



2020 BENEFITS GUIDE



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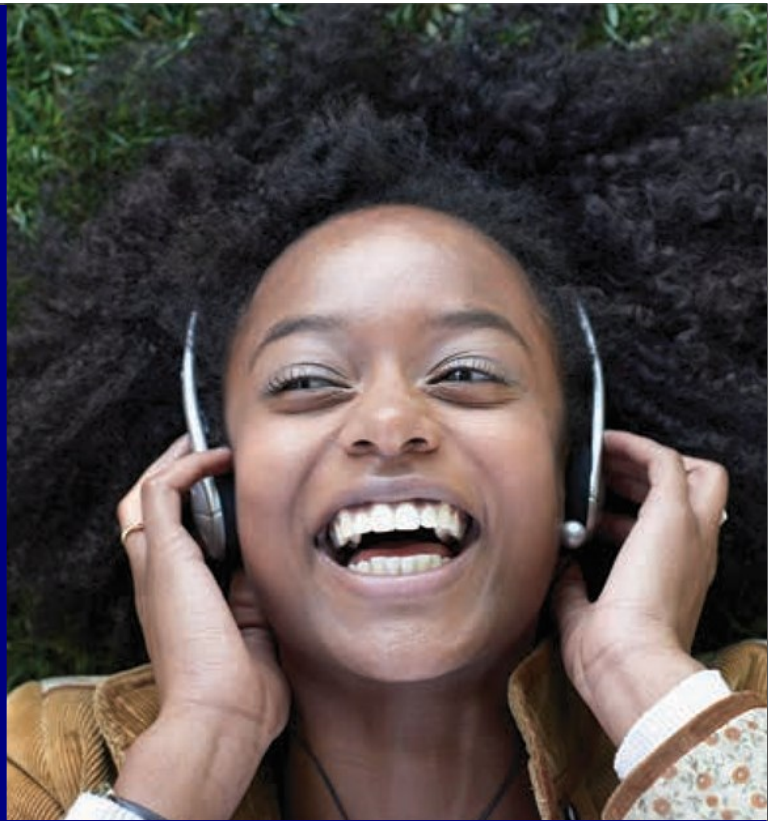


See [page 39](#) for important information concerning Medicare Part D coverage.

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 in the 2020 Plan Year.



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 2020 Plan Year, you won't be able to 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.

Associates who have company coverage in 2019 and DO NOT ACTIVELY select 2020 benefits during the Open Enrollment period of November 1 - November 15, 2019, will be enrolled in the same benefit plans based on their 2019 election, with the exception of FSAs.

FSAs require re-enrollment annually.

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.



ELIGIBILITY & ENROLLMENT

Dependent Certification

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 above.

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 mortgage statement with both the Domestic Partner and associate's name



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 the Benefits Department.

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 elections appropriately.

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, you will have higher associate contributions.

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
- ◆ Associate + Child(ren)
- ◆ Associate + Family

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



How to Enroll

1. Understand Your Choices

This Guide contains very useful reference material to help you prepare for Open Enrollment. Keep it handy so you can refer to it throughout the year or visit Sharepoint 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

- www.USAPToday.com and click the Workday link
- Workday.usap.com
- Workday mobile app

4. Go to your Workday Inbox

5. Review, update, and submit your enrollment elections by:

November 15, 2019 at 11:59 p.m. CT

6. 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.

Open Enrollment: Add or Change Benefits

Navigating to Open Enrollment in Workday

1. Visit Workday

- ◆ www.USAPToday.com and click the
- ◆ Workday link
- ◆ Workday.usap.com
- ◆ Workday mobile app

2. Go to your Workday Inbox:

- ◆ You will see a notice in your inbox to initiate your Open Enrollment event.

Complete Benefit Elections

1. On the Health Care Elections (may be Change Benefits Elections) screen, scroll to complete enrollment in available benefits.
2. Make updates to your Health Care Elections by selecting Elect or Waive for the various offerings.
3. To enroll dependents:
 - ◆ Click the lines symbol in the Enroll Dependents column and select Add My Dependent . Complete the information and click OK. Enter all mandatory information and click OK again.
4. Make Health Savings Account Plan Dependencies elections by clicking on Elect or Waive for the various offerings. If you elect coverage, provide required information in Contribution Range (Annual) column. Click Continue.
5. Make Spending Account Plan Dependencies elections by clicking on Elect or Waive for the various offerings. If you elect coverage, provide required information in Contributions column. Click Continue.

6. Make Insurance Elections by selecting Elect 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 Associate to be eligible to elect Supplemental Life/AD&D Spouse/Partner or Child.
7. Update your Beneficiary Designations (if applicable). Click Continue.
8. 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.
9. Click Submit to save the transaction.
10. Scroll to the bottom of the screen and click the Print Icon to print a paper copy of your benefits for your personal records 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 and United Healthcare depending on your region. You will be notified of the carrier utilized in your region. The plan design options are the same regardless of the carrier. 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
- ◆ 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 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 your medical carrier (contact information is at the back of this guide) to utilize virtual visits, Nurseline or to find a physician or facility/lab.

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 a percentage of the cost for each service (coinsurance) until you reach your annual out-of-pocket maximum once you've met your deductible.



MEDICAL PLAN SUMMARY

The chart below gives a summary of the Medical coverage provided by Blue Cross Blue Shield of Texas and United Healthcare. 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)						
INDIVIDUAL ⁴	\$1,000	\$2,000	\$1,750	\$3,500	\$3,000	\$6,000
FAMILY ⁵	\$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)²						
INDIVIDUAL	\$4,000	No Limit	\$3,500	No Limit	\$6,500	No Limit
FAMILY	\$8,000	No Limit	\$6,650	No Limit	\$13,000 ³	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	Under \$45	N/A	Under \$45	N/A

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

*After Deductible

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

² In-and out-of-network out-of-pocket costs do not cross apply to the deductible or out-of-pocket maximum.

³ You have a \$6,500 individual in-network out-of-pocket maximum within your total family out-of-pocket maximum.

⁴ Individual deductible applies to an associate only election.

⁵ Family deductible applies to an election other than associate only.

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 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 your medical carrier 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

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is offered through Express Scripts, administered by RxBenefits, Inc. You may find information on your benefits coverage and search for network pharmacies by logging on to www.express-scripts.com or by calling the Customer Care number: 800-334-8134.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as Generic, Preferred or Non-Preferred.

	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}						
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%*
MAIL ORDER RX (90-DAY SUPPLY)^{2,3}						
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%*

* After Deductible

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

² 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.

³ 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 Express Scripts would have paid for the same prescription drug product dispensed by a network pharmacy.

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?

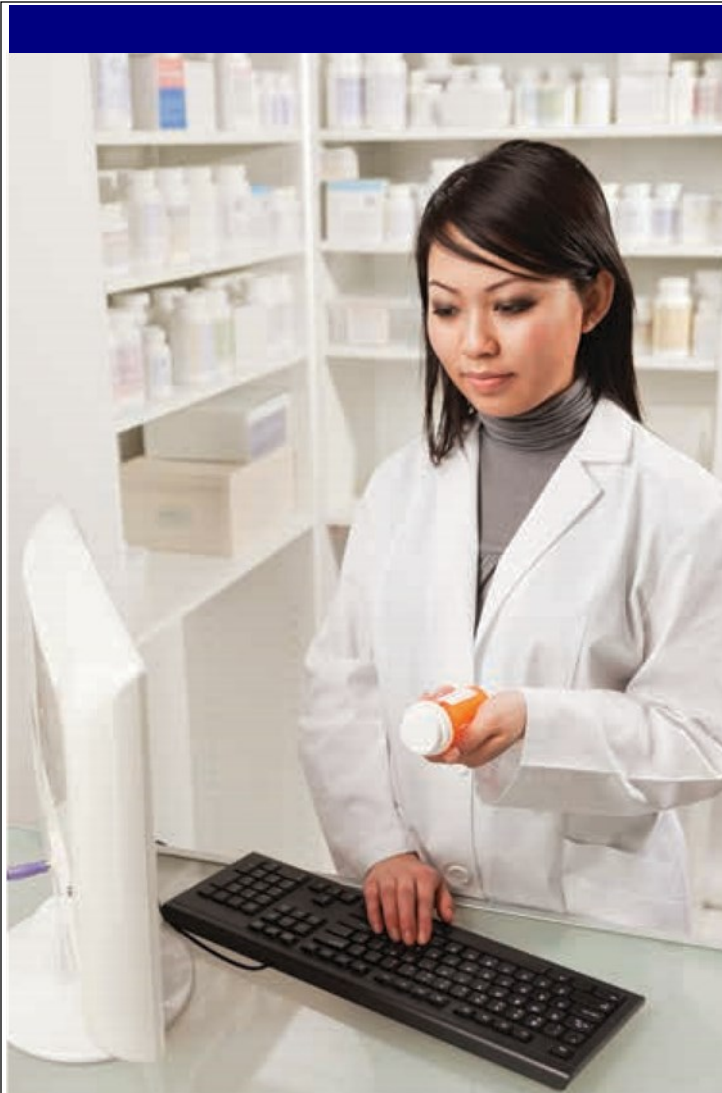
Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

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, Prosthesis 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 on workday.usap.com.

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 <small>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations may apply</small>	\$20 copay	Contact VSP
BENEFIT FREQUENCY		
EXAMINATION	Every calendar year	
LENSES	Every calendar year	
FRAMES	Every other calendar year	
CONTACT (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 when you are 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.

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.



CALCULATE
YOUR TAX SAVINGS
FROM AN HSA.



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 2020, 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 health 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

2020 HSA FUNDING LIMITS

INDIVIDUAL	\$3,550
FAMILY	\$7,100
CATCH UP (AGES 55+)	\$1,000

HSA accounts. For 2020, contributions (which include any employer contributions) are limited to the following:

See page 34 for over age 65 HSA considerations.

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.

Frequency Change for HSA Contributions

In 2020, there will be a change in the contribution frequency for the HSA. Elections will be calculated and deducted based on 24 pay periods. We encourage you to review your per pay period amount elections to ensure that it meets your financial objectives.

You will experience HSA benefit deductions only on the 1st and 2nd check of each month.

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 health care expenses, they are spent tax-free.

MONEY GOES IN	MONEY GOES OUT	HAVE MONEY LEFT? IT ROLLS OVER!
<p>You can contribute pre-tax amounts through payroll deductions.</p> <p>2020 annual maximum contributions are:</p> <ul style="list-style-type: none"> ◆ \$3,550 for associate only coverage ◆ \$7,100 if you enroll your spouse/domestic partner and/or child(ren) ◆ An extra \$1,000 if you are age 55 or older 	<p>You pay the full cost of non-preventive care, until you meet the deductible. You receive discounted rates in-network.</p> <p>When you have an eligible expense, you decide whether to use your HSA or pay for care with other resources.</p>	<p>Any money left in your account is yours to pay for health care in the future.</p> <p>If you leave the company, you can take it with you.</p>



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 \$2,700 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 \$2,700 in the LPFSA.

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 \$125,000 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.



LEARN

**MORE ABOUT
FSA LIMITS, GRACE
PERIODS AND
ROLLOVERS.**

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 participate in a FSA and claim a tax deduction at the same time.
- ◆ All 2020 Dependent Care FSA claims must be incurred by December 31, 2020 and submitted by March 31, 2021.
- ◆ The US Anesthesia Partners Health Care FSA Plan allows a 2 1/2 month grace period to incur claims using remaining 2020 dollars after the end of the plan year if you are enrolled in both the current and next year's Health Care FSA. The 2020 plan year grace period to incur ends March 15, 2021; the 2020 plan year submission period ends March 31, 2021.
- ◆ 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 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: Over-the-counter (OTC) drugs are not eligible for reimbursement through a FSA without a doctor's prescription.

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, 2020, and March 15, 2021, and submitted for reimbursement on or before March 31, 2021, 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.

You must be enrolled in 2020 and 2021 to be eligible for the grace period.

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 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 back page of this guide.

Eligible Dependent Care FSA Expenses

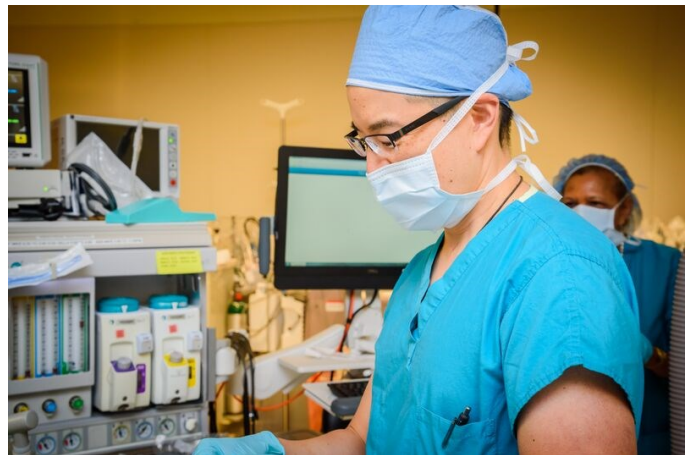
Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- ◆ 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 \$125,000 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 contribution limit for 2020 is \$2,700.	The contribution limit for 2020 is \$3,550 for individuals and \$7,100 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 2020 dollars after the end of the plan year if you are enrolled in both the current and next year's Health Care FSA. The 2020 plan year grace period to incur ends March 15, 2021; the 2020 plan year submission period ends March 31, 2021.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses. 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.
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 on 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 one times your salary, up to \$500,000. 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.



NEED HELP

**CHOOSING THE RIGHT
LIFE INSURANCE PLAN?**

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*	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*	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 will be required for any amount.
SUPPLEMENTAL DEPENDENT LIFE/AD&D	
COVERAGE AMOUNT*	Spouse—Increments of \$5,000 Child(ren)—\$5,000 or \$10,000 options
WHO PAYS	Associate
BENEFITS PAYABLE	Upon Death
MAXIMUM PAYABLE	Spouse—\$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—Amount over \$50,000 If you do not enroll when first eligible, then EOI will be required for any amount. Child(ren)—No EOI required.

*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.

LIFE AND AD&D INSURANCE RATES

How to calculate your monthly premium:

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

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	Age Band	Spouse 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) benefits are available to you. 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.

Yearly Earnings	Coverage amount with STD 1250 Plan	Coverage amount with STD 2500 Plan	Coverage amount with 1250 Plan and 1250 Buy-Up
\$50,000	\$576.92	N/A	N/A
\$100,000	\$1,153.84	N/A	N/A
\$200,000	\$1,250	\$2,307.69	\$1,250 and a buy-up of \$1,057.69
\$300,000	\$1,250	\$2,500	\$2,500
\$400,000	\$1,250	\$2,500	\$2,500



INCOME PROTECTION

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available to you. 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.

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. LTD payments will last for as long as you are medically disabled or until you reach your Social Security Normal Retirement Age. 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

Age	Rate Per \$10	\$1,250 Coverage Monthly Rate	\$2,500 Coverage Monthly Rate
Through Age 59	\$0.76	\$95	\$190
Age 60+	\$1.02	\$127.50	\$255

LTD

LTD Rates are available in Workday.

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	\$10,000	Regular 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 Institutional 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 1% 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. 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 contributions and profit sharing contributions made after three years of service.

Plan Fee

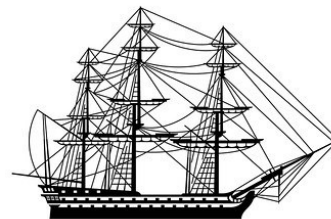
Beginning in January 2020, each plan participant will pay an annual flat fee of \$41 (\$10.25 quarterly) for recordkeeping services and other general plan administrative expenses.

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.



Vanguard®

HOME/AUTO & 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.

IDENTITY THEFT & LEGAL BENEFITS

Identity Theft Protection

Identity theft protection services from InfoArmor 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.

InfoArmor 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.

InfoArmor Provides:

- ◆ Identity Monitoring: Monitor identities to uncover identity fraud at the source
- ◆ CreditArmor: CreditArmor 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.
- ◆ Privacy Advocate Remediation: If suspicious activity is detected, a Privacy Advocate will act as a dedicated case manager to resolve the issue from start to case completion.
- ◆ \$25,000 Identity Theft Insurance Policy: Protect consumers from the financial damages of identity theft with our \$25,000 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.
- ◆ Wallet Armor: This secure, online document repository makes lost wallet replacement quick and easy.

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 Hyatt Legal, visit www.legalplans.com.

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 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.

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

Have questions about the Hospital Indemnity 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

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

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

ASSISTANCE PROGRAMS

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. The EAP benefit includes three face-to-face visits per issue with a licensed professional. 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 800-311-4327 or online at www.guidanceresources.com / Company ID: GEN311.

The Program provides referrals to help with:

- ◆ Emotional Health and Well-Being
- ◆ Alcohol or Drug Dependency
- ◆ Marriage or Family Relationship Problems
- ◆ Job Pressures
- ◆ Stress, Anxiety, Depression
- ◆ Grief and Loss

Travel Assistance

You have access to the AXA Travel Assistance 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; you and your dependents are eligible to access these services for up to 120 consecutive days for any given trip.

To receive services, call AXA Travel at 800-565-9320 (in the US) or 312-935-3654 (outside the US).

Through this program, you will be connected to a global network of:

- ◆ Over 600,000 service providers
- ◆ Air and ground ambulance services
- ◆ Trained multilingual personnel who can assist you in a travel emergency
- ◆ Medical Services: Medical and dental referrals, coordinate hospital admission, critical care monitoring, emergency medical evacuation, medical repatriation, dispatch of prescription medication
- ◆ Travel Services: Lost document and lost article assistance, emergency cash and bail assistance, arrangement for political evacuation, urgent message relay, online general travel information



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

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

Student Loan Refinancing

USAP knows that student loans can be a burden long after medical school is over. In 2020, USAP is partnering with LinkCapital to bring USAP medical professionals a competitive refinancing program.

Some of the features of the program include:

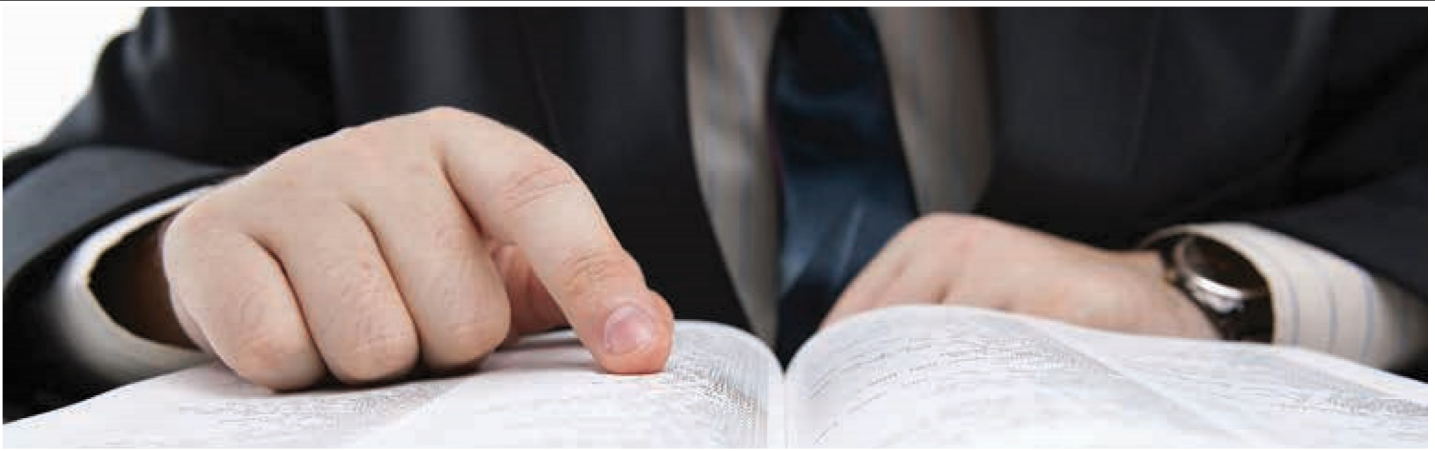
- ◆ No upfront costs or fees of any kind
- ◆ No penalty for prepayment/early payment
- ◆ No requirement that the borrower maintain deposit accounts at LinkCapital
- ◆ The ability to refinance at any time, with no fees, to take advantage of more favorable interest rates
- ◆ Complete loan forgiveness in the event of death or total and permanent disability of the borrower

To determine whether the LinkCapital Professional Refinance Loan Program works for you, visit their website at linkcapital.com or call (844) 226-LINK (5465).



ACCESS

TicketsatWork using
your phone camera or
QR scanning app!



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 during your first 14 days of continuous employment. If you enroll for benefits during this 14-day period, coverage will take effect on your date of hire.

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.

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.

There is a special enrollment window to enroll in Medicare (any part) if you enroll within 31 days after you retire or otherwise lose active US Anesthesia Partners Plan medical coverage.

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.

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).

Visit [Medicare.gov](https://www.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.

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](https://www.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, please inform Benefits by calling (855) 464-8727 or emailing benefits@usap.com.

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 39.

Q. Why did my life insurance coverage amount decrease?

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

FREQUENTLY ASKED QUESTIONS

TOBACCO/NICOTINE FAQs

Q. How do I receive the tobacco/nicotine-free credit?

A. If you are not a tobacco/nicotine user, you must go through the enrollment process to receive your tobacco/nicotine-free credit.

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 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 Life Event. Subsequent changes to your medical premium will not occur until the Life Event is approved by the benefits administrator and the designated effective date is reached.

Q. What if I or my spouse 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 free for 3 months?

A. You should respond that you and/or your spouse have not been tobacco/nicotine free for the last 3 months. When both you and your spouse are tobacco/nicotine free for 3 months, go to Workday and complete a life event certifying that you and your spouse have been tobacco/nicotine free for 3 months. You will then be eligible for the tobacco/nicotine credit.

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

A. Please inform Benefits by calling (855) 464-8727 or emailing benefits@usap.com.

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 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.



FREQUENTLY ASKED QUESTIONS

PHARMACY FAQS

Q. How do I manage my new prescriptions?

A. You should contact RxBenefits first for all of your member services pharmacy needs. Call 1-800-334-8134 or email RxHelp@rxbenefits.com Monday through Friday, 7:00 a.m.-8:00 p.m. CT.*

Retail Pharmacy

- ◆ BCBS members will have one ID card with combined medical/pharmacy information.
- ◆ UHC members will receive separate medical and pharmacy ID cards.
- ◆ Present your ID card to your pharmacy. The pharmacy will need to update your profile with the information listed on the front of your card.
- ◆ Typically, you will receive your ID card within 7-14 business days. If you haven't received your ID card, contact RxBenefits for assistance.

Mail-Order Pharmacy

- ◆ Express Scripts' Mail-Order 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 Express Scripts Mail-Order.
- ◆ Please make sure you have at least a two-week supply on hand.

Specialty Medications

- ◆ *Specialty medications must be obtained through Accredo, the Express Scripts specialty pharmacy. Specialty medications may need extra care from you and your doctor to coordinate delivery.*

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

- ◆ Ask your physician to send an electronic prescription to the Express Scripts Mail-Order Pharmacy.
- ◆ Express Scripts will coordinate with Accredo as required for all specialty medications.
- ◆ Accredo is the point of contact for you to receive your specialty medication. Please return phone calls and remain in contact with Accredo to coordinate delivery. You can reach Accredo at this number 800-803-2523.
- ◆ Call RxBenefits at any point in the process should you need customer service assistance.

BENEFIT PLAN FAQS

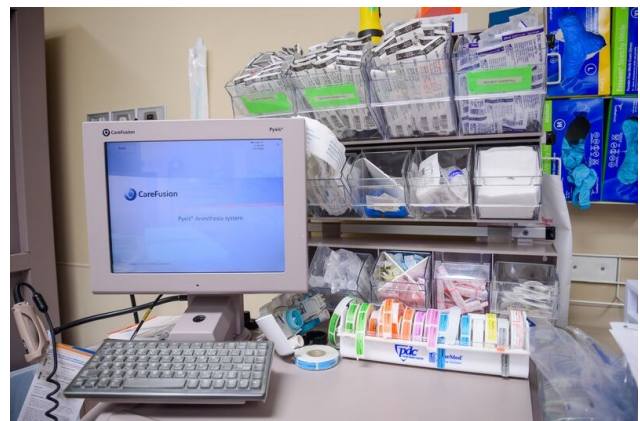
Q. What if I forgot to drop my ex-spouse during open enrollment or within 31 days of my divorce?

A. Contact the Benefits Department 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 don't 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 2020, the plan year ends December 31, 2020, but you have until March 31, 2021 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, 2020, and March 15, 2021, and submitted for reimbursement on or before March 31, 2021, any remaining balance, in the previous Plan Year that ended December 31, 2020, is eligible for reimbursement, even though the service was provided in the new Plan Year.
 - ◆ You must be enrolled in 2020 and 2021 to be eligible for the grace period.

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

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

- A.** You cannot change the frequency or amount of the FSA deduction. You can set up a one-time deduction for HSA or modify the per pay period amount. You complete a change in Workday > Benefits > Change Benefits > HSA Contribution Change.

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 will continue to be used for only non-medical eligible expenses.

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. 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 21 for the FSA vs. HSA plan comparison.

ADDITIONAL INFORMATION

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 provides a tobacco/nicotine surcharge to 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 is enrolled in a US Anesthesia Partners medical plan, the associate must certify that the spouse is also tobacco/nicotine-free in order to receive the associate credit.

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.

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)
- ◆ Your 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.



Required Notices

IMPORTANT NOTICE FROM US ANESTHESIA PARTNERS MEDICAL NETWORK ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under US Anesthesia Partners Medical Network's Medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2020. This is known as "creditable coverage." Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2020 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.

You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully. It has information about prescription drug coverage with US Anesthesia Partners Medical Network and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the prescription drug coverage offered by US Anesthesia Partners Medical Network through their Medical plan, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2020. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active associate or family member of an active associate, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop US Anesthesia Partners Medical Network coverage, Medicare will be your only payer. You can re-enroll in the employer plan during Open Enrollment or if you have a special enrollment event for the US Anesthesia Partners Medical Network plan.

You should know that if you waive or leave coverage with US Anesthesia Partners Medical Network and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if US Anesthesia Partners Medical Network's coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 800-772-1213 (TTY 800-325-0778).

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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).

PLAN CONTACT INFORMATION:

12222 Merit Drive, Suite 600

Dallas, TX 75251

855-464-8727

benefits@USAP.com

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 600 Dallas, TX 75251, by logging on to Workday and completing a life event notice, or by sending an email to benefits@usap.com to receive further instruction.

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 CONTINUATION 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 (800) 328-4337 during business hours.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the associate or former associate dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to US Anesthesia Partners' COBRA administrator. See contact information on the last page of this guide. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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 OF 1998

The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- ◆ All stages of reconstruction of the breast on which a mastectomy has been performed
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance
- ◆ Prostheses
- ◆ Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions, which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.



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 decline enrollment in a US Anesthesia Partners Medical Network's medical plan for you or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a US Anesthesia Partners Medical Network's Medical plan without waiting for the next Open Enrollment period if you:

- ◆ Lose other coverage. You must request enrollment within 31 days after the loss of other coverage;
- ◆ Gain a new dependent as a result of marriage, birth, adoption or placement for adoption. You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption; or
- ◆ Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

In addition, you may enroll in a US Anesthesia Partners Medical Network Medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain such coverage.

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

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not 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 are not 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 October 26, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

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

COLORADO – Health First Colorado
(Colorado's Medicaid Program)
& Child Health Plan Plus (CHP+)
Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid
Website: <https://www.flicaidtprrecovery.com>
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: <https://medicaid.georgia.gov/health-insurance-premium-paymentprogram-hipp>
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All Other Medicaid Website: <http://www.indianamedicaid.com>
Phone 1-800-403-0864

IOWA – Medicaid
Website: <http://dhs.iowa.gov/hawki>
Phone: 1-800-257-8563

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

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

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

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

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

MINNESOTA – Medicaid
Website: <https://mn.gov/dhs/people-we-serve/seniors/healthcare/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

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

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

NEW HAMPSHIRE – Medicaid
Website: <https://www.dhhs.nh.gov/ombp/nhhipp/>
Phone: 603-271-5218
Toll Free for HIIPP 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: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: <https://dma.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 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: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
 Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
 Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: <http://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://www.gethipptexas.com/>
 Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov>
 CHIP Website: <http://health.utah.gov/chip>
 Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/>
 Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
 Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
 Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, 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

NEW 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 US Anesthesia Partners Benefits Department 855-464-8727 or email benefits@usap.com.

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		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? Benefits Department			
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:

[Redacted]

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		COVERAGE		CONTACT			
MEDICAL BCBS & VIRTUAL VISITS Medical ID Card Issued	Blue Cross Blue Shield (BCBS) 800-521-2227 www.bcbstx.com			DENTAL No ID card issued	Cigna 800-244-6224 www.mycigna.com				
	Group Name	MSO, RCM, & Corporate	245879		Group #	Group Name	MSO, RCM, & Corporate	3337514	
		MSO OK	246864				AZ Clinical	2500677	
		AZ Clinical	241622				CO & FL Clinical	3337514	
		KS Clinical	218982				KS Clinical	2500573	
		OK Clinical	246863				OK Clinical	2500574	
		MD Clinical	228796				MD Clinical	2500575	
		TX PPO Clinical	123134				NV Clinical	2500571	
		TX HDHP Clinical	123135				TX Clinical	2500570	
WA Clinical	218984	WA Clinical	2500572						
MEDICAL UHC & VIRTUAL VISITS Medical ID Card Issued	United Healthcare (UHC) 866-633-2474 - PPO 800-864-9427 - HDHP www.myuhc.com Group#: 705755			HEALTH SAVINGS ACCOUNT Debit Card Issued, use to expiration date	HSA Bank—BCBS 800-357-6246 www.hsabank.com				
	PHARMACY	Express Scripts administered by RxBenefits, Inc. Customer Service 800-334-8134 Pharmacy Assistance 1-800-922-1557			Optum Bank—UHC 800-791-9361 www.optumbank.com				
RXBIN		610014	FLEXIBLE SPENDING ACCOUNTS & COBRA New Debit Card Issued, use to expiration date	TaxSaver Plan 800-328-4337 csr@taxsaverplan.com www.taxsaverplan.com					
ISSUER		Express Scripts		IDENTITY THEFT	InfoArmor 800-789-2720 www.infoarmor.com				
RX Group Name		MSO, RCM, & Corporate			RXBUSAN	RX Group #	Link Capital 844-266-5465 www.linkcapital.com		
		CO & FL Clinical			RXBUSAN		STUDENT LOAN REFINANCING	Hyatt Legal 800-821-6400 www.legalplans.com Group#: 160878 Access Code: GETLAW	
	Clinical	RXBUSPH			ACCIDENT, CRITICAL ILLNESS, HOME/AUTO, HOSPITAL INDEMNITY			MetLife 800-438-6388 www.metlife.com/mybenefits Plan: U.S. Anesthesia Partners, Inc. Group#: 160878	
NV Clinical	35242RX	Member ID: BCBS Member ID#, Unique Number provided by RxBenefits, or Primary Card Holder's SSN.							
VISION No ID card issued	VSP 800-877-7195 www.vsp.com Group#: 30052381			LEGAL	ComPsych 800-311-4327 www.guidanceresources.com Company ID: GEN311				
	LIFE AND AD&D	Prudential 888-257-0412 (Evidence of Insurability (EOI) Status) www.prudential/mystatus			EMPLOYEE ASSISTANCE PROGRAM	Tickets At Work 800-331-6483 www.ticketsatwork.com			
DISABILITY AND/OR FAMILY MEDICAL LEAVE		877-367-7781 (To File Claim) 800-524-0542 (Ongoing Claims) www.prudential.com/mybenefits Access Code: 52694				DISCOUNT TICKETS	BENEFITS DEPARTMENT 12222 Merit Drive, Suite 600 Dallas, TX 75251 855-464-8727 benefits@usap.com myUSAP.com		
		PET INSURANCE	Nationwide-VPI 800-540-2016 www.petinsurance.com/USAP				US ANESTHESIA PARTNERS, INC. 401(K) PLAN		
EMERGENCY TRAVEL ASSISTANCE PROGRAM	AXA Travel Assistance Program 100 miles from home for any type of travel 800-565-9320 (Inside the U.S.) 1-312-935-3654 (Outside the U.S.)			Vanguard 800-523-1188 www.vanguard.com Plan#: 097382					