2025

Annual Enrollment FAQs

ArdentHealth

Details can be found in the Annual Enrollment Guide online at **www.getardentbenefits.com/enroll**.

When is Annual Enrollment?

Annual Enrollment for the 2025 plan year will be Monday, October 28 through Friday, November 15, 2024 ***(website closes at midnight CT).***

Do I need to enroll for 2025?

No, this year is a passive enrollment, which means If you are currently enrolled, you will be automatically re-enrolled in your current medical, dental, vision, life and disability elections for 2025 unless you make changes. Any plan and rate changes will apply, and there may be changes to the medical network tiers available to you.

If you want to participate in the Flexible Spending Accounts (FSA) or a Health Savings Account (HSA) for 2025, you must enroll by November 15. Your elections for these accounts will not automatically roll over.

It is important to also review and update your life insurance beneficiary information online.

We encourage you to visit the Ardent Benefits Portal. There, you will be able to compare your choices and make your elections for 2025. You will also be able to review our Annual Enrollment guide, compare plans and view plan documents.

Are the employee premiums changing?

Yes, some employee premiums have changed. Plan costs will be displayed when you make your selections online.

IMPORTANT CHANGES FOR 2025

- Delta Dental is our new dental provider with a national network of dentists. The same two plan options we offer today are available for 2025 coverage.
- All members enrolled in a medical or dental plan will receive a new ID card.
- The IRS is increasing the amount you can contribute to your Health Savings Account (HSA) for 2025. Ardent contributions count toward this maximum. The HSA contribution limit for an individual with self-coverage will be $4,300. The 2025 HSA limit for individuals with family coverage will be $8,550.
- We will be offering a new voluntary benefit, accident insurance. Securian will be our new vendor for critical illness, hospital indemnity (previously hospital care) and accident insurance.
- Changes to the medical plans include increases in deductibles, out-of-pocket maximums, copays and coinsurance.
- Medical plan eligibility will be assigned based on your proximity to an Ardent facility. If you live within 50 miles of one of our locations, you will be eligible for the medical plans that include the Ardent Network Tier.
- We are adding a new vendor, Carrot, that provides various of programs, including support for pregnancy, postpartum, infant care, parenting and menopause.
- Dependent Care elections for highly compensated employees will have a cap of $1,600 for the 2025 plan year.

Enrollment

Who can I cover on my plans?

You may cover your spouse or domestic partner and your eligible dependent children up to age 26.

An eligible dependent includes:

- Your legal spouse – an eligible dependent spouse does not include an individual from whom you have obtained a legal separation or divorce. Please see exclusions for spouses/domestic partners who have coverage available through their employers.
- Your domestic partner – as long as he or she meets the definition of domestic partner as stated in the Domestic Partner Affidavit.
- A dependent child until the child reaches his or her 26th birthday.

For more details, please refer to the plan summaries located at www.getardentbenefits.com/plan-documents.

What information do I need to enroll?

You will need information for any eligible dependents that you wish to add for 2025. You will need to have on hand your new dependent's full name, Social Security number and date of birth.

Do I need to verify my dependents?

You must verify your newly added dependents by submitting the required documentation. Instructions will be sent to you from the Ardent Benefits Service Center. You do not have to re-verify dependents who were enrolled for 2024.

What computer may I use to enroll?

You may enroll from a computer at work or home or any computer that has access to the internet.

How do I Enroll?

If you are new to our enrollment tool, visit www.getardentbenefits.com/enroll and select Create an Account. Then, follow the on-screen prompts to create your account. You will need to have access to your email and use your mobile phone number for verification to register.

If you already have an account, visit the enrollment site at www.getardentbenefits.com/enroll, enter your email user ID, then enter your password. Select how you want to receive the verification code (email or phone), and then enter the code to verify your information.

I don't want to use the enrollment portal; can you take my enrollment over the phone?

Yes, you can call the Ardent Benefits Service Center at 855-787-0668. The hours during Annual Enrollment are Monday to Friday from 8 a.m. to 6 p.m. CT.

I am completing my Annual Enrollment elections, why don't I have the option to purchase EAP, Basic LTD, or Basic Life and AD&D insurance?

Ardent provides the employee assistance program (EAP), basic long-term disability and basic life and AD&D insurance benefits at no cost to you. Therefore, if you are eligible, you will automatically be enrolled in these benefits and do not have to select them during Annual Enrollment.

I completed my Wellness Program steps. Will my discounts show in the enrollment tool?

The site is customized with information about you, including your wellness credits. Wellness credit information will be available depending on when you completed the program steps.

Can I change my elections during the year?

After Annual Enrollment closes on November 15, 2024, IRS regulations require you to keep your elections through December 31, 2025, unless you have a Qualified Life Event. Changes must be requested within 31 days (or 60 days, in the case of a Medicaid-related special enrollment event) of the Qualified Life Event.

What if I make a mistake on my elections?

You can make updates and changes to your benefit selection until the Annual Enrollment period closes on November 15, 2024, at midnight CT. All you need to do is log in to the enrollment site and make your changes. If you make changes, ensure you submit your enrollment again.

Further, we encourage you to closely review, print and save your benefits confirmation page for your records.

After Annual Enrollment closes, you cannot make changes unless you have a Qualified Life Event.

When does benefits coverage end?

Benefits elected during Annual Enrollment will take effect on January 1, 2025, and will remain in effect for the 2025 plan year (which ends on 12/31/25) unless your employment terminates, or the plan ends. Medical, dental and vision coverages end on the last day of the month that your employment terminates. Life and disability will end on your termination date.

Whom can I contact if I have questions about enrollment or if I need help with my login or password?

If you need assistance with your login or password, you can contact the Ardent Benefits Service Center at 855-787-0668 for help.

How do I know which providers are in our networks when enrolling?

You can go to www.ardentcarecoordinators.com or call Quantum at 888-295-9299.

Please note that, although they are shown in the search engine, the below providers are excluded from the Ardent Health plan:

- Healthcare System (TX), Presbyterian Health Services (NM), or Ascension St. John (OK) except for emergency, mental health, and alcohol/drug treatment.
- No coverage will be offered at the St. Francis Health System (OK) except for emergency, mental health, alcohol/drug treatment and pediatric services (for members under age 17).
- No coverage will be offered at Akumin Amarillo/Preferred Imaging (TX).
- No coverage will be offered at CHRISTUS Trinity Mother Frances Health System except for emergency and NICU services for newborns under 34 weeks.
- Services at Texas Spine and Joint will be covered as out of network (based on plan elected), except for emergency services and Ear, Nose & Throat (ENT) procedures.

Medical & Prescription Drug Plans

How many health plan options do we have?

Ardent offers several medical plans from which to choose, including:

- Preferred Provider Organization Plan (PPO)
- Exclusive Provider Organization Plan (EPO)
- High Deductible Health Plan (HDHP)
- Open Access Plan (OAP) with value-based pricing

Medical plan eligibility will be assigned based on the proximity of your home to an Ardent facility. If the employee lives within 50 miles of one of our locations, you will be eligible for the medical plans that includes the Ardent Network Tier.

For more details, please review the 2025 Benefits Guide and Summary of Benefits and Coverage available online at www.getardentbenefits.com/enroll.

What are the different network tiers?*

Refer to the Ardent Benefits Portal to determine which plans and tiers are available to you.

If you live within 50 miles of a facility within UT Health East Texas:

Ardent Network – Ardent offers employees the best costs at facilities and providers that are part of our company; employees will pay the least when they see Ardent Network providers.

Access Direct Platinum Network – This network offers a choice of providers and facilities and covers nine counties: Smith, Cherokee, Rush, Panola, Henderson, Van Zandt, Wood, Camp, and Gregg. For members enrolled in a plan that includes this network, services not available at UTHET can be covered at Children's Medical Center or UT Southwestern at the ADP tier of benefits.

Cigna PPO Network – You may choose any provider you'd like to see in the Cigna PPO Network, without a referral, for a lower cost than an out-of-network provider.

Out-of-Network – Members with this tier available will pay the most when seeing an out-of-network provider.

Open Access – Open Access allows you the freedom to see any provider with a built-in price protection.

If you live within 50 miles of a facility within BSA Health System, Hackensack Meridian Mountainside Medical Center, Hackensack Meridian Pascack Valley Medical Cener, Hillcrest HealthCare System, Lovelace Health System, Seton Medical Center Harker Heights, Portneuf Medical Center, and The University of Kansas Health System St Francis Campus:

Ardent Network – Ardent offers employees the best costs at facilities and providers that are part of our company; employees will pay the least when they see Ardent Network providers.

UHC Choice Plus Network – You may choose any provider you'd like to see in the UHC Choice Plus Network, without a referral, for a lower cost than an out-of-network provider.

Out-of-Network – Members with this tier available will pay the most when seeing an out-of-network provider.

Open Access – Open Access allows you the freedom to see any provider with a built-in price protection.

If you live more than 50 miles for any Ardent facility:

UHC Choice Plus Network – You may choose any provider you'd like to see in the UHC Choice Plus Network, without a referral, for a lower cost than an out-of-network provider.

Out-of-Network – Members with this tier available will pay the most when seeing an out-of-network provider.

Open Acces – Open Access allows you the freedom to see any provider with a built-in price protection.

** Some network tiers might not be available based on the plan selected. As a reminder, there is no out-of-network coverage for the EPO Basic plan except for emergencies.*

Medical Plans Excluded Facilities and Providers

- No coverage will be offered at the Northwest Texas Healthcare System (TX) or Presbyterian Health Services (NM), except for emergency, mental health, and alcohol/ drug treatment.
- No coverage will be offered at the Ascension St. John (OK) except for emergency, mental health, alcohol/ drug treatment, and Colorectal services.
- No coverage will be offered at the St. Francis Health System (OK) except for emergency, mental health, alcohol/ drug treatment, and pediatric services (for members under age 17).
- No coverage will be offered at Akumin Amarillo/ Preferred Imaging (TX).
- No coverage will be offered at CHRISTUS Trinity Mother Frances Health System except for emergency and NICU services for newborns under 34 weeks. Services at Texas Spine and Joint will be covered as out-of-network (based on the plan selected), except for emergency services and Ear, Nose & Throat (ENT) procedures.

What is an Exclusive Provider Organization (EPO) plan?

An EPO plan offers members in-network coverage only. Therefore, in this plan, no coverage will be available for out-of-network providers. For emergency care you are covered no matter where your providers are — in or out of network. The plan does not require referrals from your primary care physician. This plan has copays, coinsurance and deductibles.

Since EPO members are only covered for services received from in-network providers, it's important for you to know which providers are in-network. Visit www.ardentcarecoordinators.com or call Quantum at 888-295-9299 to find in-network providers.

What is a Preferred Provider Organization (PPO) Plan?

A PPO is a type of health insurance plan that provides maximum benefits if you visit an in-network physician or provider, but still provides coverage for out-of-network providers. With a PPO plan, you can see any doctor or specialist you want without seeing your primary care physician first to get a referral. A PPO plan is a traditional plan with copays, coinsurance and deductibles.

What is a High Deductible Health Plan (HDHP)?

High Deductible Health Plans (HDHPs) are characterized by lower premiums and higher deductibles than traditional health plans. Being covered by an HDHP allows you to enroll in a health savings account (HSA). In this plan, you would be responsible for paying 100% of the services you use (except for in-network preventive services, which are covered at no charge to you) until you reach your deductible, but this gives you the benefit of controlling the quality and how much you spend on the respective service. You may use your HSA funds to pay for eligible medical expenses. Ardent matches your contributions to your HSA (up to $500 for individuals; $1,000 for all other tiers).

What is an Open Access Plan (OAP) with value-based pricing?

Open Access Plans offer similar benefits to PPO plans. This plan does not require a referral from your primary care physician and has copays, coinsurance and deductibles. In this plan, you have the freedom to see any provider that you choose, and the out-of-pocket cost is determined by the tier in which the healthcare provider is included.

What is Value-Based Pricing?

Value-based pricing is a health plan strategy where the health plan sets a ceiling on the amount it will cover for a procedure rather than having the provider determine the cost. After a healthcare service, the claim is processed, and providers will be sent an adjusted reimbursement with an explanation. Most of the time, providers accept the plan's payment.

How does Value-Based Pricing work?

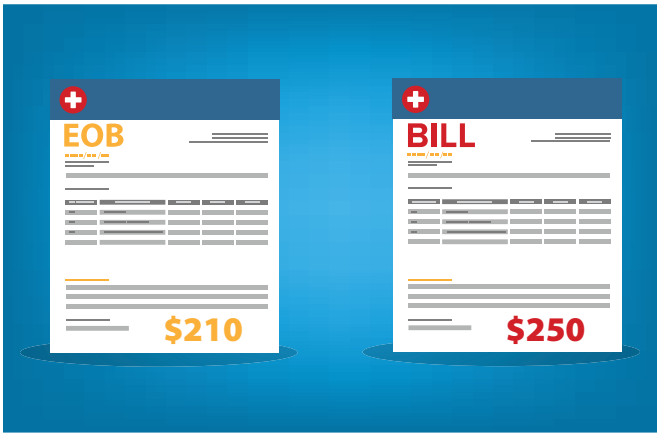
The cost for the same procedure can vary by provider or facility. For example, the cost of an MRI might range between $900 to $5,000 or more. However, the quality of the procedure and care provided is basically the same. Value-based pricing eliminates the difference in pricing by reimbursing set amount, which ensures that patients receive quality care at a more affordable cost, while paying the providers a fair payment for their services.

In the Open Access Plan with value-based pricing, you have access to the Ardent Network You can also select contracted providers through Partners Direct Health (PDH) and have the freedom to see any other provider with built-in price protection. Your medical claims will be reviewed to make sure you only pay what's fair and reasonable. While some providers may receive a payment lower than what they billed, most accept the plan's payment.

Occasionally, your provider might bill you for more than the out-of-pocket responsibility listed on your Explanation of Benefits (EOB). This is called a balance bill. If you receive a balance bill, you will need to notify Quantum Health so they can work with the provider to resolve the issue on your behalf.

Here's how to identify a balance bill

After receiving medical care, you will first receive an EOB from your health plan and then a bill from your provider sent by the doctor or health facility. Compare the "amount you owe" on the EOB to the provider bill. If the amounts listed don't match, you have a balance bill. If you receive one, call Quantum right away so they can work on your behalf to resolve it with the provider.



What happens once Quantum is notified about a balance bill?

If you receive a balance bill, contact Quantum right away. With your permission, they'll begin working to resolve the claim with the provider on your behalf. A dedicated advocate will manage provider communications and keep you updated throughout the process. Free legal support is provided, if needed.

Watch a short video on price protection and the important role you play.

Will I receive new ID cards?

All employees enroll in a plan medical plan ID cards will be mailed new ID cards in late December.

Who is Quantum Health and what do they do?

Quantum Health is the industry-leading healthcare navigation and care coordination company.

Quantum helps Ardent team members, and their family members navigate their health insurance plans, as well as the cost and complexity of healthcare. They work with healthcare providers and third-party medical plan administrators to make sure our members get the best care for the best cost, and that medical claims are paid correctly.

Quantum Health can also help members with any other benefits, such as dental, vision, life and disability insurance. Ardent partners with Quantum Health to provide you with one place to start when you need help with healthcare or benefits.

Who are the Quantum care coordinators?

Care coordinators are your personal team of nurses and benefits experts working with you and your providers to make your care simpler and more affordable. When you need help finding a provider in your network, solving a claims issue, learning about your benefits, and anything that can make your healthcare easier, your Quantum Health care coordinators are the ones to contact.

What can care coordinators help with?

Quantum Health care coordinators can help you with anything related to your healthcare and benefits. Whether you have a question about your claims or bills, need help knowing what's covered under your health plan, can't remember who administers your disability plan, want to prepare for an upcoming doctor's visit, or just need a new ID card, care coordinators are here for you. No question is too big or too small.

Can Quantum Health explain my medical bill?

The care coordinators are experts at explaining benefits and helping you understand even the most complex medical bills. If something is wrong on your bill, they will help you fix it.

How do I contact my care coordinators?

Your medical plan ID card lists the contact information for you along with the contact information if your healthcare provider needs to reach them. But you can visit www.ardentcarecoordinators.com or call Quantum at Quantum at 888-295-9299.

Dental & Vision Plans

What is the difference between the dental plans?

We offer two dental plans that cover routine checkups and other dental care: the Gold and Silver plans. The Gold plan includes orthodontia coverage in addition to everything offered within the Silver plan and provides more coverage for basic and major dental services. Employee contributions are higher for the Gold plan.

Through the vision plan, are covered members able to purchase eyeglasses and contacts or can they only choose one or the other?

Enrollees may choose lenses (contacts or lenses for frames) each year; you cannot have both eyeglasses (lenses and frames) and contacts covered under the plan during the same plan year.

Will I receive new ID cards?

You will receive a new 2025 dental ID Card. ID cards are not required to use your vision benefits. Simply advise your provider that you have VSP, and they will verify your eligibility.

How do I find out which providers are in the VSP network?

To locate a VSP vision provider in your area, call VSP at 800-877-7195 or visit www.vsp.com.

Health Savings Account (HSA)

What is a Health Savings Account (HSA)?

HSAs are individually owned accounts that allow you to set aside pre-tax dollars for qualified medical expenses. Interest or dividends accumulate tax-free, and payment of qualified medical expenses has no additional tax consequences. To open an HSA, you must be enrolled in the High Deductible Health Plan (HDHP). Use the money in your HSA to pay for the plan's deductible, co-insurance and other non-covered eligible expenses. Even after you no longer have HDHP coverage, your account remains active, and you can use the remaining balance for qualified medical expenses, but you can no longer make contributions. The assets in the HSA account always belong to you. Funds remain in the account from year to year unless they are used.

Can I enroll in the HSA with the EPO, OAP or PPO Premier Plans?

No. You can only enroll in the HSA if you are enrolled in the HDHP plan.

Who can open an HSA and who is eligible?

To be eligible you:

- Must participate in a qualifying high deductible health plan;
- Cannot participate in another health plan that is not a qualifying HDHP, such as your spouse's plan, or a Health Care Flexible Spending Account (FSA), but you can participate in a Limited-Purpose FSA for vision and dental expenses only;
- Can't be enrolled in Medicare;
- Can't be eligible to be claimed as a dependent on someone else's tax return.

How does an HSA work?

An HSA is a lot like a checking account. The combination of an HSA and HDHP plan may give you more control over managing your day-to-day expenses than a traditional health plan. To make the most of your HSA, you need to know which expenses are eligible for payment or reimbursement from your HSA. Ardent will deposit the matching contributions to your Ardent HSA (the amount depends on whether you are enrolled in the individual or another coverage tier) after the first pay period of the calendar year.

How much can I contribute to an HSA? Can I make changes during the year?

In 2025, employees can contribute up to the IRS limit of $4,300 to an HSA if they elect individual coverage, and up to $8,550 for all other coverage levels. These limits include both the employee's and Ardent's contributions. If you are age 55+, you can contribute an extra $1,000. You can make changes to your pre-tax contributions at any time during the year. The changes will be effective as soon as administratively possible after you request them.

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What happens if I don't use all the money in my HSA?

One of the best advantages of the HSA is that the funds in your account are yours—you do not lose them at the end of the year if you have not used them. If you leave the company, your HSA is yours to take with you.

How do I pay or get reimbursed for qualified medical expenses from my HSA?

The debit card is the quick and easy way to pay for eligible health care expenses using your Via Benefits health care benefit account(s). This debit card lets you pay eligible health care expenses directly from your HSA—just swipe and go. You can also submit a claim to be reimbursed from your account or to have your provider paid directly from your account.

Flexible Spending Accounts (FSA)

What are the differences in the FSA types that Ardent offers?

Ardent offers three different types of Flexible Spending Accounts (FSA): the Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA.

A **Dependent Care FSA** can be used for eligible dependent day care expenses incurred for a qualifying dependent up to the age of 13. You can also use a **Dependent Care FSA** for elderly day care or care of any other dependent who is physically or mentally incapable of self-care. The adult dependent must be your tax-qualified dependent and must live with you and require care while you work. You must claim these dependents as deductions on your federal tax return for the expenses to be eligible.

The **Health Care FSA** can be used for eligible medical, pharmacy, dental and vision expenses. If employees elect the HDHP and open an HSA, IRS regulations prohibit them from participating in a Health Care FSA. However, employees can participate in a **Limited-Purpose Flexible Spending Account (LPFSA)**, where employee contributions are still tax-free, but reimbursements are limited to eligible dental and vision expenses only.

You must make a separate election for each FSA that you enroll in. You cannot use funds from your Health Care FSA to pay for dependent day care expenses or use funds from your Dependent Care FSA to pay for medical expenses.

What is the maximum amount that I can contribute to an FSA each year?

Health Care FSA – you may set aside up to $3,200 per year to pay for eligible out-of-pocket. Not available if enrolled in an HDHP.

Limited-Purpose FSA – you may set aside up to $3,200 per year to pay for eligible expenses only. This is available only to employees enrolled in the HDHP.

Dependent Care FSA – you may set aside up to $5,000 per year used to pay for eligible expenses.

Notice for Highly Compensated Employees

The Dependent Care Flexible Spending Account (DCFSA) offered to employees by Ardent is subject to requirements imposed by §129 of the Internal Revenue Code (Code).

For Ardent to provide our employees with the tax-advantaged benefits offered under the program, the DCFSA must not discriminate in favor of "Highly Compensated Employees" (as defined under the Code), either in terms of eligibility to participate, contributions, or benefits under the program. You are classified as a Highly Compensated Employee for the 2025 plan year if your total compensation was at least $155,000 in 2024.

We have determined that a cap limiting the maximum election amount for Highly Compensated Employees is required in 2025 for the plan to continue to qualify to provide tax-advantaged benefits. Therefore, Highly Compensated Employees' DCFSA elections will be capped at $1,600 for the 2025 plan year.

Short-Term Disability (STD)

What is short-term disability insurance?

Short Term Disability (STD) benefits can pay a portion of your income if you cannot work for several weeks due to a covered non-job-related injury or illness. Injuries that happen while you are on the clock will typically be covered by workers' compensation, rather than short-term disability.

The disability benefits may be reduced if you are receiving any type of employer paid leave. This means disability benefits will be offset if you are receiving EIL, EIB or Salary Continuation payments. Certain exclusions, along with pre-existing condition limitations, apply. Please refer to the Summary Plan Description for details.

What is a pre-existing condition?

A pre-existing condition is a condition for which an employee received treatment prior to the effective date of the STD coverage.

What is an elimination period?

The waiting period before payments can begin from a disability insurance policy is known as the elimination period. Once the elimination period has elapsed, then you will begin receiving benefits, assuming that you meet the policy's definition of partial or total disability.

How much will my benefit be?

The amount of your benefit is dependent on your pre-disability earnings and the benefit percent allowed by the policy.

Long-Term Disability (LTD)

What is Long Term Disability insurance?

Long-Term Disability (LTD) Insurance pays a benefit if you become ill or injured and are unable to work for an extended period of time. If you become ill or injured, the LTD plan pays benefits after you met the waiting period and your claim is approved. You receive a percentage of your salary up to a monthly maximum.

Coverage continues until you are no longer disabled, as defined by the contract, or you reach your Social Security normal retirement age.

Eligible employees are automatically covered at no cost under the company-provided LTD plan. Some employees may be eligible to purchase optional LTD insurance.

Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to your Summary Plan Description for details.

Voluntary Benefits

Hospital Indemnity

What is Hospital Indemnity Insurance (previously Hospital Care Insurance)?

Hospital indemnity insurance provides a payout for planned or unplanned hospital stays. This includes newborn routine stay, inpatient mental health disorder stays, or outpatient mental health/substance use diagnostic screening.

We offer two plan options though Securian. You can select the benefit coverage based on your individual needs. Hospital Indemnity benefits are paid directly to the covered person, regardless of other coverage, and can be used for any purpose.

Support for your parenthood journey

Adding to your family is joyful and exciting. It can also be challenging to navigate. **BenefitBump** is here to support you along your parenthood journey. Services through BenefitBump are available when you enrolled in hospital indemnity insurance.

This service provides holistic support to help you navigate your benefits and time-off programs as you grow your family.

It provides support at every step — from pregnancy or adoption to delivery or placement, parental leave, childcare, return to work and more.

Here's how BenefitBump works:

- **Registration** – You can sign up with BenefitBump by visiting mybenefitbump.com, and get started with the program.
- **Your own Care Navigator** – Your main contact is an emotional health professional trained in employer benefits. Think of your Care Navigator as one-part project manager, one-part confidant. Your Care Navigator will be with you through every step of your parenthood journey, prioritizing your well-being along the way.
- **24/7 digital tools** – BenefitBump's website and mobile app help you stay on top of the important to-dos of your parenthood journey with timely reminders and a helpful checklist designed for your path to parenthood. More than that, BenefitBump's digital tools house a whole library of educational resources.

Accident Insurance

What is Accident Insurance?

Accident insurance covers accidental injuries and resulting treatments. Examples of covered accidents include burns, organized sports injuries, fractures and more.

Accident insurance provides a lump-sum cash payment after an accident to help you with expenses such as copays, deductible or everyday living expenses.

You will also receive an additional 25% benefit if the treatment for the accident is received at an Ardent facility.

With accident insurance you can also take advantage of Securian's health and wellness benefit. Get $50 for several types of wellness screenings, including an annual physical exam, cancer screening and mammogram.

Critical Illness Insurance

What is Critical Illness Insurance?

Critical illness insurance provides a benefit payment after diagnosis of a covered condition. Examples of critical illness include infertility, cancer, heart attack, stroke, COVID-19 and more.

We offer three plan options, and you can select the benefit coverage based on your individual needs. The Critical illness policy will pay a cash lump sum for qualified critical illnesses. The cash benefit is based on the percentage payable for the condition. The benefit is paid in addition to other insurance you may have, and benefits are paid directly to you.

Infertility - This is a new benefit addition for 2025 under the critical illness plan for Ardent employees. It provides a one-time 25% benefit if you have the inability to achieve pregnancy after one year or longer of attempting.

To receive the infertility benefit you must:

- Be between the ages of 18 to 50
- Undergo a diagnostic procedure that affirms the underlying cause of infertility
- Not transitioned through menopause or had a voluntary procedure resulting in inability to conceive (vasectomy, tubal ligation, hysterectomy, etc.)

The diagnostic procedures include:

- Diagnostic laparoscopy
- Endometrial biopsy
- Hamster egg penetration assay
- Hormone evaluation
- Huhner's test
- Hysterosalpingogram
- Hysteroscopy
- Imaging related to reproductive testing
- Laparoscopy
- Ovarian reserve testing
- Semen analysis or
- Testicular biopsy

Carrot

How does Carrot work?

Carrot to provide employees personalized support for a variety of benefits at no cost to you.

Get support with:

- Perimenopause and menopause
- Low Testosterone (low T)
- Pregnancy and postpartum
- Infant care and parenting

Through Carrot, you'll get:

- ✓ Personalized advice from Carrot Experts to help you make the most of your benefit
- ✓ A Carrot Plan — customized next steps to help you move forward, at no cost to you
- ✓ Unlimited, free video chats with medical experts and specialists
- ✓ Help finding providers near you
- ✓ Exclusive partnerships and discounts
- ✓ Expert-produced educational resources

Legal Plan

How does the MetLife Legal Plan work?

The MetLife Legal Plan provides you and your eligible dependents with services from attorneys experienced in estate planning documents, civil suits, adoption, identity theft issues, and much more.

You simply choose an attorney in any specialized area of practice from the MetLife Legal network, which is available online or by calling the MetLife Client Service Center. MetLife Legal plan will then give you an assigned case number to share with your attorney when you make an appointment.

You can speak to MetLife Network Attorneys face-to-face or by phone, or you can submit questions online to Law Firm E-Panel®. For certain legal matters, your attorney can represent you in court without you having to make an appearance. MetLife Legal Network attorneys can provide advice on any personal legal matter or representation on a number of legal services covered under your plan.

Can I get help finding the right attorney for my needs?

Yes. MetLife Legal Client Service Center representatives can help you find the right attorney to help you with your legal matter.

Are my spouse/domestic partner and children also covered on my Legal Plan?

Yes. Your spouse/domestic partner and dependent children are covered under the plan.

Identity Theft Plan

How does the ID WatchDog Identity Theft plan work?

ID Watchdog helps warn you when your personal information is stolen and helps you better protect yourself and your family from identity fraud when stolen information is used for illicit gain. You'll have greater peace of mind knowing you don't have to face the complexities of identity theft alone.

Why choose ID WatchDog?

- ID Watchdog's identity monitoring scours billions of public records to search for activity, which if unexpected, could be a sign of potential identity theft.
- Monitors your credit report from all three nationwide credit bureaus and alerts you if there are key changes to your credit report(s) and activities to your bank accounts and credit cards, which, if unexpected, could be a sign of potential fraud.
- Includes subprime loan monitoring to alert you, when easy-to-obtain loans, like payday loans are opened in your name, which could indicate possible identity theft.
- Monitors the dark web for your personal information, scanning websites, chat rooms and other forums known for trafficking stolen personal and financial information.
- Checks the USPS National Change of Address Registry to help you detect the rerouting of your mail to a new address in case it was done without your knowledge.
- Offers lock features that prevent access to your credit report with certain exceptions. Since potential creditors can't check your credit report, a lock helps better protect against identity thieves from opening new accounts in your name.

Can I cover my family on my Identity Theft plan?

Yes. Your family can be covered under the plan.

Need help enrolling or have questions about your benefits?

Contact the Ardent Benefits Service Center at 855-787-0668, Monday to Friday from 8 a.m. to 6 p.m. CST.

** These frequently asked questions (FAQs) and answers are provided for general informational purposes only. To the extent these FAQs contradict the terms of the official plan documents, the terms of the official plan documents control. Ardent reserves the right to amend or terminate the Plan, in whole or in part (and to revise these FAQs), at any time.*