterol screening
- Colorectal cancer screening for adults over 45
- Depression screening
- Diet counseling
- Falls prevention
- Hepatitis C screening
- HIV screening
- Immunization vaccines
- Obesity screening
- PrEP (pre-exposure prophylaxis) HIV prevention medication
- Sexually transmitted infections (STI) prevention counseling
- Syphilis screening
- Tobacco use screening
- Type 2 diabetes screening

What ACA preventive screenings are covered by your health plan at 100% for children?

The following ACA preventive screenings are covered at 100% by your health plan for covered dependent children:

- Alcohol, tobacco and drug assessment
- Autism screening
- Behavioral assessments
- Blood pressure screening
- Children's immunization vaccines
- Congenital hypothyroidism screenings for newborns
- Depression screening
- Developmental screening
- Dyslipidemia screening
- Fluoride chemoprevention
- Hearing screening for newborns
- Height, weight and body mass index measurements
- Hematocrit or hemoglobin screening
- Hepatitis B screening
- HIV screening
- Lead screening
- Newborn screenings
- Obesity screening and counseling
- Oral health risk assessment
- PrEP (pre-exposure prophylaxis) HIV prevention medication
- Sexually transmitted infection (STI) prevention counseling and screening
- Tuberculin testing
- Vision screening
- Well-baby and well-child visits

What ACA preventive screenings are covered by your health plan at 100% for women?

The following ACA preventive screenings are covered at 100% by your health plan. Preventive services specifically for women include:

- Anemia screening
- BRCA counseling for women at higher risk
- Breast cancer mammography and chemoprevention counseling
- Breastfeeding counseling
- Cervical cancer screening
- Chlamydia infection screening
- Contraception
- Domestic and interpersonal violence screening and counseling
- Certain items and services for pregnant women
- Gestational diabetes screening
- Gonorrhea screening
- Osteoporosis screening
- Rh incompatibility screening
- Urinary incontinence screening
- Well-woman visits

Our goal is to keep you healthy. To do this, Apella Health offers you a number of programs to prevent illness and injury.

HEALTH AND WELLNESS PROGRAMS

CarePlus Diabetes and Hypertension Disease Management Program

FREE
TO PARTICIPANTS

If you or your covered family member suffers from diabetes and/or hypertension, the CarePlus Disease Management Team invites your participation in our special program that allows you to receive nutritional education, medication management and a personal coach. Those compliant with program requirements receive their insulin controlling medications and/or hypertension controlling medications at no charge. You or your covered dependent may contact the disease management team at 864-560-6042, option 3, to discuss details and how to enroll.

Maternity Management Program

The Maternity Management Program assists women throughout their pregnancy with health and education materials, nursing advice and referrals to avoid pre-term or high-risk pregnancies.

Health plan participants (covered spouses and dependent children) may qualify for the Maternity Management Program.

Although your dependent children are eligible for the Maternity Management Program, dependent pregnancies are an exclusion under your health plan. Should you have a dependent child who is pregnant, we encourage you to contact your local Medicaid office as they may offer medical insurance on the pregnancy.

Associates who are not on the health plan may also use the program, with similar benefits.

To enroll, contact the disease management team at 864-560-6042, option 3.

HEALTH AND WELLNESS BENEFITS

To provide flexibility and choice, the health system offers several benefit options. Associates can personalize a benefit package to fit their individual needs and lifestyle.

Eligibility

Spouses who have the opportunity for medical insurance through their employer are not eligible for coverage under your health plan. This does not apply to those who are self-employed; retired; enrolled in Medicare, Tricare or COBRA or an associate married to another associate within Apella Health Management or Spartanburg Regional. For spouses who are married and both work for Spartanburg Regional or Apella, "double coverage" is not allowed.

If adding a new dependent during open enrollment, proof of your relationship to that dependent must be provided to Benefitsolver before their coverage can be approved.

Who May Be Covered on My Benefits and What Documentation is Required?		
Plan	**Spouse**	**Children**
Medical	Only if the spouse is not eligible for coverage with their employer	Yes, up to age 26
Dental	Yes	Yes, up to age 26
Life	Yes, up to $50,000 without insurability if elected when first eligible	Yes, maximum of $20,000 until age 19. You may continue coverage from age 19 up to age 25 if your child is financially dependent upon you.
Accidental Death and Dismemberment	Yes	No
Vision	Yes	Yes, up to age 26

Required Documentation

As a new hire or a newly benefits-eligible associate, you must submit proof of your relationship for the dependents you wish to cover within 31 days of your hire date or within 31 days of the date on which you become eligible for benefits. If adding a **NEW** dependent during open enrollment, proof must be submitted to Benefitsolver within 31 days of your completion of annual enrollment before their coverage can be approved.

Your spouse	Marriage license, a joint document dated within the last 90 days that contains both your spouse's name and yours and your mailing address (for example: a water bill, phone bill or power bill) and a document found in the Benefitsolver Reference Center called "Other Insurance Inquiry for Spouse" that must be completed by your spouse's employer, if applicable. If your spouse is unemployed, or on Medicare or COBRA, the document still must be completed and returned to Benefitsolver.
Your natural child whose last name is the same as yours	A copy of the long birth certificate or the pocket card birth certificate. If your child is disabled and beyond the limiting age, you must also submit a copy of the Social Security award letter.
Your natural child whose last name is different than yours	A copy of the long birth certificate as well as a document providing proof of the reason that the child's name is different than yours (for example: a marriage license where your name was changed). If your child is disabled and beyond the limiting age, you must also submit a copy of the Social Security award letter.
A stepchild	A copy of the child's long birth certificate containing the first and last name of your spouse, a copy of your marriage license to the spouse and a joint document dated within the last 90 days that contains both your spouse's name and yours and your mailing address (for example: a water bill, phone bill or power bill). If your child is disabled and beyond the limiting age, you must also submit a copy of the Social Security award letter.
An adopted child or child placed with you in anticipation of an adoption	A copy of the court order that provides proof of the adoption. If your child is disabled and beyond the limiting age, you must also submit a copy of the Social Security award letter.
A foster child	A copy of the court order that provides proof that you are the foster parent. If your child is disabled and beyond the limiting age, you must also submit a copy of the Social Security award letter.

Important information about domestic partnerships (common law marriages)

In July 2019, the South Carolina Supreme Court abolished the practice of allowing couples to claim they are married without a license if they live together long enough. In alignment with the law, the health plan only offers coverage to couples whose marriages are recognized by state law.

CHANGES TO THE COST OF CARE AT SPARTANBURG REGIONAL HEALTHCARE SYSTEM

All health plan members may see a change to the cost of care for services received at Spartanburg Regional Healthcare System hospitals. The cost of commonly used hospital-based outpatient services (i.e. labs, physical therapy, etc.) will be lower beginning Jan. 1, 2024. Health plan members are accustomed to seeing around a 50% discount on hospital-based services. This discount will no longer be applied to all services. Some services will have a set price, which will help you pay less.

Listed out below are some general cost changes to highly utilized outpatient services. These cost reductions are approximate and depend on the test performed.

- Lab services will cost 15% less.
- Physical therapy will cost 30% less.
- Imaging will cost 10 to 20% less.

EFFECTIVE DATE OF MEDICAL AND DENTAL INSURANCE

- New hire benefits-eligible associates: your hire date
- Associates transferring to benefits-eligible position: effective date of transfer
- Associates enrolling during annual enrollment: Jan. 1, 2024

WHEN MEDICAL AND DENTAL INSURANCE ENDS

- Those terminating employment: end of the month of termination
- Those transferring to non-benefits-eligible status: end of the month of transfer to non-benefits eligible status

Remote Employees

Associates who are 100% remote and live outside of our geographic region will be eligible to receive medical benefits from tier 2 providers through UnitedHealthcare Choice Plus network. Covered expenses will be subject to the tier 1 deductible and out-of-pocket instead of the higher tier 2 deductible and out-of-pocket. Note, you must be coded as 100% remote with Human Resources. Please refer to Policy IM1000.507.1 on the Hub if you have questions about remote work or how to be coded correctly.

MEDICAL INSURANCE: CHOOSE YOUR 2024 HEALTH PLAN

Healthy Choice and Value Plan

You have **two** health plans to choose from: **The Value Plan** and **The Healthy Choice Plan**. Details about each plan are on the following pages.

Which is Best For Me?

OR

Value Plan HDHP	Healthy Choice PPO
Higher deductible health plan (HDHP) Lower premium Health Savings Account eligible Prescription copays after the deductible is met	Lower deductible Higher premium Flexible Spending Account eligible Prescription copays day 1
Annual deductible	
$1,750	$750
Out-of-pocket maximum	
$4,000	$4,000
Annual average premium	
$700	$1,000
Coinsurance	
10%	20%
Copays available	
No	Yes
Health Savings Account eligible	
Yes Wellness company contribution: $750	No

The comparison on this page illustrates the differences between the two health plans for employee only coverage. The plan has similar differences for dependent coverage tiers.

Wellness funds are deposited in January of each year only if you have opened a Health Savings Account. Enrolling in the Value Plan does not automatically open the account. Use the available link on the Benefitsolver home page for UMR-Flex Spending/ Health Savings Account to open your account. During the year, all deposited funds are prorated based on the date on which you open the account.

The Value Plan – Medical

Legend:
A: Associate-only coverage
AC: Associate & children coverage
AS: Associate & spouse coverage
F: Family coverage

	Regional HealthPlus (RHP) network		UHC outside Spartanburg County	Out-of-network
Health Savings Account (If you open this account and complete wellness criteria)	**Wellness company contribution** $750(A), $1,375 (AC/AS), $1,750 (F)			
NEW **Deductible you pay** If you participate in the Health Savings Account, you choose whether to use those dollars toward meeting your annual deductible.	**Wellness participants** $1,750 (A) $3,200 (AC/AS) $3,500 (F)	**Non-wellness participants** $2,000 (A) $3,500 (AC/AS) $4,000 (F)	$3,000 (A) $4,500 (AC/AS) $6,000 (F)	$4,000 (A) $8,000 (AC/AS) $8,000 (F)
NEW **Out-of-pocket maximum** Includes deductible, coinsurance and any plan-covered prescription costs you pay out of your pocket.	$4,000 (A) $6,000 (AC/AS) $8,000 (F)	$6,000 (A) $9,000 (AC/AS) $12,000 (F)	$6,700 (A) $10,750 (AC/AS) $13,000 (F)	$12,000 (A) $24,000 (AC/AS) $24,000 (F)
Lifetime maximum	$3 million on nonessential medical benefits			
Coverage levels	**You pay**			
ACA Preventive Care visits	$0		$0	100%
Physician office visits (non-routine)	10%*		50%*	60%*
Specialist office visits (non-routine)	10%*		50%*	60%*
Hospital care, OP surgery, diagnostic services	10%*		50%*	60%*
Emergency room visit	**10%***		**10%****	**10%****
Immediate Care	10%*		50%*	60%*
Mental health/substance abuse inpatient	10%*		10%**	60%*
Chiropractic	10%*		10%**	10%**
Autism	10%*		10%**	10%**
Infertility	10%*		10%**	10%**

* After deductible
** After RHP deductible

The Healthy Choice Plan – Medical

Legend:
A: Associate-only coverage
AC: Associate & children coverage
AS: Associate & spouse coverage
F: Family coverage

	Regional HealthPlus (RHP) Network		UHC outside Spartanburg County	Out-of-network
NEW **Deductible**	**Wellness participants** $750 (A) $1,500 (AC/AS) $2,250 (F)	**Non-wellness participants** $1,000 (A) $1,750 (AC/AS) $2,500 (F)	$2,000 (A) $3,000 (AC/AS) $4,000 (F)	$4,000 (A) $8,000 (AC/AS) $8,000 (F)
NEW **Out-of-pocket maximum** Includes deductible, copays, coinsurance, and any plan-covered prescription costs paid out of your pocket.	$4,000 (A) $6,000 (AC/AS) $8,000 (F)	$4,500 (A) $6,750 (AC/AS) $9,000 (F)	$6,700 (A) $10,750 (AC/AS) $13,000 (F)	$12,000 (A) $24,000 (AC/AS) $24,000 (F)
Lifetime maximum	$3 million on nonessential medical benefits			
ACA Preventive Care visits	$0		$0	100%
Primary Care office visits (non-routine)	$30		35%*	50%*
Specialist office visits	$50		35%*	50%*
Immediate Care	$30		35%*	50%*
NEW ER	$350		$350	$350
Simple Imaging	$50		35%*	50%*
Complex Imaging	$250		35%*	50%*
Lab	$30		35%*	50%*
Therapy (PT, OT, ST)	$75		35%*	50%*
Hospital care, OP surgery	20%*		35%*	50%*
Mental health/substance abuse inpatient	20%*		20%**	50%*
Chiropractic	20%*		20%**	20%**
Autism	20%*		20%**	20%**
Infertility	20%*		20%**	20%**

* After deductible
** After RHP deductible

The Healthy Choice Plan now includes lower deductibles, lower out-of-pocket maximums and expanded copays! All members in the Healthy Choice Plan will have unlimited copays for several outpatient services, including physician office visits, labs, and imaging services. While the copays will not count towards the deductible, they do count towards the out-of-pocket maximum.

Attention Value Plan Members!

When you fill a prescription, until you have met your deductible (deductible includes medical and prescription claims), you will pay 100% of the cost of the medication you are prescribed. This does not apply to medications that are listed on the Preventive Medication List, found on the HR page of the Hub. You may use your HSA funds toward this deductible. Once you have met your deductible, your prescription copay begins.

PRESCRIPTION DRUG COVERAGE

When you elect medical coverage, you are automatically covered under the prescription drug plan.

Healthy Choice Members: Your copay for prescriptions begins as soon as you enroll and are approved in the health plan, regardless of whether your medical deductible has been met.

Value Plan Members: When you fill a prescription, until you have met your deductible (deductible includes medical and prescription claims), you will pay 100% of the plan's cost of the medication you are prescribed. This does not apply to medications that are listed on the Preventive Medication List. You may use your HSA fund towards this deductible. Once you have met your deductible, your prescription copay begins.

When you have a prescription filled, the copay is your responsibility. The amount you pay is based on the type of drug prescribed. You can lower this amount by choosing a drug that is included on the formulary: a generic drug or a preferred brand-name drug. You can also lower the amount by getting your prescription filled with our SRHS Retail Pharmacies. This team specializes in traditional retail, mail-order and specialty pharmacy services. Specifics can be found at SpartanburgRegional.com/Pharmacy.

Prescription Formulary

The prescription formulary is a list of prescription drugs that are covered by your prescription drug plan. The prescription formulary includes generic, preferred brand-name, non-preferred brand-name and specialty medications that your plan covers and lists their respective tier. It also includes medications that are excluded on your plan. The tier a medication is placed in can determine how much you will pay for the prescription. Make sure to visit the benefits section of the HR page on the Hub for a copy of the latest formulary.

The differences between generic, preferred brand-name, non-preferred brand-name, excluded and specialty drugs are described below:

- A **generic drug** is one that meets the same standards as brand-name drugs for safety, purity, strength and effectiveness. Generic drugs result in lower copays compared to brand-name drugs. These are usually on tier 1 of the formulary.
- A **preferred brand-name drug** is usually listed in tier 2 of the formulary. These drugs meet the needs of most patients and are more expensive than generic medications but less expensive than non-preferred brand-name medications on the formulary. These drugs are chosen for their clinical and cost effectiveness.
- A **non-preferred brand-name drug** is usually listed on the formulary in tier 3 and will have the highest out-of-pocket expense for any drug covered by the plan. These drugs usually have a cheaper alternative on the formulary. If you are currently using a brand-name drug that is non-preferred or not included on the formulary, the prescribing physician may assist in determining if a generic or preferred brand-name drug is an appropriate alternative.
- An **excluded drug** is a medication that is not covered on the formulary. In most cases there are multiple lower-cost options that are available and covered on the formulary.
- A **specialty drug** is a medication used to treat complex and sometimes rare medical conditions that may require additional patient education or support and routinely has a high monthly cost. You can find details of this on the formulary on the Hub.

Employee Pharmacy

Apella Health offers all its plan members (including covered dependents) the opportunity to receive discounted medications through our employee pharmacies. The amount paid by the associate is reduced over other network pharmacies for members of the health plan. Associates insured through other pharmacy plans may use the employee pharmacies. Our primary location for employee plan pharmacy services is the Pharmacy – Physician Center – Spartanburg. It is located inside the Physician Center on the corner of East Wood Street and South Church Street and offers convenient drive-thru and mail-order services. Pharmacy – Gibbs – Pelham is located on the first floor of the Gibbs Cancer Center. Hours and additional information can be found at SpartanburgRegional.com/Pharmacy. All of the pharmacies fill acute (short-term) medications, initial

Health plan members who choose to fill a brand-name medication when there is a generic available will be required to pay for the brand-name drug in its entirety. This will apply whether you choose to select a brand-name medication when a generic is available, or whether your physician prescribes a brand-name medication rather than the approved generic and marks the prescription "Dispense as written." Also, the amount paid out-of-pocket for the brand-name medication vs. the generic medication will not be credited towards your deductible or your out-of-pocket expenses.

Smartphone App at Spartanburg Regional Pharmacy Locations

Use the **RxLocal** app for:

- Easy Refills
- Order Status Notifications
- Secure Direct Messaging
- Medication Dosing Reminders

Scan the code below to download the app.

doses of maintenance (long-term) medications and assist in transferring orders through our mail-order pharmacy for routine maintenance medications.

Apella Health health plan members on maintenance medications, such as for cholesterol, diabetes, etc. (routine medications taken over a long period of time), are required to use our employee pharmacies' 90-day plan. The use of the mail-order pharmacy is preferred for refills. Associates may fill acute medications (for example, antibiotics) at other network pharmacies for a slightly higher price (e.g., CVS, Walgreens, Publix).

If a 30-day supply is needed, it must be filled at one of the SRHS retail pharmacies, and any refills after that must be for a 90-day supply and filled through one of the SRHS retail pharmacies.

Spartanburg Regional pharmacies accept a variety of payment methods, including payroll deduction (at no additional charge), FSA/HSA cards, all major credit/debit cards and contactless payments such as ApplePay and GooglePay.

You can refill your prescriptions online by visiting SpartanburgRegional.com/Pharmacy.

Retail Pharmacies

We are excited to announce that the pharmacy department has worked hard to enhance the digital services experience for our associates.

Some of the newest services offered:

- Online patient refill portal via RxLocal (visit SpartanburgRegional.com/Pharmacy)
- RxLocal smartphone app (easy refills, secure two-way messaging with pharmacy, education dosing reminders)
- Text notifications (new orders, order ready, order shipped)
- Emailed tracking information for shipped orders
- 24/7 automated telephone refill line
- Automatic refills
- Secure credit card storage
- ApplePay, GooglePay

Mail-Order Pharmacy

Apella Health offers associates a mail-order pharmacy at no charge. Save time by skipping the line at the pharmacy window or drive-thru by choosing mail order.

Prescriptions filled by our services team are all processed locally, so shipping turnaround times are accelerated. When your order ships, you will receive an email notification with tracking information so you can know exactly when to expect your order to arrive on your doorstep!

To take advantage of the mail-order pharmacy, call 864-560-9200.

Apella Health offers associates a mail-order pharmacy at no extra charge to you. Save time by skipping the line at the pharmacy window or drive-thru by choosing mail order. Receive automated emails with tracking information for USPS or FedEx shipped orders. Call 864-560-9200 to find out more.

Specialty Pharmacy Program

All health plan members must fill their specialty medications through Spartanburg Regional's Specialty Pharmacy Program, except in rare cases where the medication is not available for the pharmacy to order. Specialty prescriptions may be picked up or mailed to you at no additional charge. We have specialty pharmacists who are trained in the dispensing of these medications and are dedicated to supporting you through the entire medication process. You can easily access these pharmacy services through the pharmacy call center at 864-560-9200.

PRESCRIPTION COPAYS

Plan	Tier	SRHS Employee Pharmacy Pricing	Other Network Pharmacies Pricing
90 days	Generic	$10	Not Available
	Preferred brand without a generic alternative	$60	
	Preferred brand with a generic alternative	100% actual cost of brand	
	Non-preferred brand without a generic alternative	$90	
	Non-preferred brand with a generic alternative	100% actual cost of non-preferred brand	
	Specialty generic	Not Available	
	Specialty brand without a generic alternative	Not Available	
	Specialty brand with a generic alternative	Not Available	
30 days	Generic	$5	$15
	Preferred brand without a generic alternative	$30	$50
	Preferred brand with a generic alternative	100% of actual cost of preferred brand	
	Non-preferred brand without a generic alternative	$45	$65
	Non-preferred brand with a generic alternative	100% of actual cost of preferred brand	
30 days Specialty	Specialty generic	$50	Not Available
	Specialty brand without a generic alternative	$100	
	Specialty brand with a generic alternative	100% actual cost of specialty brand	

* Pharmacies other than the SRHS retail pharmacies are allowed for acute medications and first fills of 30 days (slightly higher pricing); additional fills must be filled at a SRHS Retail Pharmacy.

Important Info **Attention Value Plan members:** 100% of prescription expenses must be paid out of pocket until your medical deductible is met. Copays begin after you meet your deductible. You may use HSA or FSA funds toward this deductible. See the HR Benefits page of the Hub for a list of low-cost preventive medications not subject to your deductible.

If you or your dependent live outside of South Carolina and North Carolina, you qualify to have your maintenance medications shipped directly to your door using OptumRx® home delivery service at the same price as the SRHS Employee Pharmacy. As long as your address is correct, you will automatically be eligible for this benefit. Associate addresses are maintained in the HR system and can be updated via the HR Self-Service Portal; directions on how to access the portal are on page 55 of this guide. Dependent children's addresses can be updated within the benefits enrollment portal. More information about how to have your prescription transferred to OptumRx home delivery can be found in the benefits section of the Human Resources Hub page.

HSA vs FSA: WHAT'S THE DIFFERENCE?

Health Savings Account	Flex Spending Account
Eligibility	
Insurance coverage under a HDHP (Cannot be enrolled in a FSA)	Any insurance coverage or no coverage (Cannot be enrolled in an HSA)
Rollover	
Funds roll over to next plan year	Funds must be used during plan year otherwise lost (minimal IRS carryover allowed)
Ownership and Portability	
Owned by individual; portable	Owned by employer; not portable
Contribution Limit	
$4,150 for individual; $8,300 for family	$3,050
Withdrawals	
Withdrawals subject to tax and penalty	Cannot withdraw
Adjustments	
Able to adjust contribution amount during the year	Cannot adjust contribution amount once decided

At the end of the year, unused HSA dollars in your account will roll over, and you will be able to use them the following year. If you leave, the funds in the account are yours and may be rolled over to another HSA or used for valid healthcare expenses.

HEALTH SAVINGS ACCOUNT

Eligible participants in the Value Plan have the opportunity to open a Health Savings Account (HSA). If you complete the required 2023 Wellness Plan criteria, Apella Health makes an annual deposit into this account to help you pay for your healthcare needs. You may also choose to have money deducted from your paycheck (pre-tax) and automatically deposited into your HSA. These dollars can be used to pay for qualified medical, dental, vision and prescription expenses, and many over-the-counter medical and personal hygiene supplies. You may choose to use your HSA dollars now or save your HSA dollars for the future. See IRS Publication 969 at IRS.gov for additional information.

Who can and cannot have an HSA?

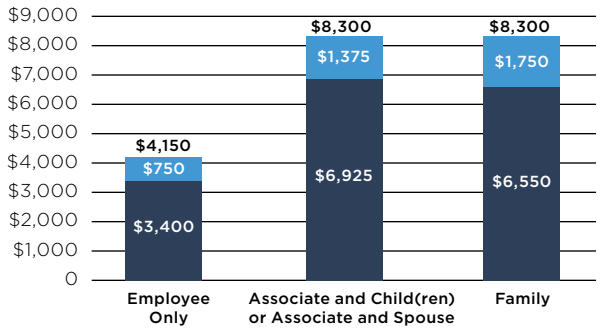
- You must be enrolled in a high-deductible health plan—the Value Plan.
- You cannot be covered by another health plan that is not a high-deductible plan.
- You cannot be enrolled in Medicare or similar plans.
- You cannot be claimed as a dependent on someone else's tax return.
- Participants and spouse cannot have a medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA).

You will receive a debit card you may use with the HSA.

The IRS allows associates aged 55+ to contribute an additional $1,000. The IRS prohibits participation in the HSA and the FSA simultaneously.

Company contributions count toward the annual allowable contribution.

2024 Limits by Tier



FLEXIBLE SPENDING PLAN

This benefit program offers you the opportunity for tax savings through participation in two flexible spending accounts (FSA): Medical Flexible Spending Account and/or Dependent Care Spending Account.

Medical Flexible Spending Account

Eligible participants may deposit up to $3,050 (in 2023) a year with pre-tax payroll deductions into a Flexible Spending Account. These tax-free dollars may be used for reimbursement of eligible expenses to you and your eligible dependents for services during the plan year that are not paid by insurance. **Associates with an active Health Savings Account may not participate in the Medical Flexible Spending Account.**

Flexible Spending Account contributions may be changed during the plan year only if you experience a qualifying event.

Other important information about flexible spending

- You do not have to be a health plan member to open the flexible spending plan.
- Funds not used during the calendar year are subject to forfeiture (except for $610, which may be rolled over to the next calendar year) if this rollover provision is approved by the IRS.
- Request for reimbursement of 2023 expenses must be before March 31, 2024.
- You must enroll in the flexible spending plan each year during open enrollment. Your prior year's election does not roll over.
- You may access your Flexible Spending Account using the online enrollment tool.

Dependent Care Flexible Spending Account

Eligible participants may deposit up to $5,000 (or $2,500 if you and your spouse file separate income tax returns) a year with pre-tax payroll deductions in your Dependent Care Spending Account.

Dependent care expenses must meet the following IRS requirements in order to qualify for reimbursement:

- If married, both you and your spouse must be working. Spouses who do not work must be full-time students or incapable of caring for themselves.
- If a married couple has two incomes, the lower of the two is the maximum allowed to be deposited annually.
- If single, dependent daycare expenses must be necessary for you to work.
- Your children must be under age 13 to use your dependent daycare dollars for reimbursement.
- Your charges to the dependent care account must not exceed the amounts deposited.

Dependent care contributions may be changed during the plan year only if you have a change in family status. You do not have a grace period in which to use remaining previous year balances. All expenses must occur before Dec. 31, 2023, and claims filed no later than March 31, 2024, to avoid forfeiture of your 2023 funds.

The comprehensive plan now offers orthodontia (braces) coverage for you and your dependents!

DENTAL INSURANCE

You have two dental plans available to you, or you can waive dental coverage.

If you enroll in a plan, the Summary Plan Description containing complete details of the plan provisions will be made available to you on the Human Resources page of the Hub.

Dental Plan

Your dental carrier is Delta Dental. You will receive a separate dental card (in addition to your medical card) if you make changes to your dental plan for 2024.

You may obtain services from any licensed dentist you wish. However, certain providers offer discounts that may result in lower out-of-pocket expenses for you.

Dental Network Information

You have two dental networks that provide deeper discounts for you:

- **PPO NETWORK:** Offers the lowest out-of-pocket cost available.
- **DELTA DENTAL PREMIER NETWORK:** May result in slightly higher charges.
- You also have the option of using an out-of-network provider where your expenses will be covered under the dental plan but may be the highest cost to you.

To find a list of Delta Dental providers, go to www.DeltaDentalSC.com.

Dental Coverage

Preventive Services • Oral exams (2 exams per 12-month period) • Cleaning • Sealants • Bitewing X-rays (2 exams per 12-month period)	**Basic Restorative Services** • Fillings • Extractions • Anesthetics • Space maintainers • Root canal therapy • Periodontics	**Major Restorative Services** • Crowns • Bridges • Repairs to existing dentures, crowns and bridges
Benefit Summary	**You Pay**	
Annual deductible	**PREVENTIVE PLAN** $50 individual $150 family	**COMPREHENSIVE PLAN** $50 individual $150 family
Preventive	20%	$0
Basic restorative	20%*	20%*
Major restorative	Not covered	50%*
Plan Limit	**The Plan Pays**	
Annual (non-orthodontia) maximum	$750 per person	$1,500 per person
Lifetime orthodontia maximum	Not covered	$2,000
	This plan might be right for you if you expect to need only routine checkups and basic care throughout the year.	This plan might be right for you if you frequently use all types of dental care or if you need orthodontia coverage (braces) for you or your covered dependents.

* After deductible is met

DELTA DENTAL®

TO SAVE THE MOST MONEY: SEE A DELTA DENTAL PPO℠ NETWORK DENTIST

Dentists can participate with Delta Dental of South Carolina through two networks:
Delta Dental PPO℠ Network or Delta Dental Premier® Network.

Be sure to ask your dentist, **"Which Delta Dental network are you in?"**

Cost Savings Example - Crown Coverage

(Assumes your deductible has been paid and shows applicable coinsurance percent)

SAVE THE MOST WITH A DELTA DENTAL PPO℠ DENTIST	
Dentist charge:	$1,200
Delta Dental allows:	$840
PPO dentist accepts:	$840
Your plan pays 50% of $840:	$420
You pay 50% of $840 (50% x $840):	$420
TOTAL YOU PAY:	**$420**

SAVE MONEY WITH A DELTA DENTAL PREMIER® DENTIST	
Dentist charge:	$1,200
Delta Dental allows:	$1,080
PPO dentist accepts:	$1,080
Your plan pays 50% of $1080:	$540
You pay 50% of $1,080 (50% x $1080):	$540
TOTAL YOU PAY:	**$540**

PAY MORE WITH AN OUT-OF-NETWORK DENTIST	
Dentist charge:	$1,200
Delta Dental allows:	$1,120
Your plan pays 50% of $1,120:	$560
You pay 50% of $1,120	$560
Plus, you pay the difference:	$80
TOTAL YOU PAY:	**$640**

SAVE THE MOST MONEY WHEN YOU SEE A DELTA DENTAL PPO℠ NETWORK DENTIST

- Before you visit your dentist, ask if he or she is in the Delta Dental PPO℠ Network.
- Your coinsurance costs are calculated on a lesser amount.
  - You will pay less out of your pocket at a PPO dentist.
  - Your benefits dollars stretch further.

SAVE MONEY WHEN YOU SEE A DENTAL PREMIER® NETWORK DENTIST

- When you visit a dentist in the Delta Dental Premier® Network, you still enjoy valuable savings.

PAY MORE WITH AN OUT-OF-NETWORK DENTIST

- When your dentist is not in a Delta Dental network, you will pay more.
- You may have to pay your dentist up front, file your own claim and receive payment from Delta Dental.

To find a dentist in the Delta Dental PPO℠ Network or Delta Dental Premier® Network, go to: www.DeltaDentalSC.com.

MORE INFORMATION ABOUT YOUR HEALTH INSURANCE

Changing Your Benefits

You can make changes to your benefits only during an annual enrollment period or if you have a qualifying event during the year. A qualifying event is defined as a change in one of the following:

- **Legal marital status:** Events that change your legal marital status, including marriage, death of spouse, divorce or annulment resulting in a loss or gain of coverage.
- **Number of dependents:** Events that change your number of dependents, including birth, adoption, placement for adoption or death of a dependent.
- **Employment status:** Termination or commencement of employment by you, your spouse or your dependent, resulting in a benefits-eligibility change and a loss or gain of coverage.
- **Work schedule:** A reduction or increase in hours of employment by you, your spouse or your dependent, commencement or return from a family medical leave of absence or a change in worksite, resulting in a benefits-eligibility change.
- **Eligibility of a dependent:** An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to an attainment of age, eligibility for coverage under another group plan or any similar circumstance as noted in the summary plan document.
- **Eligibility for Medicare or Medicaid:** An event resulting in a benefit eligibility change for Medicare or Medicaid for the associate, spouse and/or children.
- **Other:** Any other event determined to be a qualified change in status by the plan administrator.

If you have a qualifying event and want to change coverage, you may enter this change through the online enrollment tool. Benefit changes must be made within 31 days (Medicaid allows up to 60 days) of the qualifying event, must be consistent with the qualifying event and must be supported by written proof of the qualifying event within that same 31-day period. Plan changes without a qualifying event can only be made during each annual enrollment and will be effective on the following Jan. 1.

Associates changing plans (Value Plan to Choice Plan or Choice Plan to Value Plan) during a qualifying event will experience all their deductibles, out-of-pocket maximums and coinsurance accumulators being reset to zero ($0.00). New deductibles, out-of-pocket maximums and coinsurances will be required upon the change in plan type.

Coordination and Non-Duplication of Benefits

Only spouses who have no opportunity for other group medical coverage are eligible for coverage under your plan. Should you choose to cover your spouse on your medical insurance, you will be asked to provide proof that he/she has no other opportunity for group coverage by completing the "Other Insurance Inquiry for Spouse" document available on the Hub or the enrollment tool.

If a person is covered under two or more plans (including Medicare), there are rules about the order in which claims payments are made. If your children are covered by our plan and another plan, our plan will coordinate benefits so that there is no duplication of payments when a claim is received. The total reimbursement from our plan will never be more than the amount that would have been paid if our plan had been the primary plan.

In determining which spouse will cover the children, you should consider the following:

- Any existing court orders in place.
- You should evaluate both plans, including coordination of benefits, network providers, premiums, prescription drug coverage, etc.
- If you and your spouse work at Apella Health or Spartanburg Regional, only one of you may cover your children and you may not have "double coverage" on one another.

IMPORTANT: If you seek medical care inside Spartanburg County, you must use Regional HealthPlus or all charges will be denied.

MEDICAL PLAN NETWORKS AND NETWORK PROVIDERS

Apella Health works to maximize your health benefit dollars by working with certain medical providers (networks). These preferred networks of providers have agreed to negotiated rates that provide savings to our members and help reduce your out-of-pocket expenses. Networks are listed below as well as a website address where you can find physicians and providers who participate in these networks.

The provider directories can also be found on the HR Hub page under medical benefits.

- **Regional HealthPlus (RHP)** – www.RegionalHealthPlus.com

  Regional HealthPlus (RHP) is the preferred provider network (tier 1) for the health plan. RHP is a clinically integrated network of approximately 1,200 physicians and other healthcare providers that includes the employed doctors and facilities with Spartanburg Regional, along with independent physicians and facilities. The network currently includes providers in the Upstate of South Carolina and the neighboring border counties of North Carolina.

- **UnitedHealthcare Choice Plus Network** – www.uhc.com

  Wrap-around network outside Spartanburg County

- **Out-of-network**

  Any physicians/hospitals not in Regional HealthPlus or UHC network

If you are traveling and experience an emergency room visit or an emergent hospitalization in an out-of-network facility, we have procedures in place to process those claims as if they are in the RHP network, and expenses will not exceed the out-of-pocket maximum cap.

YOUR HEALTH. OUR MISSION.

Apella Health is committed to improving your health and the health of your family members. To do that, Apella Health health plans cover in-network ACA preventive visits at 100%. By getting an annual physical each year, your doctors may detect and treat conditions early, avoiding potential catastrophic health issues. Since there is no cost to you for ACA preventive visits, we encourage you to schedule a physical with your doctor. If you do not have a doctor, you may find a listing on the Hub or by visiting the Regional HealthPlus physician network site at www.RegionalHealthPlus.com.

KNOW WHO TO SEE FOR HEALTHCARE SERVICES

When you or someone in your family is sick or injured, it's important to know which doctor and healthcare facility to go to. Use this quick reference so that you make the right decision each time.

Nurse On Call Line

If you're unsure how to handle an illness or injury, contact our Nurse On Call Line at 864-591-7999.

Primary Care Physician (PCP)

Call your family doctor or primary care physician to schedule checkups, preventive care and acute illness (sudden onset of severe symptoms).

Employee Health Acute Care

While at work during normal business hours, if you are experiencing a minor illness, you may contact Employee Health for an acute care visit. The charge for this is $20 for Healthy Choice Plan members and $40 for Value Plan members until the deductible is met. Health plan members must present the current insurance card at the time of the visit or pay the full $40 fee. Associates not on the health plan may also use this facility for $40 per visit. Acute care services for all employed associates are provided by a nurse practitioner, and payroll deduction is allowed to pay for the services. Those insured on the Apella Health health plan will have their claims automatically filed for them. Services include: assessment and treatment of minor illnesses (such as sinus infections, upper respiratory symptoms, urinary tract infections, sore throats, sprains/strains, rapid strep tests, rapid flu tests, college physicals and immunization records).

Immediate Care

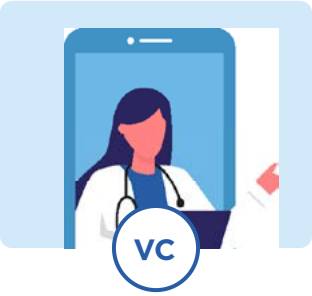
Use an immediate care facility when you need to treat a medical condition sooner than a scheduled office visit. Immediate Care Centers can treat symptoms, such as sore throat, common sprains, diarrhea, fever without rash, vomiting, urinary tract infections, or broken bones of the wrist, hand, arm or foot. Find an Immediate Care Center at SpartanburgRegional.com/ImmediateCare.

Emergency Department

An emergency department should be used for injuries that are life-threatening, including chest pains, shortness of breath, loss of balance, difficulty speaking, weakness or paralysis, head injuries, eye injuries, deep cuts requiring stitches and vision loss.

Find your symptoms, find your care.

Know where to go when you're not feeling well.



VIRTUAL CARE

Virus and flu symptoms and non-emergency care.*

- Coughs, colds or sore throats
- Cold sores
- Constipation
- Ear pain
- Eye infections/ pink eye
- Fevers
- Flu symptoms
- Headaches
- Insect bites
- Mild asthma/allergies
- Minor sports injuries
- Sinus infections or bronchitis
- Skin rashes, poison ivy or infections
- Stomachaches, vomiting or diarrhea
- Urinary tract infections

PRIMARY CARE PROVIDER

Non-emergency medical care, preventive and comprehensive care and routine checkups.

- Lab tests such as liver function, thyroid, hormone levels and cholesterol
- Ongoing medications, like birth control
- Chronic conditions, such as anxiety, depression, diabetes or high cholesterol
- Referrals to other medical specialists

If you do not have a primary care provider, visit our website to find a physician.

IMMEDIATE CARE

Non-life-threatening situations or non-emergency care after hours and weekends.

- Coughs, colds or sore throats
- Ear pain
- Eye infections
- Minor illness or injuries
- Sprains or strains
- Possible broken bones
- Sports injuries
- Sinus infections
- Urinary tract infections
- Vomiting or diarrhea

EMERGENCY DEPARTMENT

Life-threatening situations and serious symptoms. Call 9-1-1, especially for stroke and heart attack.

- Chest pain or pressure
- Convulsions or seizures
- Difficulty breathing or choking
- Difficulty speaking, drooping face or numbness of limbs
- Loss of consciousness
- Poisoning
- Severe head, neck or back injury
- Severe bleeding or burns
- Severely broken bones or loss of limb

Provided by SRHS clinicians, **VIRTUAL CARE** is fast and convenient, with visits for as little as $19. Connect by e-visit, chat or video.

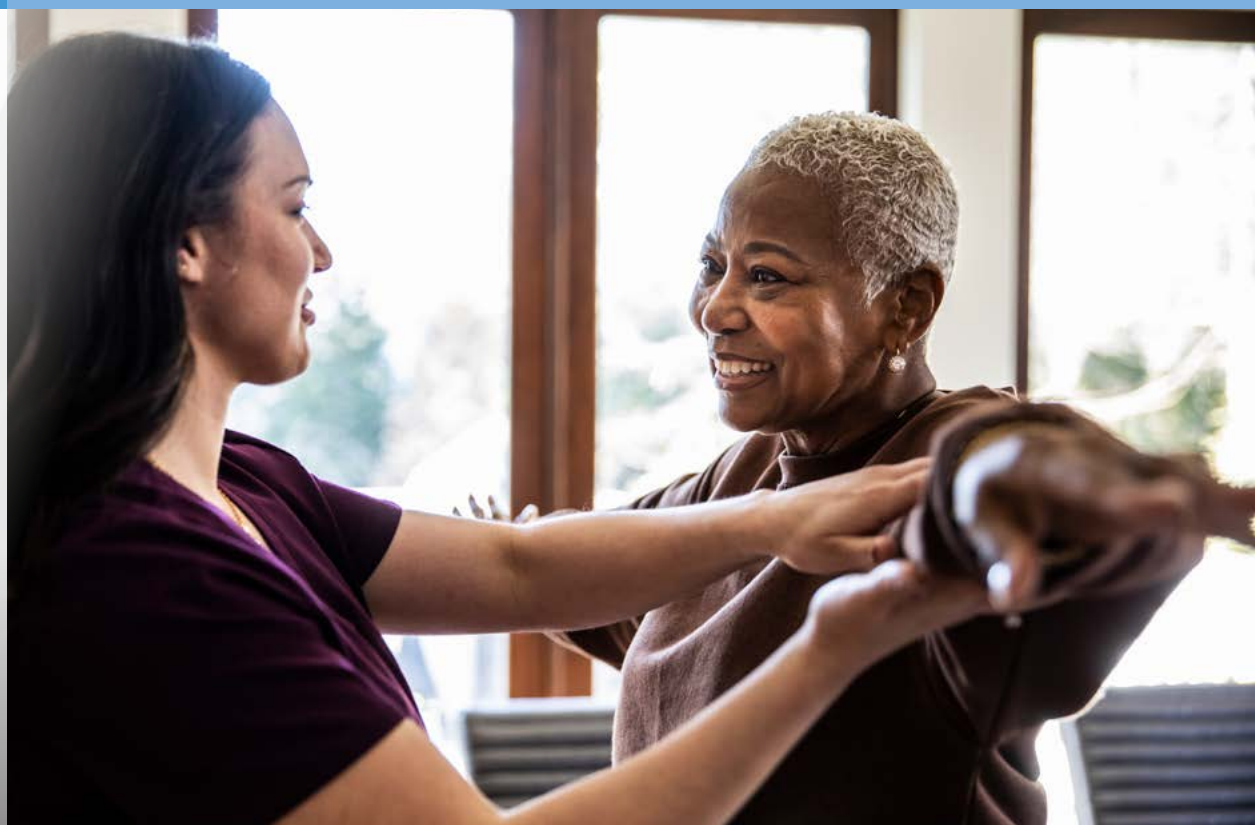
Get started at SpartanburgRegional.com/VirtualCare

**Not able to prescribe controlled substances.*

Spartanburg Regional Healthcare System

SpartanburgRegional.com

Short-term disability is available to full-time associates without submitting evidence of insurability. Illnesses and non-work-related injuries may be excluded as preexisting if you received treatment within three months before your initial enrollment. The preexisting clause ends after you have been enrolled in the plan for 12 months.



LEAVES OF ABSENCE, DISABILITY AND PTO

Family Medical Leave Act

Associates who have been employed for one year and have worked 1,250 hours within the previous 12 months may be eligible for the Family Medical Leave Act (FMLA). The FMLA protects your position while you are out due to your own serious illness or injury or that of an immediate family member, certain military leaves, or a birth or adoption. FMLA does not provide a monetary benefit.

The FMLA policy is on the Hub under "Departments," "Policies and Procedures," (policy number IM1000.508) or online at dol.gov.

Paid Time Off (PTO)

Full-time and regularly scheduled part-time (at least 20 hours per week) benefits-eligible associates may be eligible for PTO.

PTO may be used for time away from work for vacation, holidays, personal time, personal or family illness/emergency or bereavement for a death in the family.

Associates can voluntarily transfer accrued PTO from their PTO account to the Employee Emergency Fund to support coworkers in times of extraordinary hardship. If you wish to transfer accrued PTO to the Employee Emergency Fund, contact the Spartanburg Regional Foundation at 864-560-6467.

You can find the accrual rates and other details by referencing the PTO policy on the Policy Hub page.

Short-Term Disability Coverage

Full-time associates can purchase short-term disability, providing partial salary replacement in cases of non-work-related disabilities. The company shares the cost of this plan. Paid time off (PTO) may also be used as a supplement to short-term disability. Preexisting exclusions do apply. More information is on the Human Resources page of the Hub.

Short-Term Disability Coverage

Associate Status	Effective Date of Coverage	Amount of Coverage	Cost to You
Non-exempt and exempt associates	91st day of active service	60% of your salary up to $2,000/week with a 14-day or a 28-day waiting period	You pay only 50% of the total cost of your disability coverage.

Short-term disability is available to all full-time associates without submitting evidence of insurability. Illnesses and non-work-related injuries may be excluded as preexisting if you received treatment within three months before your initial enrollment. The preexisting clause ends after you have been enrolled in the plan for 12 months.

Long-term Disability Coverage

Full-time associates are automatically enrolled in long-term disability insurance—insurance that offers partial salary replacement in situations of extended disability leave exceeding 180 days. Apella Health pays the cost of coverage.

Any payments made under the plan will be reduced by the amount of any Social Security disability benefits, no-fault automobile insurance benefits, mandated state and federal disability benefits or other income benefits you receive. Preexisting exclusions apply. Please reference the summary plan document on the Human Resources page of the Hub for more information.

Long-Term Disability Coverage

Associate Status	Effective Date of Coverage	Amount of Coverage	Cost to You
Non-exempt and exempt associates	91st day of active service	50% of your salary up to $6,000/month after 180 days of disability	Apella Health pays the full cost of this benefit

Any required evidence of insurability documents will be made available as you enroll in your benefits.

LIFE INSURANCE

Basic Term Life Insurance

Apella Health provides all full-time, benefits-eligible associates one times their salary in basic term life insurance. Your annual salary is defined as your base salary and excludes supplemental earnings, such as overtime.

Dependent Life Insurance

Full-time associates may purchase supplemental dependent and spousal life and spousal accidental death and dismemberment insurance that pays a lump-sum benefit if your covered spouse or a covered dependent child dies.

All life insurance on an associate and/or a spouse is reduced at ages 65, 70 and 75. Supplemental life insurance premiums are reduced accordingly.

New hires or newly benefits-eligible associates may elect spousal supplemental life insurance up to $50,000. Any amounts over $50,000 and up to $100,000 will require completion and approval of an Evidence of Insurability (EOI) document. Elections must be made within 31 days of your eligibility date.

Any other associates choosing to increase their spouse's supplemental life insurance will require completion and approval of evidence of insurability.

New hires and active employees may choose to cover their dependent children in increments of $5,000, $10,000, $15,000 or $20,000 within 31 days of first becoming eligible or during annual enrollment. EOI is not required on eligible dependent children.

Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance

New full-time associates or newly benefits-eligible associates may purchase Supplemental Life Insurance in increments of $10,000 up to $500,000 on themselves, as long as it is elected within 31 days of their eligibility date. The Guaranteed Issue amount of Supplemental Life insurance for all new hires and newly benefits-eligible associates is $250,000. Amounts elected above $250,000 will require evidence of insurability.

Full-time associates also are eligible to purchase AD&D Insurance. AD&D pays the full benefit amount if you die as the result of an accident and will pay a portion of the benefit if a serious accident results in dismemberment, depending on the nature of your injury.

Life and Disability Insurance			
Coverage Type	**Amount**	**Cost**	**Notes**
Basic Life Insurance	Non-Exempt and Exempt Associates: 1x annual salary up to $500,000	$0	Apella Health pays the cost of your basic life insurance.
Supplemental Associate Life	Up to $500,000 in increments of $10,000	Based on age rate per $1,000*	Evidence of Insurability (EOI) will be required for amounts greater than the guaranteed issue amount and increases in your coverage.
Supplemental Associate AD&D	Up to $500,000 in increments of $10,000	Flat fee per $1,000 of coverage*	Spouse AD&D coverage is also available up to $100,000.
Dependent Life	Spouses: $5,000 units of coverage up to $100,000	Based on age rate per $1,000 of coverage*	If you and your spouse both work for Spartanburg Regional and/or Apella, you may not cover one another and only one parent may cover the dependent children.
	Children: $5,000 units of coverage up to $20,000	$5,000 units of coverage*	Evidence of Insurability (EOI) will be required for amounts greater than the guaranteed issue amount and any increases in your coverage. Children age 14 days to 6 months are eligible for $500 life insurance. Coverage for children is available as long as they qualify as dependents under the Life Insurance Plan Document.

* Rates listed within the Benefitsolver enrollment tool.

NEW TRANSAMERICA LIFE INSURANCE — GUARANTEED ISSUE, NO EVIDENCE OF INSURABILITY REQUIRED

In addition to life insurance, this product offers a benefit that helps with the cost-of-living expenses if in need of care, helping with costs not covered by medical insurance such as a caregiver (home or in a facility), out-of-pocket deductibles or other bills. This policy accumulates cash value, has a guaranteed 3% interest rate and the premiums are paid via payroll deduction.

During the 2024 annual enrollment period, associates may purchase up to $150,000 of life insurance with guaranteed issue, meaning no health questions, physical or bloodwork required. Other guaranteed issue amounts are available for spouses and dependent children. New hires or newly benefits-eligible associates may elect up to $150,000 in life insurance with no medical questionnaire within 31 days of first becoming eligible.

To enroll in this benefit for 2024, use the online enrollment tool. If you have questions, contact the life enrollment call center at 1-877-221-0423.

NEW INDIVIDUAL WHOLE AND TERM LIFE INSURANCE

Effective Jan. 1, 2024, the Cincinnati Whole Life Insurance product will be replaced by the new TransAmerica Life Insurance benefit. If you wish to maintain your current Cincinnati Whole Life Insurance, you must contact them at 1-800-783-4479 and set up direct bill. The current Cincinnati Whole Life Insurance benefit will not rollover to the new TransAmerica benefit. You must actively enroll in the TransAmerica Life Insurance benefit for 2024 if you would like that added benefit.

APELLA HEALTH 401(K) RETIREMENT SAVINGS PLAN

As an associate of Apella Health, you have the opportunity to participate in a 401(k) tax-deferred plan with a company match. New associates are automatically enrolled in the employer-sponsored 401(k) plan. You may opt out of the plan.

Details of the 401(k) Savings Plan are:

- You may contribute to the retirement plan via payroll deductions on a pre-tax or an after-tax (Roth) basis.
- You may choose to join the Roth or the tax-deferred 401(k) plan or to spread your contributions across both plans up to the annual IRS limit.
- You can increase or decrease your contribution per the plan rules.
- You may choose from a wide variety of investment options.
- For the 2024 calendar year, Apella's matching contribution will be a 100% match on the first 1% of your salary that you contribute and 50% on all your salary that you contribute from 2% to 6% of your pay each payday up to an annual maximum of $11,550.
- Associate contributions are always 100% vested, and vesting for the company match is two years following your Apella Health hire date.
- For more information, contact Human Resources or visit www.NetBenefits.com.

	Roth 401(k)	**Pre-Tax 401(k)**
Contributions	Designated Roth associate elective contributions are made with **after-tax dollars**.	Traditional, pre-tax associate elective contributions are made with **before-tax dollars**.
Taxation of Withdrawals	Withdrawals of contributions and earnings are not taxed provided it's a qualified distribution from an account held for at least five years and is made: • On account of disability, • On or after death, or • On or after attainment of age 59½.	Withdrawals of contributions and earnings **are** subject to Federal and most State income taxes.
Required Distributions	Distributions must begin no later than age 72, unless still working.	Distributions must begin no later than age 72, unless still working.

ALLONE HEALTH EMPLOYEE ASSISTANCE PROGRAM

AllOne Health offers a wide range of benefits to help improve mental health, reduce stress and make life easier—all easily accessible through a member portal and app. All services are free and confidential. In addition to counseling, AllOne Health provides life coaching, financial and legal consultation, a personal assistant and medical advocacy, just to name a few. Call 866-216-1996 or visit aoh.mylifeexpert.com. The employer code is SRHS059.

Free Depression and Anxiety Screening and Referral

Associates and their family members have the opportunity to receive free virtual depression and anxiety screenings. If needed, you will be provided with the opportunity for a referral to help equip you with information, counseling and education to deal with your anxiety and/or depression. Referrals are handled by AllOne Health, our confidential Employee Assistance Program.

If you want your virtual visit to be credited towards a "preventive" wellness visit for health plan wellness incentive payments, notify the Employee Assistance Program liaison, who will inform UMR that you have completed a wellness visit. As a reminder, health plan members must complete at least one preventive visit between October 2023 and September 2024 as one of the required items to receive wellness incentives funding in January 2025.

You may schedule your free, confidential, virtual depression screening by calling Kaitlin Blanco-Silva at 803-630-5793 or emailing kaitlin.blanco-silva@allonehealth.com.

Free Counseling Services for Associates and Their Family Members

AllOne Health is a **free, confidential employee assistance counseling service** available to associates and their dependents. Associates may receive up to eight counseling services per event at no charge. If there is a need to extend the counseling, AllOne Health maintains a network of providers that are covered under a variety of health plans and specialize in a number of mental and behavioral health concerns.

How do I use EAP?

- Call 1-866-216-1996 and ask for a referral.
- Go to aoh.mylifeexpert.com and request counseling.
- Talk to your supervisor about getting help through EAP.

Voluntary Product Wellness Benefits

The accident critical illness and hospital indemnity plans both pay you when a wellness screening is completed upon providing proof of the approved screening for the associate and/or covered dependent. The application is easy to fill out and includes common screenings, like certain blood tests, Pap smear, skin cancer screening, lipid panels, cardiac exercise stress test, electrocardiogram (ECG), immunizations and interscholastic sports physician exam.

VOLUNTARY BENEFITS

Voluntary benefits are those benefits offered to eligible associates sponsored by companies other than Apella Health. You are offered the opportunity for payroll deduction to pay for these benefits. Apella Health has no responsibility nor decision-making ability in how these plans are administered. All questions and claims must be submitted to the company offering the benefits.

These associate-paid coverages are offered at group rates and offer conversion of coverage to individual policies after termination of employment. Sun Life is the provider for accident insurance, cancer insurance and critical illness insurance. The Medical Bridge plan with Colonial Life will be replaced by a Hospital Indemnity plan offered through Sun Life. The following voluntary benefits are available for 2024.

Accident Insurance

Accidents can happen anytime, anywhere, and they happen more often than you think. At work, at home, at the ballpark or in your car. Sun Life accident insurance can help protect you, your spouse or your children from the unexpected expenses of an accident. If you are enrolled in this coverage in 2023 and wish to continue coverage in 2024, you do not need to do anything. Your coverage will automatically roll over for 2024. If you wish to enroll for the first time, make changes in your coverage or stop coverage, you must do so by using the online enrollment tool (same as medical, dental, etc.).

Cancer Insurance

In the U.S., the lifetime risk of developing cancer is one in three for men and women, according to the American Cancer Society's 2019 data. Sun Life cancer insurance can help you pay for out-of-pocket expenses resulting from cancer treatment. The plan has an annual wellness benefit that offers a payment to covered members upon their completion of preventive screening tests. Sun Life cancer insurance plan also offers a $10,000 lump sum payment upon the first diagnosis of cancer.

If you are enrolled in this coverage in 2023 and wish to continue coverage in 2024, you do not need to do anything. Your coverage will automatically roll over to 2024. If you wish to enroll for the first time, make changes to your current coverage or stop coverage, you must do so using the online enrollment tool (same as medical, dental, etc.).

Critical Illness insurance

A critical illness can be devastating to any family. Sun Life critical illness insurance complements group medical coverage by helping with the direct and indirect costs associated with a specified illness. It pays a preselected lump sum directly to you. If you are enrolled in coverage in 2023 and wish to continue coverage in 2024, you do not need to do anything. Your coverage will automatically roll over to 2024. If you wish to enroll for the first time, make changes to your current coverage or stop this coverage, you must do so using the online enrollment tool (same as medical, dental, etc.).

Hospital Indemnity

The Sun Life hospital indemnity plan will offer enhanced protection for out-of-pocket expenses associated with initial hospitalizations, ER visits and more. This plan also pays a higher initial hospitalization benefit if the associate is admitted to a Spartanburg Regional facility. The plan includes an annual wellness benefit that offers a payment to covered members for receiving preventive screenings, physicals and/or vaccinations. If you wish to maintain your current coverage in 2024, you do not need to do anything. If you wish to make changes in your coverage or stop coverage, you may use the online enrollment tool to do so.

Vision Plan

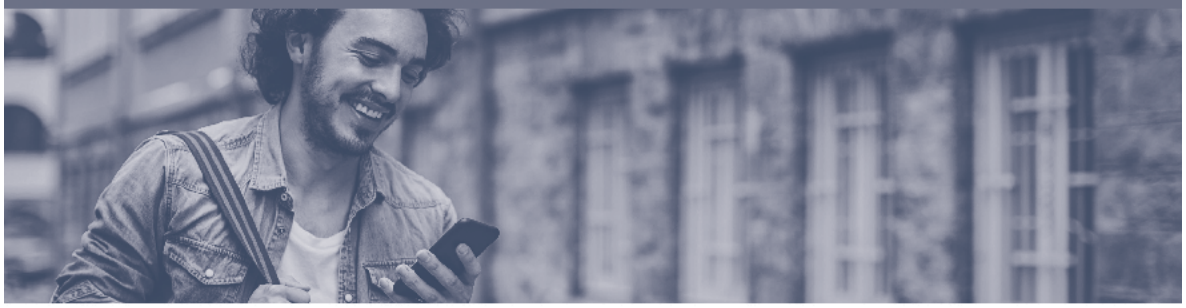
Full-time and part-time associates have the option of choosing a vision insurance plan that features a basic benefit or an enhanced benefit. See the premium differences in the basic Silver Plan and the enhanced Gold Plan on page 53.

CHARGE	SILVER PLAN	GOLD PLAN
Exam	$10 copay	$0 copay
Std. Contact Lenses Fit & Follow Up	Up to $55	
Premium Contact Lenses Fit & Follow Up	10% off retail	
Frames	$130 allowance	$150 allowance
Single Vision Plastic Lenses	$25 copay	$0 copay
Bifocal Plastic Lenses	$25 copay	$0 copay
Trifocal Plastic Lenses	$25 copay	$0 copay
Standard Progressive Lenses	$25 copay	$0 copay
Premium Progressive Lenses	$90 copay, 80% of charge less $120 allowance	$0 copay, 80% of charge less, $120 allowance
Conventional Contact Lenses	$0 copay, $130 allowance, 15% off balance over $130	$0 copay, $150 allowance, 15% off balance over $150
Disposable Contact Lenses	$0 copay, $130 allowance, plus balance over $130	$0 copay, $150 allowance, plus balance over $150

Associates enrolled in the vision plan in 2023 will automatically roll over to the same plan in 2024. If you wish to make changes in your coverage or stop coverage, you must do so by using the online enrollment tool (same as medical, dental, etc.). For any questions, contact EyeMed at 1-866-939-3633.

EYEMED MEMBERS APP

An app that fits your vision



Managing vision benefits with our mobile app for members is easy – just as it should be. When they download the EyeMed Members App from the App Store or Google Play, employees can:

1 GET STARTED	Log in using their fingerprint or facial recognition (for iPhones and iPhone X)	Learn about benefits	Search thousands of in-network eye doctors
2 SEE AN EYE DOCTOR	Schedule an eye exam straight from a phone or tablet	Get turn-by-turn directions to the eye doctor	Shake to view an ID card (and save it to Apple Wallet on iPhones)
3 USE THE TOOLS AND EXTRAS	Create reminders to schedule an exam or reorder contact lenses	Save prescription info	Check out exclusive member deals and discounts

OTHER BENEFITS

Adoption Benefits

Apella Health offers financial reimbursement to associates who are building families through adoption. These benefits are available to full-time and part-time, benefits-eligible associates after they have been employed for one year.

- Eligible adoption-related expenses will be reimbursed up to $10,000 (or $12,000 for a special-needs child) once per lifetime.
- Adopted children must be under 18 and not biologically related to either parent.
- Eligible adoption-related expenses include:
  - Agency and placement fees
  - Legal fees and court costs
  - Medical expenses of the birth mother and child, not covered by insurance
  - Temporary foster care expenses
  - Immigration, immunization and translation fees
  - Transportation and lodging
- Associates may qualify for family medical leave during the adoption process.
- Associates must be actively at work to receive reimbursement.
- Associates should talk to Human Resources for a consultation interview and application prior to beginning the adoption process.

Child Development Program

Your child may be enrolled in the Ida Thompson Child Development Program at Bright Horizons. This program enables associates to have their children cared for by highly qualified and dedicated staff in a clean, safe environment located in close proximity to work. The program is designed for children from 12 weeks through 12 years. Applications may be obtained at the child development office.

Credit Union Services

Apella Health offers two credit unions for associates: Founders Federal Credit Union and VITAL Federal Credit Union. Both credit unions provide 24/7 access to your accounts, internet banking and competitive loan options. Learn more at Founders Federal Credit Union: foundersfcu.com or VITAL Federal Credit Union: vitalfcu.com.

Direct Deposit

You can avoid long bank lines by having your paychecks directly deposited into your personal bank account. You may have your paycheck split between a maximum of three separate bank accounts.

Patient Engagement Center

The Patient Engagement Center is a leading provider of health information and telephonic nursing triage services. Staffed around the clock, the Patient Engagement Center provides associates and the community with telephone access to non-emergency health information, including triage services, general health information and timely physician and service referrals. Call the Patient Engagement Center at 864-591-7999.

Employee Health Services

Associates joining the 2024 Wellness Plan will receive a free annual health assessment, including optional fasting labs. Employee Health offers free immunizations for measles, mumps, rubella, varicella, hepatitis B and Tdap; first aid treatment; minor illness assessments; blood pressure assessments; wellness counseling; return-to-work assessments and work-related injury/illness care.

Acute care services for all employed associates are provided by a nurse practitioner, and payroll deduction is allowed to pay for the services. Those insured on the Apella Health health plan will have their claims automatically filed for them. Services provided include assessment and treatment of minor illnesses such as sinus infections, upper respiratory symptoms, urinary tract infections, sore throats and sprains/strains; rapid strep tests; rapid flu tests and college physicals/immunization records.

NEW

Employment and Salary Verifications: Introducing The Work Number from Equifax

Are you buying a home or a car, leasing an apartment or applying for a loan and need proof of your employment or income? The Work Number makes it easy and is available 24/7! This confidential service is available online at www.theworknumber.com or by phone Monday-Friday 8 a.m. – 8 p.m. at 800-367-5690.

To access TheWorkNumber.com:

1. Start by going to employees.theworknumber.com.
2. Select "Log In" and follow the simple prompts; the Employer Code is 10275642.
   - If this is your first time, pick "Register Now."
   - If a returning user, enter your username and password you set up.
3. The screen prompts will walk you through all the steps to help verify your identity and keep your account private while offering helpful messages if you have problems.

NEW

Pre-check is no longer used for employment and salary verifications. Please see information on this page about The Work Number from Equifax to read about how to complete employment and salary verifications online or by phone.

Parking

The healthcare system provides free parking for associates. Security officers are on duty 24 hours a day at the main campus to escort associates to their cars, if necessary. Associates are not allowed to park in patient or visitor parking areas.

Rewards and Recognition

You will be recognized through the Apella Health associate service recognition gift program for milestone years of service. In addition, there are many other ways to be recognized, including monthly and annual recognition programs. Please visit the Hub for more details about this program.

Tuition Reimbursement Plan

Eligible associates may apply for partial reimbursement of pre-approved tuition expenses for college or university courses (leading toward a degree) taken during off-duty hours. See the Tuition Reimbursement Policy on the Hub for more information.

Wireless Discount Programs

Associates may qualify for a discount on AT&T and Verizon Wireless service, telephones and accessories. The service must be set up in the name and Social Security number of the Apella Health associate to qualify.

Contact AT&T at 864-553-1518 (Mention FAN: 03064194) and Verizon at verizonwireless.com/discount.

DISCOUNT AND ASSOCIATE PURCHASE PROGRAMS

Cafeteria Discounts

Associates with identification badges will receive a discount off the posted visitor pricing at Spartanburg Medical Center (Allspice Cafeteria and Tower Cafe), Pelham Medical Center (Dogwood Cafe), Ellen Sager Cafe, Union Medical Center, Cherokee Medical Center and SMC – Mary Black Campus. This discount applies to non-packaged items.

Community Discounts

By properly identifying yourself as an Apella Health associate, you can receive discounts at numerous community businesses. Visit the Hub for more details.

Entertainment Discount Tickets

You may purchase discount tickets for Biltmore House, Carowinds and Dollywood. Please visit the Human Resources Hub page for more information.

Purchasing Power

This program is an exclusive employee purchase benefit that helps you get everything from brand-name computers and electronics to furniture and appliances and pay over six or 12 months directly from your paycheck. While not a discount program, it does provide you with a reliable way to fit unexpected purchases into your budget. You'll always know the total product cost up front—no credit checks, down payments or hidden fees. The program is available to associates who are full-time or part-time, benefit eligible with six months of completed service, earning at least $16,000 a year. The program is available throughout the year to help you get what you need when paying with cash or credit is challenging. To learn more and create your free online account to unlock your spending power, visit spartanburg.purchasingpower.com or call 1-888-670-3477.

YOUR LEGAL RIGHTS

Affordable Care Act

Apella Health is committed to offering you a highly competitive benefits program that encourages personal accountability and healthy behavior. Below is a summary of changes, year by year, of the Affordable Care Act.

Changes effective Jan. 1, 2011, are listed here:

- If your child lost eligibility for our health plan when he or she turned 19 or was no longer a full-time student and you would like to enroll your child who is under age 26 on our plan, you may do so during our open enrollment period.
- In the past, our plans shared in the cost of your healthcare expenses up to $3 million over the course of your lifetime. Our plan will no longer have lifetime limits on **essential medical benefits.** If you lost eligibility for our health plans when your healthcare costs reached the minimum essential benefits lifetime limit, you can now re-enroll in our plans.
- Any claims on you, your covered spouse or your covered children will no longer be subject to preexisting condition limitations.
- You may no longer use your flexible spending plan to purchase over-the-counter medications.

The maximum annual medical flexible spending dollars you may defer has been reduced to $2,750.

Beginning 2013 forward, all employers are required to publish a uniform formatted document to explain their health plans. This document, the **Summary of Benefits and Coverage and Uniform Glossary,** is available on the Hub and a copy is available upon request.

Beginning 2013 forward, preventive services such as evidence-based services, immunizations, preventive care for children and many women's preventive services must be covered at 100% by health plans.

Beginning 2013 forward, employers are required to report the cost of coverage under an employer-sponsored group health plan on your W-2 form. This will provide useful and comparable consumer information on the cost of healthcare coverage.

Beginning 2014, clinical trials that treat cancer or other life-threatening diseases are covered under the health plan.

Beginning 2014, tax credits are available for people with incomes between 100% and 400% of the poverty line who are not eligible for other coverage (Health Care Exchanges).

Beginning 2014, if your employer does not offer insurance, you will be able to buy it directly in the Health Insurance Marketplace.

Americans who earn less than 133% of the poverty level will be eligible to enroll in Medicaid.

Most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans.

Effective Jan. 1, 2015, a new provision ties physician payments to the quality of care they provide.

Employers with 100 or more full-time equivalent associates face fees beginning Jan. 1, 2015, if they do not offer affordable, minimum value health coverage to at least 70% of their full-time workforce. This number increased to 95% effective Jan. 1, 2016.

Apella Health health plan believes it is not a "grandfathered health plan" under the Patient Protection and Affordable Care Act. Employers with 100 or more full-time equivalent associates will face fees beginning Jan. 1, 2016, if they do not offer affordable, minimum value health coverage to at least 95% of their full-time workforce. Grandfathered health plans may not include certain consumer protections of the Affordable Care Act that apply to non-grandfathered health plans.

You may access the Department of Labor's website at **dol.gov/ebsa/healthreform** to view a table summarizing which protections do and do not apply to grandfathered health plans and what might cause a plan to change from grandfathered health plan status. You may also direct your questions to:

Plan Administrator Health Plan
Apella Health
700 North Pine Street
Spartanburg, SC 29303

IMPORTANT NOTICE FROM APELLA HEALTH ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Apella Health 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. Apella Health has determined that the prescription drug coverage offered by the Apella Health health plan 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 Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 Apella Health coverage will not be affected. You can keep this coverage if electing Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Apella Health 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 an Apella Health health plan 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 19 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 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 for personalized help (see the inside back cover of your copy of the "Medicare & You handbook for the telephone number) or 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 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 new 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 begins in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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.[1]

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 employee 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 Plan Administrator, Health Plan, Apella Health Management, 700 North Pine Street, Spartanburg, SC .

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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Apella Health Management		4. Employer Identification Number (EIN) 81-4193950
5. Employer address 700 North Pine Street		6. Employer phone number 864-560-6000
7. City Spartanburg	8. State SC	9. ZIP code 29302
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) 864-560-6041	12. Email address eedwards2@srhs.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time and part-time equivalent associate

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Natural children, step-children, adopted children and children placed in the home for adoption or foster care up to age 26 and children over the age of 26 who are not capable of self-care

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Women's Health and Cancer Rights

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, covers reconstructive surgery following a mastectomy provided in a manner determined by a physician's consultation. This includes reconstruction of the breast on which the mastectomy was performed, surgical reconstruction of the other breast for symmetrical appearance, prostheses and treatment of the other physical complications at any stage of the mastectomy, including lymphedemas. These reconstructive benefits are subject to the same terms and limitations as other covered medical and surgical benefits and are in accordance with federal regulations.

Pregnancy Accommodation Act

Effective May 17, 2018, the SC Pregnancy Accommodation Act protects individuals from employment discrimination for medical needs arising from pregnancy, childbirth or related medical conditions. The act, which amended the SC Human Affairs Law, also requires that employers provide reasonable accommodations for medical needs arising from pregnancy, childbirth or related medical conditions. Should you have any questions about this, please contact your Human Resources office.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 prohibits the plan from limiting a mother's or a newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery. Newborn babies must be added to the plan and plan-required documentation provided to Benefitsolver within 31 days of the birth. When these steps are complete and approved, the baby's coverage will be effective retroactively to the date of birth.

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 Jan. 31, 2019. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: www.medicaid.georgia.gov
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

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: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739 or 651-431-2670

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Website: http://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 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://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

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: http://gethipptexas.com/
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: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since Jan. 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Associate 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

NOTICE OF GROUP HEALTH PLAN'S EXEMPTION FROM THE MENTAL HEALTH PARITY ACT

This notice must be provided to you under the requirements of the Mental Health Parity Act of 1996 (MHPA) because the group health plan identified below is claiming the 1% increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase 1% or more due to the application of MHPA's requirements.

This notice is to inform you that the group health plan identified below is claiming the exemption from the requirements of MHPA. The exemption is effective as of the date below since benefits under your group health plan may change. It is important that you contact your plan administrator or the plan representative identified below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified below, the plan will provide you or your representative, free of charge, a summary of the information upon which the plan's exemption is based.

Notice of Group Health Plan's Exemption From the Mental Health Parity Act

Group Health Plan Name: Apella Health Health Plan

Plan Administrator: Beth Edwards

Telephone Number: 864-560-6041

Address: 700 North Pine Street

City: Spartanburg

State: SC

Zip Code: 29303

Oct. 1, 2023

NOTICE REGARDING WELLNESS PROGRAM

The Employee Wellness Plan is a voluntary wellness program available to all associates. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, heart disease). You will also be asked to complete a biometric screening, which will include vital signs, waist measurement, height and blood tests.

In 2024, Apella Health health plan participants will be asked to complete at least one preventive screening to be eligible for 2024 health plan incentives. The qualifying preventive screenings include the following: mammogram, Pap smear, colonoscopy, PSA, medical provider preventive physical exam, virtual screening for depression and anxiety, dental screening or vision exam. Please note that unless you advise the Employee Health staff otherwise, your wellness labs will be entered into your medical chart with Epic and your medical provider will be able to view these results. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Associates participating in the wellness program may receive an incentive and free fitness room membership. Associates who are not participants of the Apella Health health plan who are wellness program participants will be eligible for free fitness room membership as well as the ability to participate in wellness programs.

Additional incentives of up to 5,000 points (per year) may be available for associates participating in certain health-related activities (onsite fitness classes, wellness events) or achieving certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Employee Health at 864-560-1485.

The information from your Health Risk Assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and it may also be used to offer you services through the wellness program, such as diabetes, hypertension, chronic disease or maternity management. You also are encouraged to share your results or concerns with your own medical provider.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Apella Health may use aggregate information it collects to design a program based on identified health risks in the workplace, the Employee Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are Employee Health/Wellness and Regional HealthPlus staff in order to provide you with services under the wellness program. Your medical provider may be able to view your annual wellness labs in Epic.

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you promptly and provide information regarding the breach.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Health at 864-560-6192.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

- The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. GINA is effective for plan years beginning after May 21, 2009 (Jan. 1, 2010 for calendar year plans). Regulations implementing the provisions of GINA were made public on Oct. 1, 2009.
- Builds on HIPAA's protections. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents a plan or issuer from imposing a preexisting condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information).
- Additional underwriting protections. GINA provides that group health plans and health insurance issuers cannot base premiums for an employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)
- Prohibits requiring genetic testing. GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear that the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that a participant or beneficiary undergo a genetic test.
- Restricts collection of genetic information. GINA also prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). The regulations provide several examples illustrating GINA's application to HRAs.
- An exception is included for incidental collection, provided the information is not used for underwriting. However, the regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.
- Other protections. GINA also contains individual insurance market provisions, administered by the Department of Health and Human Services' Centers for Medicare & Medicaid Services; privacy and confidentiality provisions, administered by the Department of Health and Human Services's Office for Civil Rights; and employment-related provisions, administered by the Equal Employment Opportunity Commission (EEOC).

If you are a new hire: As a newly hired, benefits-eligible associate, you are offered an initial enrollment period of 31 days from your hire date to elect benefits and to provide the required supporting documentation to Benefitsolver.

The choices you make during this 31-day period will remain in effect for the remainder of 2024 and cannot be changed until the next plan year during Open Enrollment or within 31 calendar days after a qualifying life event.

If you have had a qualifying event: Certain events in your life, such as marriage, divorce, gain or loss of coverage due to a job change, childbirth, death of a covered dependent, etc., allow you to make changes to your benefit plans. If you experience a qualifying life event during the plan year, it is important that you make the changes online within 31 calendar days of the qualifying life event date.

You must also provide supporting documentation of your life event to Benefitsolver within that same 31-day period.

Benefit Eligibility

Type of Benefit	Full-Time Associates	Part-Time Benefits-Eligible Associates	PRN Associates
Core Benefits			
401(k)	✓	✓	✓
Adoption Benefits	✓	✓	
Associate Discount Program	✓	✓	✓
Cafeteria Discounts	✓	✓	✓
Credit Union	✓	✓	✓
Dental Insurance	✓	✓	
Diabetes/Hypertension Management Program for Health Plan Members	✓	✓	
Direct Deposit of Paychecks	✓	✓	✓
Employee Assistance Program	✓	✓	✓
Employee Health Acute Care	✓	✓	✓
Family Medical Leave (eligible to apply)	✓	✓	✓
Flexible Spending Accounts	✓	✓	
Health Savings Accounts (Plan Members)	✓	✓	
Ida Thompson Daycare Program	✓	✓	
Life Insurance	✓		
Long-term Disability	✓		
Medical Insurance	✓	✓	
Paid Time Off (PTO)	✓	✓	
Service Recognition Program	✓	✓	
Short-term Disability	✓		
Spartanburg Regional Pharmacy Privileges	✓	✓	✓
Tobacco/Nicotine Coaching Program	✓	✓	✓
Tuition Reimbursement	✓	✓	
Voluntary Benefits			
Accident Insurance	✓	✓	
Cancer Insurance	✓	✓	
Critical Illness Insurance	✓	✓	
Hospital Indemnity Insurance	✓	✓	
Purchasing Power Program	✓	✓	
Vision Insurance	✓	✓	
Whole and Term Life Insurance	✓	✓	

BENEFITS DASHBOARD

If you are a current employee and you make **no** changes to your benefits, all of them (with the exception of flexible spending) will roll over to 2024.

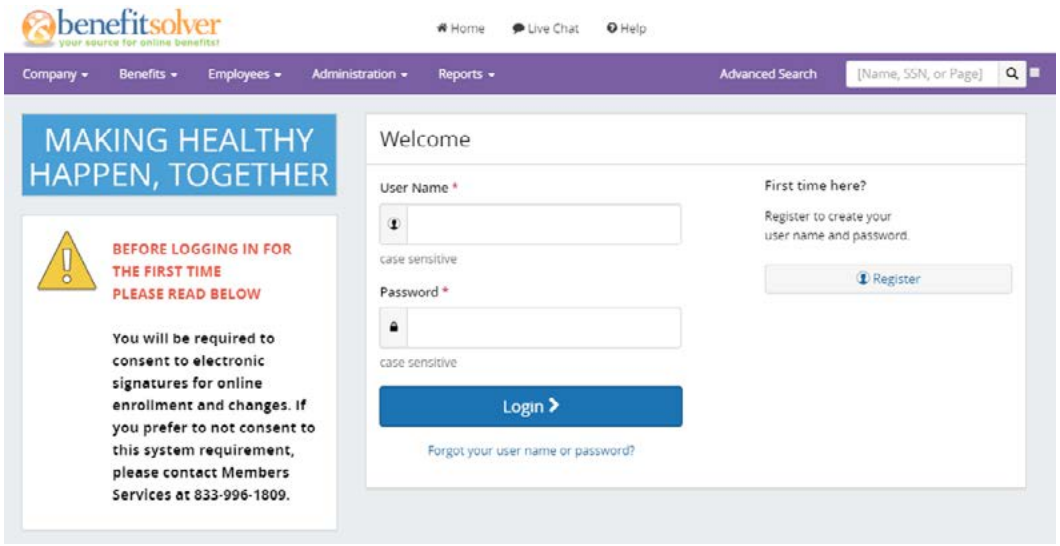
If you are a new hire, you may access the enrollment tool online at ApellaHealthBenefits.com.

Important Note:

- If this is the first time you have used the Benefitsolver enrollment tool, you will be required to register to receive a username and password.
- If you have used the Benefitsolver enrollment tool before and do not recall your username or password, please contact Benefitsolver at the number listed on the sign-in screen or use the password reset function.
- After you enroll, you must accept/save your changes—otherwise your current benefit elections will roll over, with the exception of flexible spending.

Two ways to enroll:

- Visit ApellaHealthBenefits.com.
- From the Hub, click on "Favorites," then click "Human Resources," then "Benefits," then "Online Enrollment for Apella Health associates."



Action Needed

Who is your beneficiary?

Please make sure you add a beneficiary to any life insurance products in which you are enrolled.

2024 ASSOCIATE PLAN PREMIUMS

Apella Health has tiered medical premiums based on your hourly rate of pay. Use the table below to determine what your medical premium will be based on your hourly rate of pay.

If you are unsure of your hourly rate of pay, it is on your pay stub.

Biweekly Medical Premiums (Full-Time Associates)

	Value Health Plan				Healthy Choice Health Plan			
Hourly Rate	Associate Only	Associate + Spouse	Associate + Children	Family	Associate Only	Associate + Spouse	Associate + Children	Family
Under $24.99	$23.24	$86.48	$81.14	$91.56	$36.99	$133.95	$123.25	$166.75
$25.00 – $34.99	$25.10	$93.46	$87.69	$98.96	$39.98	$144.78	$133.21	$180.24
$35.00 – $44.99	$28.32	$105.36	$98.86	$ 111.56	$44.23	$160.09	$147.31	$199.30
$45.00 or more	$30.73	$114.35	$107.29	$121.08	$48.02	$173.75	$159.89	$216.33

Biweekly Medical Premiums (Part-Time Associates)

	Value Health Plan				Healthy Choice Health Plan			
Hourly Rate	Associate Only	Associate + Spouse	Associate + Children	Family	Associate Only	Associate + Spouse	Associate + Children	Family
Under $24.99	$59.54	$132.73	$124.55	$147.09	$102.15	$226.28	$208.24	$302.11
$25.00 – $34.99	$64.34	$143.46	$134.61	$158.96	$110.42	$244.55	$225.06	$326.52
$35.00 – $44.99	$72.53	$161.71	$151.75	$179.21	$122.09	$270.44	$248.89	$361.08
$45.00 or more	$78.73	$175.53	$164.70	$194.52	$132.51	$293.53	$270.14	$391.89

Dental Plan Premiums

Biweekly Dental Premiums (Full-Time Associates)		
Tier	**Preventive Plan**	**Comprehensive Plan**
Associate Only	$1.80	$8.19
Associate + Children	$7.96	$20.14
Associate + Spouse	$5.65	$18.56
Family	$10.70	$29.24

Biweekly Dental Premiums (Part-Time Associates)		
Tier	**Preventive Plan**	**Comprehensive Plan**
Associate Only	$4.26	$10.86
Associate + Children	$11.91	$24.41
Associate + Spouse	$8.44	$21.60
Family	$16.04	$35.08

Vision Plan Premiums

Biweekly Vision Premiums (All Associates)		
Tier	**Silver Plan**	**Gold Plan**
Associate Only	$4.06	$5.64
Associate + Children	$6.26	$8.70
Associate + Spouse	$6.51	$9.06
Family	$8.96	$12.47

DEFAULT COVERAGE

If you do not elect coverage for your core benefits by the deadline (within a specified annual enrollment period or 31 days from your date of employment or 31 days from your transfer to a benefits-eligible status) you will receive default coverage shown below.

Default Coverage		
	Full-Time Associate	**Part-Time Associate**
Medical	No coverage	No coverage
Dental	No coverage	No coverage
Basic Life Insurance	Enrolled	N/A
Supplemental Associate and/or Dependent Life Insurance	No coverage	N/A
Flexible Medical Spending Account	$0	$0
Health Savings Account	No coverage	No coverage
Dependent Care Spending Account	$0	$0
Short-term Disability	No coverage	N/A
Long-term Disability	Enrolled	N/A

WHEN DO I GET PAID?

Below you will find the 2024 pay periods. The cutoff time period for making changes in your direct deposit information, tax withholding, 401(k), 457(b), insurance, etc., is no later than the Wednesday before the end of the pay period date. This change would be reflected on the following payroll deposit date. Holidays may vary.

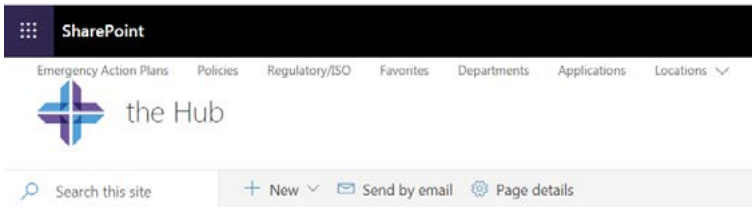
Pay Period	Pay Period Begins	Pay Period Ends	Pay Deposit Date	Quarter
1	12/17/23	12/30/23	1/5/24	1
2	12/31/23	1/13/24	1/19/24	1
3	1/14/24	1/27/24	2/2/24	1
4	1/28/24	2/10/24	2/16/24	1
5	2/11/24	2/24/24	3/1/24	1
6	2/25/24	3/9/24	3/15/24	1
7	3/10/24	3/23/24	3/29/24	1
8	3/24/24	4/6/24	4/12/24	2
9	4/7/24	4/20/24	4/26/24	2
10	4/21/24	5/4/24	5/10/24	2
11	5/5/24	5/18/24	5/24/24	2
12	5/19/24	6/1/24	6/7/24	2
13	6/2/24	6/15/24	6/21/24	2
14	6/16/24	6/29/24	7/5/24	3
15	6/30/24	7/13/24	7/19/24	3
16	7/14/24	7/27/24	8/2/24	3
17	7/28/24	8/10/24	8/16/24	3
18	8/11/24	8/24/24	8/30/24	3
19	8/25/24	9/7/24	9/13/24	3
20	9/8/24	9/21/24	9/27/24	3
21	9/22/24	10/5/24	10/11/24	4
22	10/6/24	10/19/24	10/25/24	4
23	10/20/24	11/2/24	11/8/24	4
24	11/3/24	11/16/24	11/22/24	4
25	11/17/24	11/30/24	12/6/24	4
26	12/1/24	12/14/24	12/20/24	4

HOW TO VIEW MY CHECK STUB, CHANGE MY BANK, NAME, ADDRESS OR W-4

Name changes, address changes and W-4 changes must be made online using the Self-Service Portal. Name changes must be supported with a new Social Security card showing the new name.

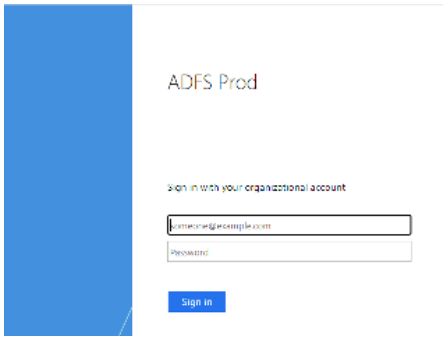
Steps to access the Self-Service Portal

1) Go to the Hub and click on "Applications."

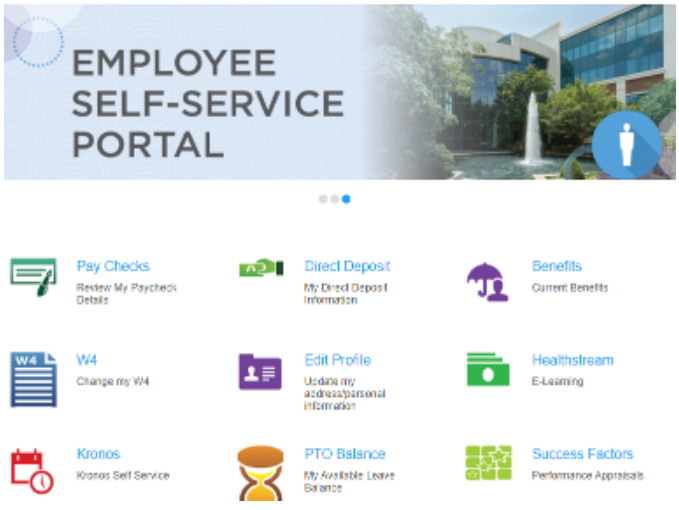


2) Choose "HR Self-Service Portal."

3) Complete your system username and password (log-in credentials).

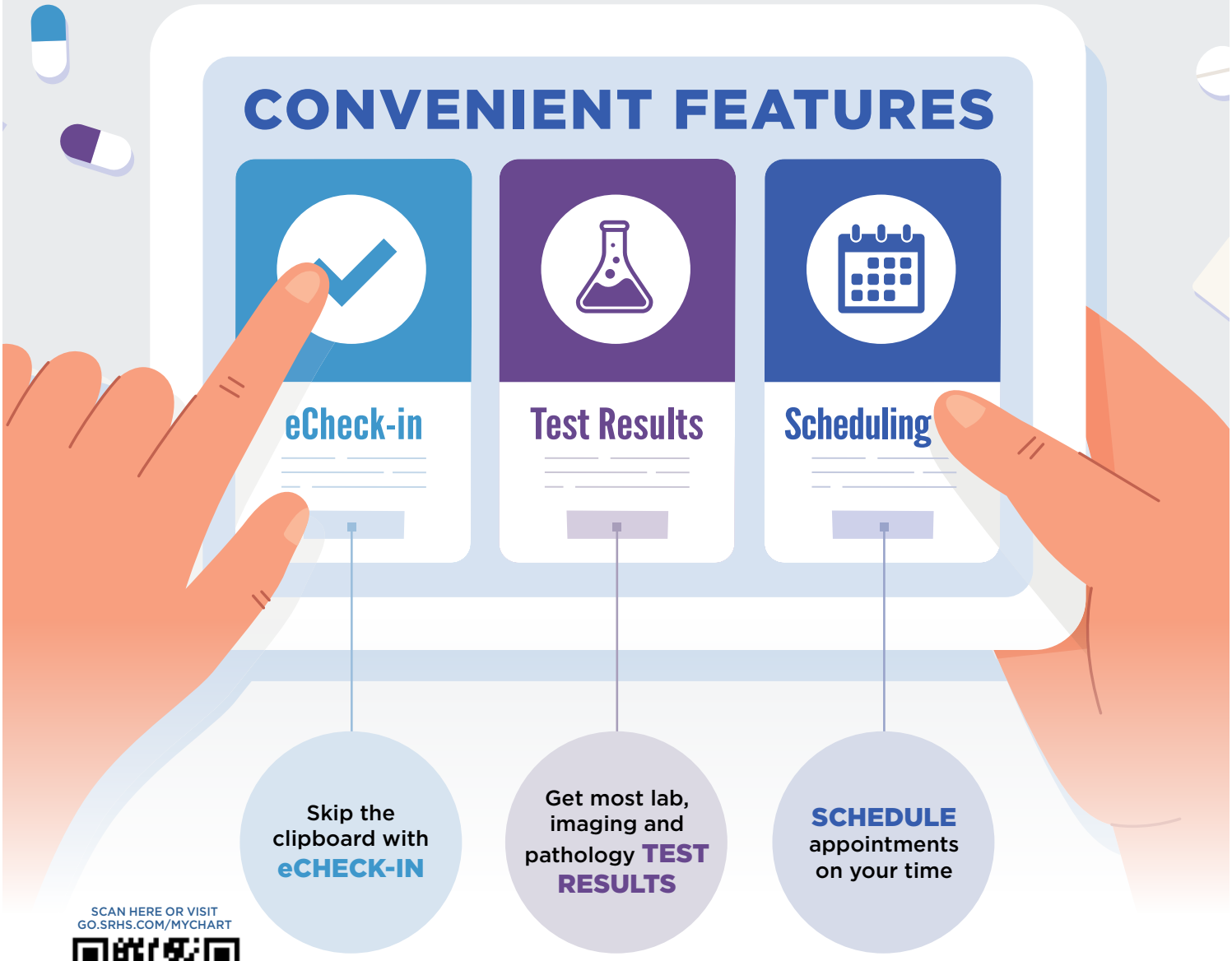


4) Choose the option you need.



SIGN UP TODAY!

mychart



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