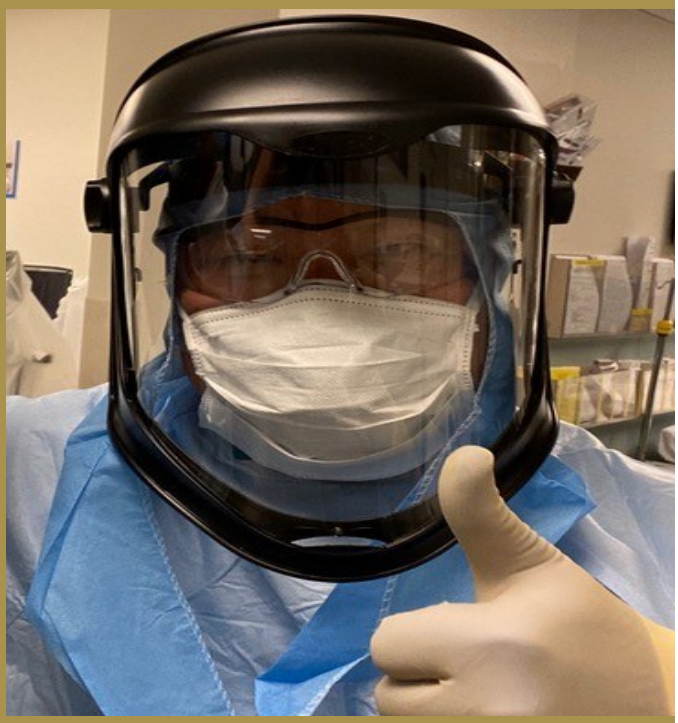
2023 BENEFITS GUIDE

US ANESTHESIA PARTNERS™

Medicare Part D Notice on Page 47



US ANESTHESIA PARTNERS

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See **page 47** for important information concerning Medicare Part D coverage.

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

WELCOME

At US Anesthesia Partners, we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits. This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family.

Go Mobile!

Download benefit vendor apps to get your ID Cards and other benefit information as well as submit claims for FSA expenses.

Have a Smartphone?

This Benefit Guide is equipped with mobile-friendly barcodes. These barcodes are more commonly referred to as "Quick Response" codes, or QR codes. Scanning these codes will take you to a separate site on your phone, allowing you to see new content. They might show you a website, video or article. They can take you anywhere—you just have to scan them first.

So How Do I Scan Them?

First, you'll need one of the many free QR Reader Apps available for smartphones or tablets. After the download, just open your new App and follow the directions to scan the QR code. The App will read it and immediately take you to that code's content.

ELIGIBILITY & ENROLLMENT

Read this section to increase your understanding of the rules that govern this program, including important deadlines, changes allowed during the plan year, and dependent eligibility.

Eligibility

If you are a full-time associate of US Anesthesia Partners who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in the Medical, Dental, Vision, Life and Disability Plans, along with the Flexible Spending Accounts (FSAs) and additional benefits.

When Does Coverage Begin?

The elections you make are effective on the date of hire. Due to IRS regulations, once you have made your choices for the Plan Year, you won't be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

If You Do Not Enroll

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

Associates who have coverage in the current plan year and DO NOT ACTIVELY select benefits during the 2023 Open Enrollment period of November 1 - November 15, will be enrolled in the same benefit plans based on the current election, with the exception of FSAs.

FSAs require re-enrollment annually.

Be sure to update your Tobacco/Nicotine status otherwise your premium will default to include the surcharge.

If You Are A New Hire (Onboarding)

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

Eligible Dependents

Dependents eligible for coverage in the US Anesthesia Partners benefits plans include:

- Your legal spouse/domestic partner (or common-law spouse in states which recognize common-law marriages).
- Children up to age 26 (includes birth children, step-children, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse/domestic partner).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

You may be asked for supporting documentation to provide proof of valid dependent status. You will be notified when action is required.

ELIGIBILITY & ENROLLMENT

Dependent Verification

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

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

You will be notified if the plan requires documentation.

Some examples of supporting documentation are as follows:

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

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

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

Qualifying Life Events

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

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

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

Things to Consider

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

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

ENROLLMENT TIPS

Preparing to Enroll

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

Please note that associate contributions vary depending on the level of coverage you select. In general, the more coverage you have, the higher your associate contributions will be.

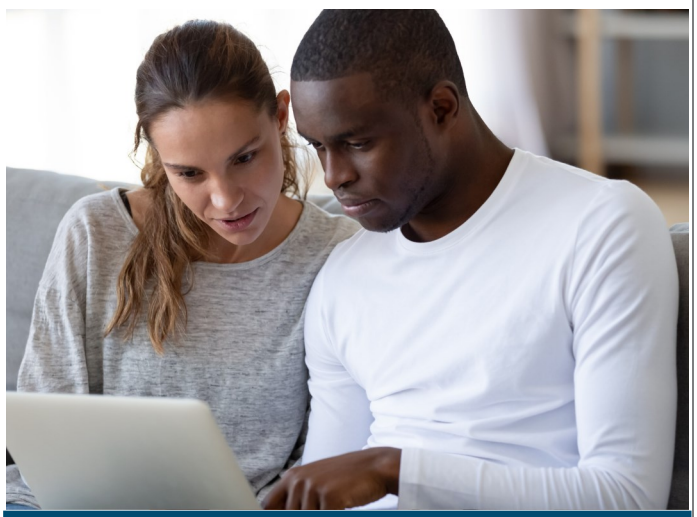
Keep in mind that you may select any combination of Medical, Dental and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself. The only requirement is that you, as an eligible associate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

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

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

TIP

You can bypass entering the SSN during enrollment, but it is a government requirement that we collect the social security numbers.



How to Enroll

1. **Understand Your Choices**

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

2. **Review Your Options with Your Family**

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

3. **Visit Workday**

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

4. **Go to your Workday Inbox**

5. **Save Your Elections**

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

Enrollment: Add or Change Benefits

Navigating to Benefit Enrollment in Workday

1. **Visit Workday**

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

2. **Go to your Workday Inbox:**

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

Complete Benefit Elections

1. Complete your tobacco/nicotine attestation. Select No if you and your spouse/partner, if enrolled, have been tobacco/nicotine free for the past three months. Click Continue.
2. When the page reloads, click Continue again.
3. The next screen will display all of your benefit options, each with their own box. Click on the bottom of your desired benefits to make your elections - it will either say Enroll or Manage.
4. To enroll dependents:

- After you've clicked into the desired benefit and made your plan election, click Confirm and Continue.
- On the Dependents page, click on Add New Dependent. Complete the information and click OK. Enter all mandatory information and click Save. If your dependent is already in the Workday system, they will be listed on the Dependents page and you can select/unselect the box next to their name accordingly. Click Save.

5. Make Health Savings Account Plan Dependencies elections by clicking on Select or Waive for the various offerings. Click Confirm and Continue. If you elect coverage, provide required information in the Contribute section. Click Save.
6. Make Spending Account Plan Dependencies elections by clicking on Select or Waive for the various offerings. Click Confirm and Continue. If you elect coverage, provide required information in the Contribute section. Click Save.
7. Make Insurance Elections by selecting Select or Waive for the various offerings in the Insurance Plan Dependencies and Coverage Limitations section. Click Continue.

- **Note**: You must elect Supplemental Life/AD&D for yourself to be eligible to elect Supplemental Life/AD&D for your Spouse/Partner or Child.

9. Update your Beneficiary Designations (if applicable) within the appropriate benefits. Make your election and click Confirm and Continue. Make your beneficiary entries or changes and click Save.
10. Click Review and Sign to review your Elected Coverages, Waived Coverages and Beneficiary Designations. Scroll down the page to Attach Dependent Documentation (if applicable) and click the I Agree checkbox to confirm your selections. Click Submit to save the transaction.
11. Scroll to the bottom of the screen and click the Print Icon to print a paper copy of your benefits for your personal record or click Done to complete the process.

TIP

You can always visit Workday to view your benefit elections.

MEDICAL BENEFITS

Our Medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as affordable prescription medication. US Anesthesia Partners offers Blue Cross Blue Shield. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will be in place for all of the Plan Year, unless you have a Qualifying Life Event.

Medical Plan Offering

You have a choice of three different medical plans. All three plans cover the same eligible services. The difference is in how you pay for the services.

- Traditional Preferred Provider Organization (PPO) Plan
- Core High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)
- Value High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

Plan Features

- Preventive care is covered at 100% by the plan in-network
- MDLive Virtual Visits are available to plan members for a lower cost than a typical office visit
- 24-Hour Nurseline—When you have questions about your health, it helps to have an expert to turn to. You can get advice from a registered nurse anytime, 24/7. Just call and you can ask a nurse your questions. It's simple, there's no additional cost - and it can give you the peace of mind you need. The Nurseline can help you:
  - Decide when to visit your doctor, or go to an Urgent Care or ER.
  - Find network doctors and schedule appointments.
  - Understand your medications and how to take them safely.
  - Learn about checkups or preventive care.

MEDICAL PLAN SUMMARY

The chart below gives a summary of the Medical coverage provided by Blue Cross Blue Shield of Texas. All covered services are subject to Medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PPO		HDHP CORE		HDHP VALUE	
	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]
CALENDAR YEAR DEDUCTIBLE (YOU PAY)[4]						
INDIVIDUAL[2]	$1,000	$2,000	$1,750	$3,500	$3,000	$6,000
FAMILY[3]	$2,000	$4,000	$3,500	$7,000	$6,000	$12,000
COINSURANCE (You Pay)	20%*	40%*	20%*	40%*	30%*	50%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)[4]						
INDIVIDUAL[2]	$4,000	No Limit	$3,500	No Limit	$6,500	No Limit
FAMILY[3]	$8,000	No Limit	$6,650	No Limit	$13,000[5]	No Limit
LIFETIME MAXIMUM	Unlimited		Unlimited		Unlimited	
COPAYS/COINSURANCE						
PRIMARY CARE SERVICES	$35 copay	40%*	20%*	40%*	30%*	50%*
SPECIALIST SERVICES	$55 copay	40%*	20%*	40%*	30%*	50%*
PREVENTIVE CARE	100% covered	40%*	100% covered	40%*	100% covered	50%*
URGENT CARE	$75 copay	40%*	20%*	40%*	30%*	50%*
EMERGENCY ROOM	$250 copay and 20* coinsurance	$250 copay and 20* coinsurance	20%*	20%*	30%*	30%*
VIRTUAL VISITS	$25 copay	N/A	$44[6]	N/A	$44[6]	N/A

*After Deductible

Note: If you experience an emergency out-of-the-country, the plan will reimburse reasonable and customary rates.

[1] Out-of-network reimbursement is subject to allowable amounts.

[2] Individual deductible applies to an associate only election.

[3] Family deductible applies to any election other than associate only.

[4] In and out-of-network out-of-pocket costs do not cross-apply to the deductible or out-of-pocket maximum.

[5] You have a $6,500 individual in-network out-of-pocket maximum within your total family out-of-pocket maximum.

[6] Full cost. After you meet your deductible, coinsurance applies.

MEDICAL PLAN OPTIONS

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

Medical Premiums

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

Virtual Visits and Finding Providers

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

Preferred Provider Organization Plan (PPO)

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

For most routine and office services, you pay a copay (refer to page 8 for additional information).

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

High Deductible Health Plan (HDHP)

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

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

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

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

Find A Doctor or Hospital

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

How to Search

1. **Navigate to www.bcbstx.com**

   BlueCross BlueShield of Texas is the medical carrier for those living in and out of Texas.

2. **Locate "Find a Doctor or Hospital"**

   You can find it in the blue search bar near the top of the page. Click there.

3. **Click "Search as Guest"**

   Even if you are not yet a member, you can search the BlueCross BlueShield of Texas database.

4. **At this point, you can select "Find an In-Network Provider" or "Search All Providers"**

   - If you select "Find an In-Network Provider", you will then indicate that you get your insurance through your employer. Next, you will indicate whether you are a member or you are shopping for a plan. Select that you are looking for medical care, your state, and finally select the appropriate plan/network—see opposite list.
   - If you select "Search All Providers", you will move on to step 5 immediately.

5. **Enter the location where you would like to search for care**

6. **Use the next page to refine your search**

   - If you selected "Search All Providers", then you can use this webpage to refine the plan/network. Keep in mind that if you do not, these search results may show providers who are not considered in-network and whose services from those providers may not be covered by your plan. Be sure to confirm those details before seeking care.
   - You can use this webpage to refine your search by any of the filters on the left hand side of the webpage.

US Anesthesia Partner Networks

Your medical plan network depends on your group number. Please see the below chart for your group number and network based on the state in which you live.

State	Network
Colorado	BlueChoice PPO
District of Columbia	BlueChoice Advantage Open Access
Florida	Network Blue
Indiana	BlueChoice PPO
Kansas	BlueChoice PPO
Maryland	BlueChoice Advantage Open Access
Nevada	BlueChoice PPO
North Carolina	BlueChoice PPO
Pennsylvania	BlueChoice Advantage Open Access
Texas	BlueChoice PPO
Tennessee	BlueChoice PPO
Washington	BlueChoice PPO
Wisconsin	Blue Preferred POS

HOW THE HDHP WORKS FOR IN-NETWORK CARE

THE DEDUCTIBLE

- For associate-only coverage, you meet the individual in-network deductible.
- If you enroll your spouse/partner and/or child(ren), you and your dependents must meet the full family in-network deductible before the plan shares the cost of non-preventive care.
- You pay all expenses at the network discount other than preventive services until you meet the plan year deductible.
- After the deductible is met, you pay coinsurance until you meet the out-of-pocket maximum.

THE OUT-OF-POCKET MAXIMUM

- The Individual out-of-pocket maximum applies to associate-only coverage.
- If you enroll one or more dependents, the plan begins paying 100% for the remainder of the plan year for any individual:
  - After the family maximum is met, or
  - For the HDHP Value plan, after the individual's out-of-pocket maximum of $6,500 is met; this is only applicable to in-network services.
- Remember, the out-of-pocket maximum includes the deductible and coinsurance.

HEALTH CARE COST TRANSPARENCY

High Deductible Health Plans and tools such as Flexible Spending Accounts have helped put the power of health care spending in consumers' hands. This means you have control over how your health care dollars are spent. But with the cost of services varying widely even within the same network and geographic area, how can you be sure you're getting the most bang for your health care buck? Use the online tools provided by BlueCross BlueShield to compare costs for everything from imaging tests like MRI's to major surgeries.

LEVEL OF CARE OPTIONS

Save time and money by reviewing your level of care options before you need medical attention (primary care, virtual visits, urgent care, etc.).

- For basic problems visit your primary doctor or make a Virtual Visit with a physician.
- Use Urgent Care for after-hours care and minor emergencies.
- Reserve the Emergency Room for life threatening emergencies (car/bike accidents, heart attack symptoms, stroke symptoms, severe bleeding, etc.).
- Watch out for stand-alone ER facilities, they look like Urgent Care facilities, but you are charged like a true Emergency Room.

THINK ABOUT IT...

With the dollars you save in HDHP premiums, you can contribute to your HSA pre-tax, use it to pay for qualified health care costs, and carry an unused balance forward from year to year to use for future health care expenses — even if you leave the company.

TIP

Save Money by Seeing In Network Physicians and Taking Advantage of Preventive Care Services Offered by Your Plan.

PHARMACY BENEFITS

Our pharmacy vendor is CVS Caremark. Considering the pharmacy needs of yourself and/or your family during Benefit Enrollment can help you determine your medical plan for the upcoming plan year. Your pharmacy benefit is part of maintaining your well-being and can help keep costs low throughout the year.

CVS Caremark

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

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

In-Network Pharmacies and Mail Order

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

Specialty Pharmacy

If you have a complex or chronic condition you may utilize a specialty pharmacy. CVS Specialty will offer you support via a dedicated CareTeam that will help you manage your prescription, from getting started, to side effects, to financial assistance and more. You can also choose how you get your medication: you can pick it up at any CVS pharmacy (including those inside Target stores) or have it delivered anywhere that's convenient. You can also go to CVSspecialty.com/enroll to access your information and track orders/refills, manage payments, etc. Please note that the Specialty Pharmacy is only available in-network.

90-Day Supplies and Mail Service Pharmacy

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

CVS caremark®

PHARMACY PLAN SUMMARY

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is offered through CVS Caremark. You may find information on your benefits coverage and search for network pharmacies by logging on to www.caremark.com or by calling the Customer Care number 888-963-7290.

Your cost is determined by the tier assigned to the prescription drug product.The prescription tiers are Generic, Preferred, Non-Preferred, or Specialty.

	PPO		HDHP CORE		HDHP VALUE	
	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]	IN-NETWORK	OUT-OF-NETWORK[1]
RETAIL RX (30-DAY SUPPLY)[2,3,4]						
GENERIC	$15 copay	20%*	20%*	20%*	30%*	30%*
PREFERRED	$40 copay	20%*	20%*	20%*	30%*	30%*
NON-PREFERRED	$80 copay	20%*	20%*	20%*	30%*	30%*
PRUDENTRX	$0 copay or 30% coinsurance[5]	N/A	$0 copay or 30% coinsurance*[5]	N/A	$0 copay or 30% coinsurance*[5]	N/A
MAIL ORDER RX (90-DAY SUPPLY)[2,3,4]						
GENERIC	$38 copay	20%*	20%*	20%*	30%*	30%*
PREFERRED	$100 copay	20%*	20%*	20%*	30%*	30%*
NON-PREFERRED	$200 copay	20%*	20%*	20%*	30%*	30%*
PRUDENTRX	$0 copay or 30% coinsurance[5]	N/A	$0 copay or 30% coinsurance*[5]	N/A	$0 copay or 30% coinsurance*[5]	N/A

*After Deductible

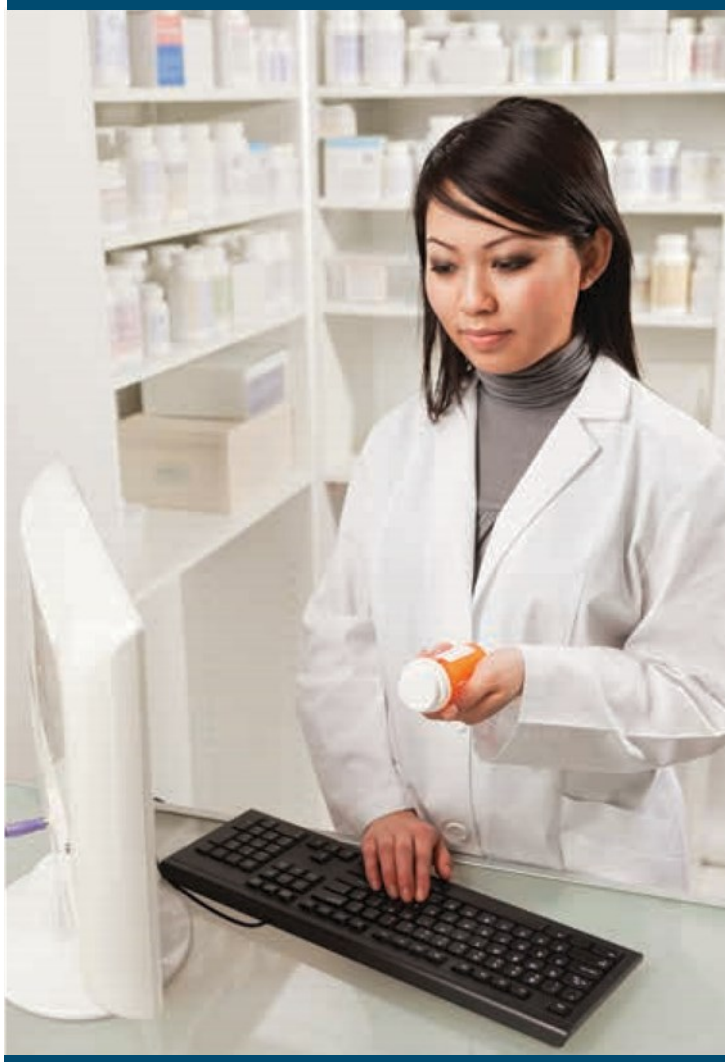
[1] Out-of-network reimbursement is subject to allowable amounts.

[2] Manufacture RX Discount Cards are not applied to the deductible or out-of-pocket maximum.

[3] For the PPO plan, if a member purchases preferred/non-preferred brand name drugs when a generic equivalent exists, he or she will be required to pay the difference between the cost of the generic and preferred/non-preferred brand name drug, plus the preferred brand name copayment amount.

[4] If you purchase a prescription drug product from a non-network pharmacy, you are responsible for any difference between what the non-network pharmacy charges and the amount CVS Caremark would have paid for the same prescription drug product dispensed by a network pharmacy.

[5] For specialty drugs on the PrudentRx formulary. If you sign up for PrudentRx the cost is zero, otherwise it is 30%. If a specialty drug is not on the PrudentRx drug list, the applicable tier will apply. If you are in a HDHP you must first meet the deducible.



Q&A GENERIC DRUGS

What is a generic drug?

When a new, FDA-approved drug goes on the market, it may have patent or exclusivity protection that enables the manufacturer to sell the drug exclusively for a period of time. When those expire or no longer serve as a barrier to approval, other companies can make it in generic form.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA requires generic drugs to have the same high quality, strength, purity and stability as brand-name drugs.

Are generic drugs as safe as brand-name drugs?

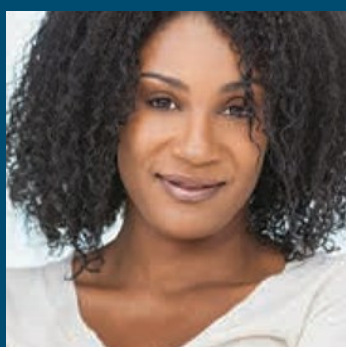
Yes. The FDA must approve the generic drug before it can be marketed.

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.



NEED ADDITIONAL GENERIC DRUG FACTS?

DENTAL BENEFITS

Routine preventive care such as regular Dental checkups can help lower your risk of stroke and heart disease. US Anesthesia Partners' Dental coverage will provide you and your family affordable options for overall health. Coverage is available from Cigna.

You have a choice of two dental plans through Cigna, Standard Dental PPO and Premier Dental PPO. Your dental benefits are designed to help you maintain your dental health.

How the Plans Work

With the Standard PPO and Premier Dental PPO plans, your coverage includes a wide range of eligible services through the Cigna Dental PPO Network, such as:

- Preventive care (cleanings, X-rays and more)
- Basic Care (fillings, basic restorative work and root canals)
- Major services (bridges, crowns, and more)
- Premier Plan only: Orthodontics for child(ren) up to age 19

Note: Orthodontia services are paid over an 18-month period. If your covered dependent obtains orthodontia services, you must remain in the Premier Dental PPO for the full duration of the payout period in order to maximize the lifetime benefit.

Network Dentists

Your Plan's in-network dentists have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a dentist who doesn't participate in your Plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at www.mycigna.com.

BRUSH UP
ON CARING
FOR YOUR TEETH

DENTAL PLAN SUMMARY

Dental Plan benefits are available to you. The chart below gives a summary of the Dental coverage provided by Cigna.

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

*After Deductible
Note: Reimbursements are the same in-network and out-of-network. Out-of-network reimbursements will be subject to reasonable & customary standards with the potential for balance billing.

TIP

Flossing isn't fun, but it can go a long way toward preventing gum disease.

VISION BENEFITS

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, US Anesthesia Partners offers a comprehensive vision benefit provided by VSP.

Vision Premiums

Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your monthly premium. You can find premium information during enrollment in Workday.

Vision Plan Summary

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

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

VISION		
	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	$25 copay	Up to $30
LINED BIFOCAL LENSES	$25 copay	Up to $50
LINED TRIFOCAL LENSES	$25 copay	Up to $65
STANDARD PROGRESSIVE LENSES	$55 copay	Up to $50
PREMIUM PROGRESSIVE LENSES	$95—$105	Up to $50
CUSTOM PROGRESSIVE LENSES	$150—$175	Up to $50
FRAMES		
RETAIL FRAME EQUIVALENT	$130 allowance	Up to $70
CONTACT LENSES		
ELECTIVE OR NECESSARY	$130 allowance	Up to $105
COPAYS		
EXAMINATION	$10 copay	$45
FRAMES	$25 copay	Up to $70
DIABETIC EYECARE PLUS PROGRAM Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations may apply	$20 copay	Contact VSP
BENEFIT FREQUENCY		
EXAMINATION	Every calendar year	
LENSES	Every calendar year	
FRAMES	Every other calendar year	
CONTACTS (in lieu of Lenses and Frames)	Every calendar year	

HEALTH SAVINGS ACCOUNTS

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to a HSA are tax-free, and no matter what, the money in the account is yours. Use it to pay for eligible health care expenses even after you are no longer enrolled in a qualified High Deductible Health Plan (HDHP).

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your Plan.

Once your account is opened, you will be issued a debit card, giving you direct access to your account balance. You must have a balance to use your account. When funded, you then decide when and if you want to use your account dollars for qualified expenses. You can use your debit card to pay. There are no receipts to submit for reimbursement; however, you should keep your receipts with your tax records.

Eligible expenses include doctors' office visits, eye exams, prescription expenses and laser eye surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

CALCULATE

YOUR TAX SAVINGS FROM AN HSA.

Eligibility

You are eligible to open and fund a HSA if:

- You are enrolled in USAP's High Deductible Health Plan.
- You are not covered by your spouse/domestic partner's non-HDHP health plan, and your spouse does not have a Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, Medicaid or TRICARE.
- You have not received Department of Veterans Affairs Medical benefits in the past 90 days for non-service-related care.

HEALTH SAVINGS ACCOUNTS

How to Enroll

Follow the instructions during your self-service enrollment session in Workday.

If you are age 55 or older in 2023, you are eligible for the HSA catch up. You'll notice that there are two HSA options for you to elect in Workday: the regular HSA and the HSA catch-up. You'll need to elect both to participate in both.

Once enrolled, you will receive a welcome package from the HSA vendor. Additionally, the bank may request additional information to validate the Customer Identification Program (CIP) banking requirements for opening a US bank account. Otherwise, your account will open automatically.

You may roll over funds from another HSA once your bank account has been opened.

Maximize Your Tax Savings

Contributions to a HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified heath care expenses, they are spent tax-free.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2023, contributions (which include any employer contributions) are limited to the following:

2023 HSA FUNDING LIMITS	
INDIVIDUAL	$3,850
FAMILY	$7,750
CATCH UP (AGES 55+)	$1,000

See page 40 for over age 65 HSA considerations.

To participate, employees are required to contribute a minimum of $250 annually.

HSA Max Saver Plan

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

Frequency of HSA Contributions

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

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

TIP

PRO TIP: Enroll in the Max Saver Plan!
It is the ideal option for those participants wanting to reach the IRS maximum limit every plan year.

HEALTH SAVINGS ACCOUNTS

Maximize Your Tax Savings

Contributions to a HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified heath care expenses, they are spent tax-free.

MONEY GOES IN	MONEY GOES OUT	HAVE MONEY LEFT? IT ROLLS OVER!
You can contribute pre-tax amounts through payroll deductions. 2023 annual maximum contributions are: ♦ $3,850 for associate only coverage ♦ $7,750 if you enroll your spouse/domestic partner and/or child(ren) ♦ An extra $1,000 if you are age 55 or older	You pay the full cost of non-preventive care, until you meet the deductible. You receive discounted rates in-network. When you have an eligible expense, you decide whether to use your HSA or pay for care with other resources.	Any money left in your account is yours to pay for health care in the future. If you leave the company, you can take it with you.

$$$

TIP

Funds in your HSA will roll over from year to year, allowing you to save money for future medical expenses.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA) allow you to set aside pre-tax dollars to pay for out-of-pocket health care expenses such as deductibles, copays and coinsurance, as well as dependent care expenses.

Health Care Flexible Spending Account (FSA)

You can contribute up to $2,850* for qualified Medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with a FSA debit card at the same time you receive them, allowing you to avoid waiting for reimbursement.

Limited Purpose Flexible Spending Account (LPFSA)

Designed to complement a Health Savings Account, a Limited Purpose Flexible Spending Account (LPFSA) allows for reimbursement of eligible Dental and Vision expenses. You will also be able to use the LPFSA for eligible medical expenses once you reach your medical plan deductible. To utilize this feature, you must submit a claim with documentation showing you have met your medical plan deductible to TaxSaver Plan. The LPFSA debit card can only be used for eligible dental and vision expenses. You may contribute up to $2,850* in the LPFSA.

*To participate, employees are required to contribute a minimum of $25 annually.

Dependent Care Flexible Spending Account (FSA)

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well—whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax dollars up to $5,000* to help pay for expenses associated with dependents under the age of 13 or expenses for the care of a disabled spouse or dependent. The maximum amount will be reduced to $2,500* if your earnings are greater than $135,000 annually. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

FSA GENERAL RULES & RESTRICTIONS

In exchange for the tax advantages that FSAs offer, the IRS has imposed several rules and restrictions for FSAs. Below are the summary of rules and restrictions.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for FSAs:

- Your dollars cannot be transferred from one FSA to another.
- You cannot request reimbursement from an FSA and claim a tax deduction for that expense at the same time.
- All 2023 Dependent Care FSA claims must be incurred by December 31, 2023 and submitted by March 31, 2024.
- The US Anesthesia Partners Health Care FSA Plan allows a 2 1/2 month grace period to incur claims using remaining 2023 dollars after the end of the plan year. The 2023 plan year grace period to incur claims ends March 15, 2024; the 2023 plan year submission period ends March 31, 2024.
- You must "use it or lose it"—any unused funds will be forfeited (with the exception of the grace period).
- You cannot change your FSA election during the Plan Year unless you experience a Qualifying Life Event.
- Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.
- While FSA debit cards allow you to pay for services at the point of sale, they do not remove the IRS regulations for substantiation.

Substantiation

Substantiation references required documentation to support an eligible expense when using a flexible spending account debit card. You should always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide support of an eligible claim may cause the expense to be deemed taxable.

Substantiation of claims has never been easier! The FSA vendor will coordinate with US Anesthesia Partners medical, dental, and vision plans to reduce, or in some cases, eliminate substantiation of receipts for US Anesthesia Partners plans. Be sure to keep your receipts for expenses that may not be substantiated through US Anesthesia Partner reporting and for your personal tax records.

TIP

Get Your Benefits to Go

Download the free TaxSaver secure mobile application to manage your benefits on the go.

- Check account balances
- Review claims previously submitted
- File claims
- View account activity
- Contact customer service

Download the app today on your Apple or Android devices.

HEALTH CARE FSA GUIDELINES

Which Dependents are Eligible

Your federally recognized dependents, whom you claim on your annual tax forms, such as your spouse/partner and dependent child(ren) may participate in this plan.

How to Use the Account

If you enroll in a regular FSA or Limited Purpose FSA, you will receive a FSA debit card. You will use this card until it expires.

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

When using your FSA debit card, you may, from time to time, need to submit documentation to substantiate the claim. The FSA vendor will contact you and request the appropriate documentation, typically a detailed invoice along with an Explanation of Benefits (EOB) from your insurance company.

When you do not use the FSA debit card, you may submit a claim form to the FSA vendor to receive reimbursement.

The FSA vendor is your point of contact for all questions related to your debit card and claim reimbursements. See contact information located on the last page of this guide.

Be sure to always keep your receipts as part of your personal income tax records.

Eligible Health Care FSA Expenses

Visit TaxSaverPlan.com for a list of eligible expenses.

Please note: Due to the CARES ACT, over-the-counter (OTC) drugs are now considered eligible reimbursement items from Health Care FSAs without the need for a physician's prescription. For a list of additional over-the-counter eligible items, please visit:

https://www.taxsaverplan.com/resources/list-of-eligible-items/over-the-counter/

2 1/2-Month Grace Period

FSA participants have an additional 2 1/2-month grace period of time to incur expenses after the Plan Year ends (December 31).

If an expense is incurred between December 31, 2023, and March 15, 2024, and submitted for reimbursement on or before March 31, 2024, any remaining balance, will be eligible for reimbursement, even though the service was provided in the new Plan Year. The 2 1/2-month grace period only applies to the Health Care FSA.

The grace period does not apply to the Dependent Care FSA.

DEPENDENT CARE FSA GUIDELINES

Which Dependents are Eligible

- Your children, grandchildren, brothers or sisters younger than age 13 who reside in your household for more than one half of the year and who do not provide more than one half of their own support for the year.
- A disabled spouse/partner who resides in your household for more than one half of the year.
- Any disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one half of the year.

How to Use the Account

Dependent Care FSA claims may be submitted when you have a receipt and will be processed for reimbursement when you have funds in the account.

Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes. In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

The FSA vendor is your point of contact for all questions related to your debit card and claim reimbursements. See contact information on the last page of this guide.

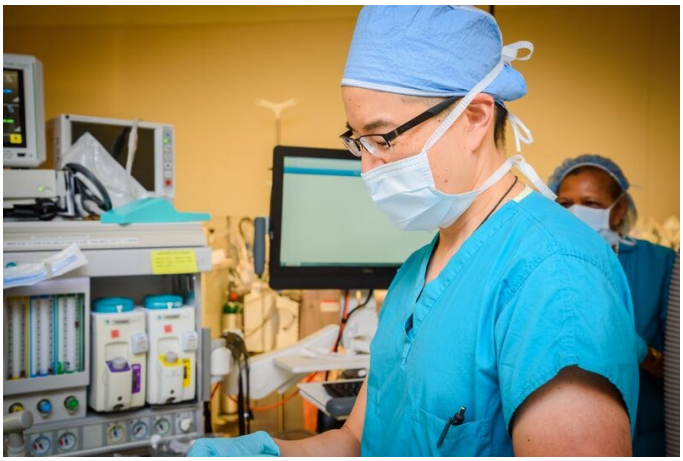
Eligible Dependent Care FSA Expenses

Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13, a disabled spouse, or a disabled dependent.
- The maximum amount will be reduced to $2,500 if your earnings are greater than $135,000 annually.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home. Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care



FSA VS. HSA: WHICH IS RIGHT FOR YOU?

Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you? The chart below explains the main differences between FSAs and HSAs to help you make the right choice for you and your family. See the contact information on the last page of this guide to visit the vendor sites to find eligible expenses, FSA and HSA calculators, and FAQs.

	FSA	HSA
OWNERSHIP	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
ELIGIBILITY & ENROLLMENT	The employer determines eligibility for a FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction.	The money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	The USAP contribution limit for 2023 is $2,850.	The contribution limit for 2023 is $3,850 for individuals and $7,750 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Includes a FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement and/or substantiation of debit card use.	HSAs include a debit card. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses or pay yourself back feature.
ROLL OVER OR GRACE PERIOD	The US Anesthesia Partners Health Care FSA Plan allows a 2 1/2 month grace period to incur claims using remaining 2023 dollars after the end of the plan year: ♦ The 2023 plan year grace period to incur ends March 15, 2024 ♦ The 2023 plan year submission period ends March 31, 2024.	You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement. ♦ The money in the account rolls over from year to year. ♦ Funds are always yours and may be used for future qualified expenses.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, dental care, and vision care. If you have a HSA, it is limited to dental, vision, and medical expenses after you have met your deductible. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: **Dependent Care FSA** – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. **Limited Purpose FSA** – Covers eligible dental, vision, and medical expenses after you have met your deductible. Limited Purpose FSAs are offered in conjunction with a HSA.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

SURVIVOR BENEFITS

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you have Life insurance now, chances are, you can take comfort in knowing that you can provide to those who depend on you.

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

Life and AD&D benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

Basic Life and AD&D benefits are provided to you as a part of your basic coverage. US Anesthesia Partners provides associates with Basic Life and AD&D insurance through Prudential, which guarantees that loved ones, such as a spouse/domestic partner or other designated survivor(s), continue to receive part of an associate's benefits after death.

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

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

Beneficiary Designation

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by US Anesthesia Partners. Benefits payable for a dependent's death under the Prudential insurance are payable to you.

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

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

LIFE AND AD&D INSURANCE

Eligible associates may purchase additional Life and AD&D insurance for themselves and their families. Premiums are paid through post-tax payroll deductions.

BASIC LIFE/AD&D	
COVERAGE AMOUNT[1]	One time your salary or $50,000 (full-time physicians)
WHO PAYS	US Anesthesia Partners
BENEFITS PAYABLE	Upon death or dismemberment
MAXIMUM PAYABLE	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
SUPPLEMENTAL ASSOCIATE LIFE/AD&D	
COVERAGE AMOUNT[1]	Increments of $10,000
WHO PAYS	Associate
BENEFITS PAYABLE	Upon death
MAXIMUM PAYABLE	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes, over $300,000 If you do not enroll when first eligible, then EOI[2] will be required for any amount.
SUPPLEMENTAL DEPENDENT LIFE/AD&D	
COVERAGE AMOUNT[1]	Spouse/Partner—Increments of $5,000 Child(ren)—$5,000 or $10,000 options
WHO PAYS	Associate
BENEFITS PAYABLE	Upon Death
MAXIMUM PAYABLE	Spouse/Partner—$500,000 The benefit cannot be more than 100% of the Associate Supplemental Life Coverage Child(ren)—$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Spouse/Partner—Amount over $50,000 If you do not enroll when first eligible, then EOI[2] will be required for any amount. Child(ren)—No EOI required.

[1] The Life Insurance Benefit will reduce to 65% of the Life Insurance Benefit at age 65 and reduce to 50% of the Life Insurance Benefit at age 70.

[2] If EOI is required, you will be notified. If coverage is approved, USAP will be notified and we will add your coverage effective as of the date of approval or 01/01/2023, whichever is later.

LIFE AND AD&D INSURANCE RATES

How to calculate your monthly premium:

(Coverage Amount / $1,000) * Age Band Rate = Monthly Premium

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

Associate

Age Band	Associate Life Rate Per $1,000	Cost with $100,000 Coverage	Cost With $75,000 Coverage	Cost With $25,000 Coverage
>20	0.0710	$7.10	$5.33	$1.78
20-24	0.0710	$7.10	$5.33	$1.78
25-29	0.0800	$8.00	$6.00	$2.00
30-34	0.1000	$10.00	$7.50	$2.50
35-39	0.1230	$12.30	$9.23	$3.08
40-44	0.1670	$16.70	$12.53	$4.18
45-49	0.2550	$25.50	$19.13	$6.38
50-54	0.3940	$39.40	$29.55	$9.85
55-59	0.5950	$59.50	$44.63	$14.88
60-64	0.9170	$91.70	$68.78	$22.93
65-69	1.5780	$157.80	$118.35	$39.45
70-74	2.7990	$279.90	$209.93	$69.98
75+	5.4660	$546.60	$409.95	$136.65

Spouse/Partner

Age Band	Spouse/ Partner Life Rate Per $1,000	Cost with $100,000 Coverage	Cost With $75,000 Coverage	Cost With $25,000 Coverage
>20	0.0570	$5.70	$4.28	$1.43
20-24	0.0700	$7.00	$5.25	$1.75
25-29	0.0800	$8.00	$6.00	$2.00
30-34	0.1000	$10.00	$7.50	$2.50
35-39	0.1100	$11.00	$8.25	$2.75
40-44	0.1320	$13.20	$9.90	$3.30
45-49	0.1950	$19.50	$14.63	$4.88
50-54	0.2930	$29.30	$21.98	$7.33
55-59	0.4500	$45.00	$33.75	$11.25
60-64	0.7340	$73.40	$55.05	$18.35
65-69	1.2900	$129.00	$96.75	$32.25
70-74	2.1940	$219.40	$164.55	$54.85
75+	4.3730	$437.30	$327.98	$109.33

Child(ren)

Child(ren) Life Coverage Amount	Cost Per Month
$5,000	$2.13
$10,000	$4.25
Child(ren) Life Coverage through age 25	

INCOME PROTECTION

US Anesthesia Partners offers disability coverage to protect you against an unfortunate or debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short Term Disability (STD) Insurance

Short Term Disability (STD) insurance protects a portion of your income if you become partially or totally disabled for a short period of time. If enrolled and approved for medical disability leave, STD benefits replace 60% of your weekly income, up to maximum of $2,500 per week after a 7-day elimination period.

With STD, the benefit won't necessarily replace a true 60% of your weekly income, depending on what your yearly earnings are. For example, if 60% of your weekly earnings is more than $1,250, then you will be capped at the $1,250 coverage amount in the STD 1250 Plan. If 60% of your weekly earnings is more than $2,500, then you will be capped at the $2,500 coverage amount in the STD 2500 Plan. See chart for examples.

STD payments will last as long as you are medically disabled up to 90 days. Monthly premiums are determined by age and coverage amount. Certain provisions and exclusions may apply. See the summary plan description for more information.

Completing an Evidence of Insurability form (EOI) may be required to finalize your enrollment in disability or supplemental life benefits. If EOI is required, you will be notified.

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

Yearly Earnings	Coverage amount with STD 1250 Plan	Coverage amount with STD 2500 Plan	Coverage amount with Employer Paid 1250 Plan and 1250 Buy-Up
$50,000	$577	N/A	$577, no buy-up
$100,000	$1,154	N/A	$1,154, no buy-up
$200,000	$1,250	$2,308	$1,250 and a buy-up of $1,058
$300,000	$1,250	$2,500	$1,250 and a buy-up of $1,250
$400,000	$1,250	$2,500	buy-up of $1,250

INCOME PROTECTION

Long Term Disability (LTD) Insurance

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

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

If medically disabled, LTD benefits replace 60% of your income, up to a maximum of $10,000 or $15,000 (see LTD chart) per month after a 90-day elimination period. You are considered disabled when Prudential determines that, due to your *sickness* or *injury*:

- You are unable to perform the *material and substantial duties of your regular occupation*, or you have 20% or more loss in your *monthly earnings*; and
- You are under the *regular care* of a *doctor.* The loss of a professional or occupational license or certification does not, in itself, constitute disability.

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

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

Disability Premium Calculation

STD

(60% of weekly earnings± / $10) * rate = monthly premium

±Up to Maximum Coverage Amount

Age	Rate Per $10	$1,250 Coverage Monthly Rate	$2,500 Coverage Monthly Rate
Through Age 59	$0.853	$106.63	$213.25
Age 60+	$1.145	$143.13	$286.25

LTD

LTD Rates are available in Workday.

(60% of monthly earnings± / $100) * rate = monthly premium

±Up to Maximum Coverage Amount

Job Group	LTD Monthly Coverage Maximum	Definition of Disability
Physicians	$15,000	Specialty Occupation for Anesthesia Physicians
Clinical	$10,000	Regular Occupation
MSO/RCM/ Corporate Directors & Executives	$10,000	Regular Occupation
MSO/RCM/ Corporate	$10,000	Regular Occupation for 36 months, then any Occupation

401(k) PLAN

US Anesthesia Partners, Inc. 401(k) Plan can be an easy way to save for your future.

Automatic Enrollment

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

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

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

If you do not want to be enrolled, want to change your deferral percentage, or investments, you must contact Vanguard Participant Services at 800-523-1188.

Employer Match

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

Discretionary Profit Sharing

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

Vesting

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

Plan Fee

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

Loans

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

Connect with Vanguard

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

ACCIDENT INSURANCE

Accident insurance coverage provides you with payment for a covered accident. It also pays if you undergo testing, receive medical services, treatment or care for any one of more than 150 covered events as defined in your group certificate. This includes hospitalization resulting from an accident and accidental death or dismemberment. Payments are made directly to you to use as you see fit. They can be used to help pay for medical plan deductibles and copays, out-of-network treatments, your family's everyday living expenses, or whatever else you need while recuperating from an accident.

COVERED CONDITIONS	LOW PLAN METLIFE ACCIDENT INSURANCE PAYS YOU	HIGH PLAN METLIFE ACCIDENT INSURANCE PAYS YOU
INJURIES		
FRACTURES	$50 - $3,000	$100 - $6,000
DISLOCATIONS	$50 - $3,000	$100 - $6,000
SECOND AND THIRD DEGREE BURNS	$50 - $5,000	$100 - $10,000
CONCUSSIONS	$200	$400
CUTS/LACERATIONS	$25 - $200	$50 - $400
EYE INJURIES	$200	$300
MEDICAL SERVICES AND TREATMENT		
AMBULANCE	$200 - $750	$300 - $1,000
EMERGENCY CARE	$25 - $50	$50 - $100
NON-EMERGENCY CARE	$25	$50
PHYSICIAN FOLLOW-UP	$50	$75
THERAPY SERVICES	$15	$25
MEDICAL TESTING BENEFIT	$100	$200
MEDICAL APPLIANCES	$50 - $500	$100 - $1,000
INPATIENT SURGERY	$100 - $1,000	$200 - $2,000
HOSPITAL COVERAGE (ACCIDENT)		
ADMISSION	$500 - $1,000 per accident	$1,000 - $2,000 per accident
CONFINEMENT Non-ICU confinement paid for up to 365 days ICU confinement paid for 30 days	$100 (non-ICU) - $200 (ICU) a day	$200 (non-ICU) - $400 (ICU) a day
INPATIENT REHAB Paid per accident	$100 a day, up to 15 days	$200 a day, up to 15 days
HOSPITAL COVERAGE (SICKNESS)		
ADMISSION Payable 1 x per calendar year	$150 (non-ICU) - $300 (ICU)	$150 (non-ICU) - $300 (ICU)
CONFINEMENT Paid per sickness	$100 (non-ICU) - $200 (ICU) Payable up to 30 days per sickness	$100 (non-ICU) - $200 (ICU) Payable up to 30 days per sickness
ACCIDENTAL DEATH		
Associate receives 100% of amount shown, Spouse/Domestic Partner receives 50% of amount shown, & Child(ren) receive 20% of amount shown	$25,000 $75,000 for common carrier	$50,000 $150,000 for common carrier
DISMEMBERMENT, LOSS AND PARALYSIS		
DISMEMBERMENT, LOSS AND PARALYSIS	$250 - $10,000 per injury	$500 - $50,000 per injury
OTHER BENEFITS		
LODGING Pays for lodging for companion up to 30 nights per calendar year	$100 per night, up to 30 nights; up to $3,000 in total lodging benefits available per calendar year	$200 per night, up to 30 nights; up to $6,000 in total lodging benefits available per calendar year

TIP

Have questions about the Accident Plans?
Call MetLife for assistance.
See last page of this guide for contact information.

CRITICAL ILLNESS

This is coverage that can help cover the extra expenses associated with a serious illness. When a serious illness happens to you or a loved one, this coverage provides you with a lump-sum payment of your choice of either $15,000 (Low Plan) or $30,000 (High Plan) in initial benefits upon diagnosis. The total benefit amount available to you is three times the initial benefit amount you select, either $45,000 or $90,000, in the event that you suffer more than one covered condition. Payment(s) you receive will be made in addition to any other insurance you may have and may be spent as you see fit.

COVERED CONDITIONS*	INITIAL BENEFIT	RECURRENCE BENEFIT
FULL BENEFIT CANCER	100% of Initial Benefit	100% of Initial Benefit
PARTIAL BENEFIT CANCER	25% of Initial Benefit	25% of Initial Benefit
HEART ATTACK	100% of Initial Benefit	100% of Initial Benefit
STROKE	100% of Initial Benefit	100% of Initial Benefit
CORONARY ARTERY BYPASS GRAFT	100% of Initial Benefit	100% of Initial Benefit
KIDNEY FAILURE	100% of Initial Benefit	Not Applicable
ALZHEIMER'S DISEASE	100% of Initial Benefit	Not Applicable
MAJOR ORGAN TRANSPLANT BENEFIT	100% of Initial Benefit	Not Applicable
22 LISTED CONDITIONS	25% of Initial Benefit	Not Applicable
Addison's disease Lou Gehrig's disease Cerebrospinal meningitis (bacterial) Cerebral palsy Cystic fibrosis Diphtheria Encephalitis Huntington's disease Legionnaire's disease Malaria Multiple sclerosis (definitive diagnosis) Muscular dystrophy Myasthenia gravis Necrotizing fasciitis Osteomyelitis Poliomyelitis Rabies Sickle cell anemia Systemic lupus erythematosus (SLE) Systemic sclerosis (scleroderma) Tetanus Tuberculosis		
HEALTH SCREENING (WELLNESS) BENEFIT Provided if the covered insured takes one of the covered screening/prevention tests; payable 1x per calendar	$50 Low Plan $100 High Plan	Paid per covered person per year

*Pre-existing conditions and exclusions apply.

TIP The Health Screening Benefit helps you pay for a portion of the premium. You are giving yourself a discount by completing a standard health screening!

TIP Have questions about the Critical Illness Plans? Call MetLife for assistance. See last page of this guide for contact information.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance coverage provides you with payments when you are admitted and when you are confined to a hospital due to an accident or illness, and the policy and certificate requirements are met. Typically, a flat amount is paid for admission, and a daily amount is paid for each day of a hospital stay. It also pays extra benefits for admission to or confinement in an Intensive Care Unit (ICU), and for other benefits and services. Payments are made directly to you to use as you see fit. They can be used to help pay for medical plan deductibles and copays, for out-of-network stays, for your family's everyday living expenses, or for whatever else you need while recuperating from an illness or accident.

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

BENEFIT TYPE		LOW PLAN METLIFE ACCIDENT INSURANCE PAYS YOU	HIGH PLAN METLIFE ACCIDENT INSURANCE PAYS YOU
HOSPITAL COVERAGE (ACCIDENT)			
ADMISSION Must occur within 180 days after the accident	**Non-ICU**	$500 per accident	$1,000 per accident
	ICU	$1,000 per accident	$2,000 per accident
CONFINEMENT Must occur within 180 days after the accident	**Non-ICU**	$100 a day, up to 365 days	$200 a day, up to 365 days
	ICU	$200 a day up to 30 days	$400 a day up to 30 days
INPATIENT REHAB Stay must occur immediately following hospital confinement and occur within 365 days of accident		$100 a day, up to 15 days per accident and 30 days per calendar year	$200 a day, up to 15 days per accident and 30 days per calendar year
HOSPITAL COVERAGE (SICKNESS)			
ADMISSION Payable 1x per calendar year	**Non-ICU**	$500	$1,000
	ICU	$1,000	$2,000
CONFINEMENT Paid per sickness	**Non-ICU**	$100 a day, up to 365 days	$200 a day, up to 365 days
	ICU	$200 a day up to 30 days	$400 a day up to 30 days
OTHER BENEFITS			
LODGING Benefit provided for a companion accompanying a covered insured while hospitalized		$100 a day Up to 30 days per calendar year; lodging facility must be located within 50 miles from covered person's primary residence	$200 a day Up to 30 days per calendar year; lodging facility must be located within 50 miles from covered person's primary residence
HEALTH SCREENING (WELLNESS) BENEFIT Provided if the covered insured takes one of the covered screening prevention tests; payable 1x per calendar		$50	$100

TIP The Health Screening Benefit helps you pay for a portion of the premium. You are giving yourself a discount by completing a standard health screening!

TIP Have questions about the Hospital Indemnity Plans? Call MetLife for assistance. See last page of this guide for contact information.

IDENTITY THEFT & LEGAL BENEFITS

Identity Theft Protection

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

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

Allstate Provides:

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

Legal Benefits

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

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

Examples of covered services include:

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

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

TIP You can enroll in Identity Theft Protection at any time during the year!

HOME/AUTO AND PET INSURANCE

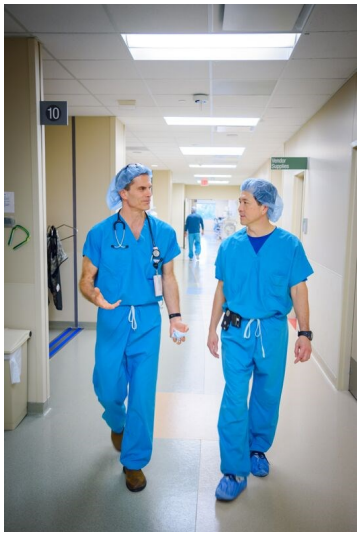
US Anesthesia Partners knows the value of well-rounded, balanced associates, which is why we offer additional benefits to help you manage your life.

Home/Auto Insurance

US Anesthesia Partners provides you access to competitive Auto and Homeowners insurance through MetLife. Your coverage will belong to you and stay with you, even if you leave the Company, so you can always take advantage of low rates. Homeowners insurance includes coverage for your house, condo or rental property. This benefit is not offered in Florida. Additional residency restrictions may apply.

Auto insurance includes coverage for your automobile (including classic and antique cars), boat, motor home or recreational vehicle. You may start or stop your coverage at any time during the year and may set up payroll deductions.

Call 800-438-6388 or visit www.metlife.com/mybenefits to sign up today.



Pet Insurance

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

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

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

Pet insurance does not cover the following services:

- Congenital or hereditary defects or diseases.
- Elective and cosmetic procedures.
- Expression or removal of anal glands or anal sacculitis.
- Breeding or conditions related to breeding.
- Diagnostic tests and treatments for conditions excluded or limited by the policy.
- Special diets, pet foods, vitamins, mineral supplements, boarding or transporting expenses, and grooming costs.
- Diseases that are preventable by vaccines.
- Behavioral problems.
- Orthodontics, endodontics and removal of deciduous teeth.
- Diagnosis, medical management or surgical correction of anterior cruciate ligament (ACL) damage or rupture during the first 12 calendar months of policy effectiveness.

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

EMPLOYEE ASSISTANCE PROGRAM

Employee Assistance Program (EAP)

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

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

The New Directions program provides referrals to help with:

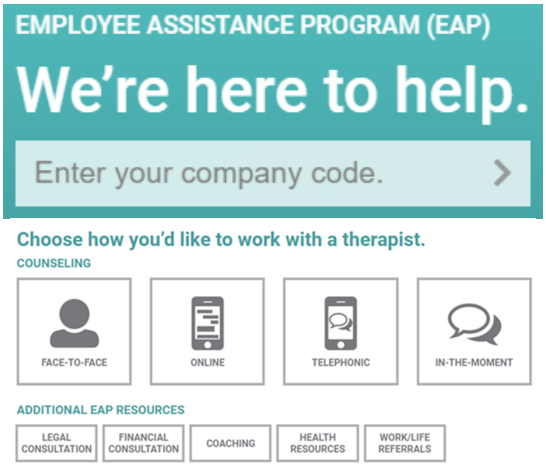
- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Stress, Anxiety, Depression
- Grief and Loss
- Child/Elder Care
- Daily Living
- Career and Work
- Family Resources
- Financial Resources
- Emergency Resources

Online Therapy

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

How Online Therapy Works

1. On your web browser, enter eap.ndbh.com
2. Enter the company code: usap



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

ADDITIONAL BENEFITS

Discount Tickets

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

To become a member:

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

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

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

ACCESS
TicketsatWork using your phone camera or QR scanning app!

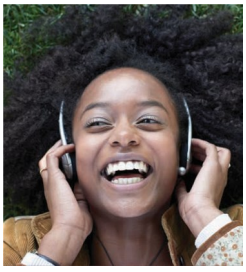
For more information, call 1-800-331-6483 or email customerservice@ticketsatwork.com.

Travel Assistance

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

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

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



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

Pre-Trip planning

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

Traveling assistance

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

Emergency assistance

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

* Emergency Assistance services may be insured under a group or blanket insurance policy issued by Life Insurance Company of North America. All other NYL GBS Secure Travel services are NOT insurance and do not provide reimbursement of expenses or financial losses. Expenses for medical care are not covered.
** Covered person is responsible for any advances, payments, travel-related or replacement costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.
*** Initial transport by ambulance following a covered medical emergency is excluded

DOMESTIC PARTNERSHIPS

INFORMATION ABOUT DOMESTIC PARTNERSHIPS

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

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

SPECIAL TAX RULES FOR DOMESTIC PARTNERS

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

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

MAKING CHANGES DURING THE YEAR

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

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

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

OVER 65 CONSIDERATIONS

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

Medicare Eligible Considerations

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

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

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

HSA Considerations

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

Visit Medicare.gov for more information.

Medicare and Over 65 FAQs

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

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

TIP The Social Security Administration has gone digital! You can create an online account and immediately access your Social Security information. You can sign up here: https://secure.ssa.gov/RIL/SiView.action

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

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

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

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

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

Visit medicare.gov for more information.

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

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

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

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

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

A. It is located in this guide on page 47.

Q. Why did my life insurance coverage amount decrease?

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

WELLNESS INFORMATION

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

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

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

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

TOBACCO/NICOTINE SURCHARGE

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

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

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

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

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

FREQUENTLY ASKED QUESTIONS

TOBACCO/NICOTINE FAQS

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

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

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

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

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

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

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

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

Q. How much is the tobacco/nicotine surcharge?

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

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

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

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

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

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

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

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

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

Q. How do I update my designation?

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

Q. How can I quit smoking?

A. Here are several resources to assist you:

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

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

FREQUENTLY ASKED QUESTIONS

PHARMACY FAQS

Q. How do I manage my new prescriptions?

A. You should contact CVS Caremark for your member services pharmacy needs. You can call 1-888-963-7290—24 hours a day for assistance.

- **Retail Pharmacy**
  - Your BCBS ID care will contain both medical and pharmacy information.
  - Present your ID card to your pharmacy. The pharmacy will need to update your profile with the new information.
  - If you are a new hire or newly eligible for benefits, typically you will receive your ID card within 7-14 business days after your enrollment is finalized.
- **Mail Service Pharmacy**
  - CVS Caremark's Mail Service Pharmacy is not required, except for specialty medications.
  - If you have used a Mail Order benefit from your previous plan, ask your physician to send an electronic prescription to the CVS Caremark Mail Service Pharmacy.
  - Please make sure you have at least a two-week supply on hand.
- **Specialty Medications**

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

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

BENEFIT PLAN FAQS

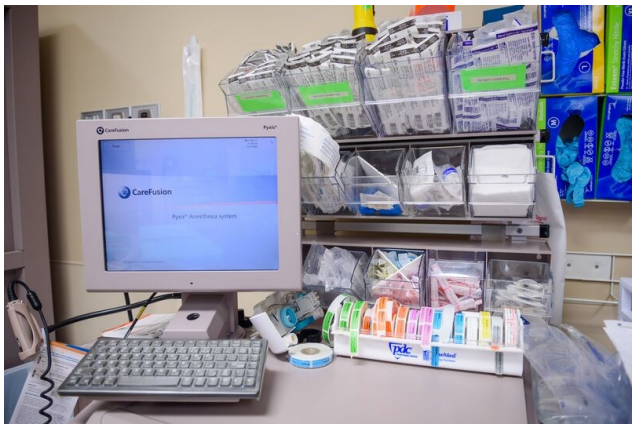
Q. What if I forgot to drop my ex-spouse/partner during open enrollment or within 31 days of my divorce?

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

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

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

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



FREQUENTLY ASKED QUESTIONS

ACA AND COBRA RELATED FAQS

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

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

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

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

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

A. An associate and/or their dependents are eligible to continue group health care under COBRA if coverage is lost under the following scenarios:

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

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

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

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

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

FREQUENTLY ASKED QUESTIONS

FSA AND HSA FAQS

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

A. Below are important submission dates to remember.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Why would I pay for some benefits with pretax money?

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

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

A: The LPFSA is for those participants with the US Anesthesia Partners Core and Value plans and can be used for dental, vision, and medical expenses once you meet your medical plan deductible. To utilize this feature, you must submit a claim with documentation showing you have met your medical plan deductible to TaxSaver Plan. The LPFSA debit card can only be used for non-medical eligible expenses.

Q. How do I substantiate a claim?

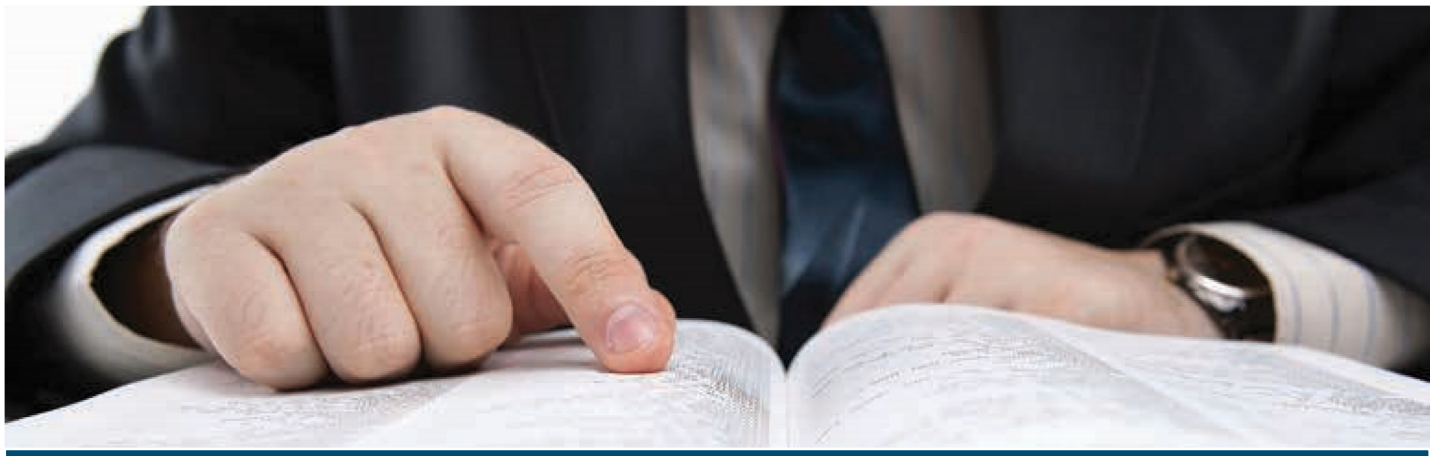
A. TaxSaver Plan will coordinate with US Anesthesia Partners medical, dental and vision plans to reduce, or in some cases, eliminate substantiation of receipts for US Anesthesia Partners plans.

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

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

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

A. Both plans allow associates to set aside pre-tax dollars for eligible health care expenses. If enrolled in a high deductible medical plan, you can contribute to both the Limited Purpose FSA and the HSA. If enrolled in a PPO medical plan, then you can only participate in the Health Care FSA. You do not have to be enrolled in a US Anesthesia Partners medical plan to enroll in the Health Care FSA. You must be enrolled in a US Anesthesia Partners medical plan to participate in the US Anesthesia Partners HSA plan. See page 25 for the FSA vs. HSA plan comparison.



GLOSSARY

Coinsurance: The percentage of covered expenses (20%, for example) that you are responsible for paying after you meet your annual deductible.

Copay: A fixed dollar amount ($35, for example) that you pay out of your pocket when you receive certain services.

Deductible: The amount of covered expenses that must be paid by a covered person each calendar year before the plan begins paying certain benefits. The deductible does not apply to services covered by a copay, except emergency room services.

Eligible Associate: If you are regularly scheduled to work 30 hours or more per week, you are eligible to enroll in US Anesthesia Partners benefits.

Elimination Period (disability benefits): This is defined as a period of continuous disability which must be satisfied before you are eligible to receive benefit payments. This period is a duration of 7 days for short term disability and 90 days for long term disability.

Evidence of Insurability (EOI): This refers to a statement of your medical history. You provide this statement of medical history to the insurance company by completing a questionnaire, and they use your statement to determine if coverage may be issued.

Family Maximum: If you cover family members, the plan limits both your annual deductible and annual out-of-pocket maximum. When a combination of all your family's deductible expenses reach the family deductible amount, your family no longer pays any further deductibles. When the family maximum is met for the calendar year, no other family members will be required to meet further annual deductibles or out-of-pocket maximums for the rest of that year.

Flexible Spending Account (FSA): FSAs allow you to reimburse yourself with tax-free dollars for certain health care and/or dependent care expenses. If you choose to participate in one or both FSAs, you decide how much to contribute to each account. Your contributions remain in your account during the plan year until you file a claim for reimbursement.

Health Savings Account (HSA): A HSA is a tax-advantaged account that works in combination with a high deductible health plan. When you enroll in a HSA plan, you choose how much to contribute to your account. You pay no taxes on your contributions or the interest your account earns, as long as the money is spent on qualified health care expenses. You can take your HSA with you if you change jobs, because it is your money.

Limited Purpose FSA (LPFSA): Associates enrolled in the HDHP can contribute to this account. The Health Care Limited Purpose FSA can be used for eligible expenses, such as vision, dental, and medical expenses once you reach your medical plan deductible.

Out-of-Pocket Maximum: This helps protect you from catastrophic costs during the year. When the copays and coinsurance (if applicable) you pay for covered expenses reaches the annual maximum in a calendar year, the plan pays 100% of most remaining covered expenses for that person for the rest of the year.

Substantiation: Requirement to provide documentation for eligible expenses applied to flexible spending account and health savings account debit cards. You should always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide support that an expense was valid can result in your expense being deemed taxable.

Qualifying Life Event: Associates may make changes to their coverage outside the Open Enrollment period if they experience a qualifying life event. Pregnancy and marriage are two examples of qualifying life events. Refer to page 4 for additional details.

Required Notices

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. U.S. Anesthesia Partners has determined that the prescription drug coverage offered by the BlueCross BlueShield PPO, BlueCross BlueShield HDHP Core and BlueCross BlueShield HDHP Value plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2023
Name of Entity/Sender:	U.S. Anesthesia Partners
Contact—Position/Office:	Human Resources
Address:	12222 Merit Dr., Ste. 600 Dallas, TX 75251
Phone Number:	855-948-4238

Women's Health and Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

HIPAA Privacy and Security

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

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

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

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

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

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

GENERAL NOTICE OF YOUR RIGHTS GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

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

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

QUALIFYING EVENTS

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

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

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

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

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

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

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOU WHEN YOU LOSE GROUP COVERAGE

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COVERAGE PROVIDED

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

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

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

PERIOD OF COVERAGE

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

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

PERIOD OF COVERAGE CONTINUED

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

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

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

HEALTH FSA INFORMATION

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

ALTERNATE RECIPIENTS UNDER QMCSOS

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTUNUATION COVERAGE?

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

PLAN CONTACT INFORMATION

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

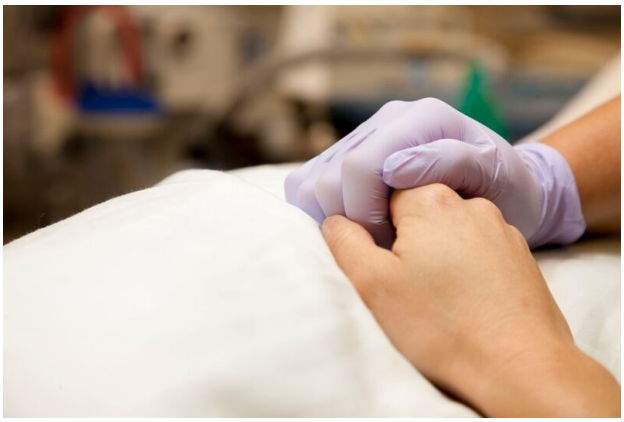
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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



HIPAA SPECIAL ENROLLMENT EVENTS

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

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

Loss of eligibility includes but is not limited to:

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

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

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

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

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

GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

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

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

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

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

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

WEBSITE	https://www.mass.gov/masshealth/pa
PHONE	1-800-862-4840 TTY: 617-886-8102

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

WEBSITE	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

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

PENNSYLVANIA – Medicaid

WEBSITE	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
PHONE	1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA - Medicaid

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

TEXAS – Medicaid

WEBSITE	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

WEBSITE	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
MEDICAID AND CHIP PHONE	1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

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

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

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

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

HOW CAN I GET MORE INFORMATION?

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

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

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

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.

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.

3. Employer Name US Anesthesia Partners			4. Employer Identification Number (EIN)
5. Employer Address 12222 Merit Drive, Suite 700			6. Employer Phone Number
7. City Dallas	8. State TX		9. Zip Code 75251
10. Who can we contact about associate health coverage at this job? HR Operations			
11. Phone Number (if different from above) 855-464-8727	12. Email Address benefits@usap.com		

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

- As your employer, we offer a health plan to:
  - ✓ All associates. Eligible associates are:

  - ✓ Some associates. Eligible associates are:

    Full-time, scheduled 30 hours per week.

    Part-time working 30 hours per week per ACA guidelines

- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are:

    Spouse or Domestic Partner (same-sex and opposite-sex)

    Children under age 26 and Disabled Children of any age who are incapable of self-support

  - 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 associate 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 associate 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.

N O T E S

IMPORTANT CONTACTS

COVERAGE	CONTACT
MEDICAL BCBS & VIRTUAL VISITS Medical ID Card Issued	**Blue Cross Blue Shield (BCBS)** 800-521-2227 www.bcbstx.com

Clinical / ISS Group#		MSO/RCM/CORP Group#	
CO	301420	CORP/RCM	245879
DC	320326	CO MSO	320325
FL	301417	FL	301413
IN & OH	301420	MD MSO	301415
KS	218982	NC MSO	320327
KY & TN	301420	NV MSO	320333
MD	301418	OK MSO/RCM	246864
NV	301414	PA MSO	320332
OK	246863	TX MSO	320328
TX	301419	WA MSO	320334
WA	218984	WI CORP/RCM	301416
ISS Clinical & MSO Value No HSA	320383	ISS MSO PPO/CORE/ VALUE	320335

COVERAGE	CONTACT
PHARMACY ID Card same as Medical ID card	**CVS Caremark** Customer Service 888-963-7290 www.caremark.com

RXBIN	004336
ISSUER (80840)	9151014609
RXGRP	RX20CR

Member ID: BCBS Member ID# or Primary Card Holder's SSN.

COVERAGE	CONTACT
DISABILITY AND/ OR FAMILY MEDICAL LEAVE	**New York Life** Policy#: STD LK 752818, LTD LK 966572 800-238-2125 (To File Claim) Nyl.com/customer-forms Fax: 800-642-8553 Email scanned documents to: DallasFCO.Intake2@newyorklife.com
LIFE AND AD&D	**New York Life** Policy#: FLX 969844 Evidence of Insurability (EOI) 866-607-2360
IDENTITY THEFT	**Allstate Identity Protection** 800-789-2720 www.myAIP.com clientservices@infoarmor.com
PET INSURANCE	**Nationwide-VPI** 800-540-2016 www.petinsurance.com/USAP
DISCOUNT TICKETS	**Tickets At Work** 800-331-6483 www.ticketsatwork.com Company Code: USAPFUN
US ANESTHESIA PARTNERS, INC. 401(K) PLAN	**Vanguard** Plan#: 097382 800-523-1188 www.vanguard.com

COVERAGE	CONTACT
DENTAL No ID card issued	**Cigna** 800-244-6224 www.mycigna.com

Group Name		Group #
MSO/RCM/CORP	3337514	
CO & FL Clinical	3337514	
DC Clinical	2500575	
IN & OH Clinical	2501758	
KS Clinical	2500573	
KY & TN Clinical	2501757	
MD Clinical	2500575	
NV Clinical	2500571	
OK Clinical	2500574	
TX Clinical	2500570	
WA Clinical	2500572	

COVERAGE	CONTACT
VISION No ID card issued	**VSP** Group#: 30052381 800-877-7195 www.vsp.com
HEALTH SAVINGS ACCOUNT Debit Card Issued, use to expiration date	**HSA Bank** 800-357-6246 www.hsabank.com
FLEXIBLE SPENDING ACCOUNTS & COBRA Debit Card Issued, use to expiration date	**TaxSaver Plan** 800-328-4337 csr@taxsaverplan.com www.taxsaverplan.com
EMERGENCY TRAVEL ASSISTANCE PROGRAM	**NYL GBS Secure Travel** Policy#: OK971285 Group#: 57 202-331-7635 (Outside of the U.S.) 888-226-4567 (Within the U.S.) ops@us.generaliglobalassistance.com
LEGAL	**MetLife Legal Plans** Group#: 160878 800-821-6400 www.legalplans.com
ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY	**MetLife** Group#: 160878 800-438-6388 www.metlife.com/mybenefits Plan: U.S. Anesthesia Partners, Inc.
AUTO/HOME INSURANCE	**MetLife** Group#: 160878 800-438-6388 www.metlife.com/mybenefits Code: U.S. Anesthesia Partners
EMPLOYEE ASSISTANCE PROGRAM	**New Directions** Passcode: USAP 800-624-5544 eap.ndbh.com Manager's Resources Login: Manager
VERIFICATION OF EMPLOYMENT & INCOME	**The Work Number** Company code: 16163 800-367-5690 www.theworknumber.com

Benefit Changes?

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

Qualifying Life Events

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

Enrollment in Workday

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

Questions?

855-464-USAP(8727)

Monday-Friday 8 a.m. to 6 p.m. CT

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

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