Ardent[SM] HEALTH SERVICES

# Annual Enrollment for 2024 FAQs*

## When is Annual Enrollment?

Annual Enrollment for the 2024 plan year will be Monday, October 30 through Friday, November 17, 2023 (website closes at midnight CT).

## Do I need to enroll for 2024?

YES, this year is an active enrollment, which means your benefit elections from last year will not roll over to 2024.

All employees must enroll by November 17 to get benefits like medical, dental or vision coverage, or spending accounts for 2024—even if you do not plan to make changes to your benefit elections. ***If you do not choose, you will lose your coverage.***

We encourage you to visit the Ardent Benefits Portal. There, you will be able to compare your choices and make your elections for 2024. 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.

## Are there any benefits changes for 2024?

Yes, there are some changes for 2024:

- **The NEW medical plan**
  In 2024 we are adding an Open Access Plan (OAP) with value-based pricing. Visit the Ardent Benefits Portal to see the plans available to you.

- **Quantum Health**
  When you enroll in one of the Ardent medical plans, you will automatically be enrolled in the Quantum Health program—at no cost to you. You will have a personal team of care coordinators with nurses, benefit experts and claims specialists ready to support all your healthcare needs.

- **New dental carrier**
  Ameritas is our new dental carrier with a national network of dentists. Two plan options are available for 2024 coverage.

- **Increase to HDHP deductibles**
  The HDHP deductibles in the Ardent Network tier will be increasing to $1,600 for individuals and $3,200 for families per IRS rules.

- **Increase to IRS maximum contribution limits to the HSA**
  The IRS is increasing the 2024 HSA contribution limit for an individual with self-coverage to $4,150 and $8,300 for family coverage. Ardent contributions count toward this maximum.

- **Life and Disability Insurance Harmonization**
  For 2024, all employees will be under the same life and disability policies. For changes and rates visit the Ardent Benefits Portal.

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

**If you're based in Nashville or you're a remote employee, this change doesn't apply to you.*

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# ENROLLMENT

### What information do I need to enroll?

You will need information for any eligible dependents that you wish to add for 2024. You will need to have on hand your new dependent's full name, Social Security number and date of birth. You must verify your ***newly added*** dependents by submitting the required documentation. Instructions will be sent to you from the Ardent Benefit Service Center. You do not have to re-verify dependents who were enrolled for 2023.

### 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 17, 2023, IRS regulations require you to keep your elections through December 31, 2024, 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 17, 2023, 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, 2024, and will remain in effect for the 2024 plan year (which ends on 12/31/24) 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.

# MEDICAL & PRESCRIPTION DRUG PLANS

### How many health plan options do we have?

Ardent offers several medical plan 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

For more details, please review the 2024 Benefits Guide and Summary of Benefits and Coverage available online at **www.getardentbenefits.com/enroll**.

**The EPO plan is only available for Nashville based or remote employees. Refer to the Ardent Benefits Portal to determine which plans are available to you.*

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

During annual enrollment, you can contact UMR's specialized team of Plan Advisors at 866-675-1610 on weekdays, 7 a.m. – 7 p.m. CT. They can answer medical plan questions, including whether a provider is in the Ardent Network or the UHC Choice Plus Network.

Ardent offers employees the best costs at our facilities and providers. Employees pay the least when they see Ardent Network providers. In addition, here are some plan specifics to keep in mind:

- If you enroll in the PPO, EPO or HDHP plans, click here to search the United Healthcare Choice Plus Network and the Ardent Network.
- If you enroll in the Open Access plan with value-based pricing, you'll have access to the Ardent Network. You can also select contracted providers through Partners Direct Health (PDH) and have the freedom to see any provider with built-in price protection (i.e., value-based pricing). To search PDH providers, you can visit providers.partnersdirecthealth.com. Enter your zip code to begin your search.

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

- No coverage will be offered at the Northwest Texas 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).

## What are the different network tiers?

**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:** You'll pay the most when seeing an out-of-network provider.

**Open Access:** Allows you the freedom to see any provider with built-in price protection.

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

## 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 a referrals from your primary care physician. This plan has copay, coinsurance and deductibles.

This plan offers two network tier: *The Ardent Network* and the *UHC Choice Plus Network*.

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. To find participating in-network providers visit www.umr.com. UMR plan advisors are available at 866-675-1610, weekdays from 7 a.m. to 7 p.m. CST.

## 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.

This plan offers three network tiers: *The Ardent Network, UHC Choice Plus Network*, and *Out-of-Network*.

## 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). This plan offers three network tiers: *The Ardent Network, UHC Choice Plus Network*, and *Out-of-Network*.

## 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. This plan offers two network tiers: *The Ardent Network* and *Open Access.*

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## 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?

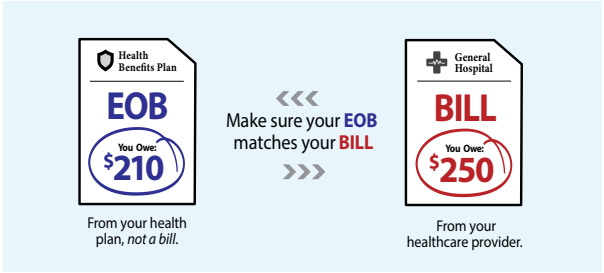
The cost for the same procedure can vary by provider or facility. For example, the cost of an MRI might range between $900 to $5,000 or more. However, the quality of the procedure and care provided is basically the same. Value-based pricing eliminates the difference in pricing with a set amount and ensures 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 enrolled employees will receive a new 2024 ID card to use for medical and pharmacy benefits. New cards will be mailed in late December to your home address currently on file in the payroll system.

## Who is Quantum Health and what do they do?

Quantum Health is the industry-leading healthcare navigation and care coordination company. Quantum helps employees 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 care coordinators are the ones to contact.

## What can care coordinators help with?

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.

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### 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.

# 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 High and Low plans. The High plan includes orthodontia coverage in addition to everything offered within the Low plan and provides more coverage for basic and major dental services. Employee contributions are higher for the High plan.

### How do I find out which providers are in the Ameritas networks?

During Annual Enrollment you can call **877-313-0033** (Available Oct. 1 - Dec. 31, 7:00 am – Midnight, CT) if you have questions regarding the plans or if you need help finding a provider. After annual enrollment, you can find participating dental providers at **www.ameritas.com** or call 800-487-5553.

### 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 2024 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 ACCOUNTS (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.

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

In 2024, employees can contribute up to the IRS limit of $4,150 to an HSA if they elect individual coverage, and up to $8,300 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.

### 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 a FSA each year?

In 2024, an individual's pre-tax contributions to the Health Care FSA are limited (by federal law) to $3,050 per year. The Dependent Care FSA contributions remain capped at $5,000 per year maximum.

### For Health Care Flexible Spending Accounts (FSAs), does the $3,050 limit apply to a husband and wife jointly, or can they each defer $3,050 under each of their plans?

The limit is per individual, so each working spouse could elect up to $3,050 per year if both of their employers offer this type of account.

## SHORT-TERM DISABILITY (STD)

### What is short-term disability insurance?

Short Term Disability 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.

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### 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.

# CRITICAL ILLNESS

### What is critical illness insurance?

Cigna's Critical Illness insurance can help provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered critical illness. Cigna Critical Illness insurance pays you, or whomever you designate, a lump-sum benefit for diagnosis of a covered critical illness or specified event such as a heart attack, stroke, invasive cancer, coma paralysis and more.

Your Cigna Critical Illness insurance plan comes with a Wellness Incentive benefit. This benefit is paid for each covered person who completes at least one wellness treatment, health screening or preventive care service. The benefit is limited to one per year per covered person. Review the plan materials for information about this coverage.

# HOSPITAL CARE

### What is Hospital Care Insurance?

Cigna's Hospital Care Insurance is supplemental coverage that pays you benefits if you are hospitalized.

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

# 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, 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.

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# 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.

### How does identity theft happen, and how can ID Watchdog help?

There are numerous ways identity theft can occur. For instance, a cyber criminal could trick you into giving up your personal information through a convincing email or fake website, gain access to your information through a data breach, or purchase your stolen information on the dark web.

- 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 Benefit Service Center at 855-787-0668, Monday to Friday from 8:00 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.*