2026 ANNUAL ENROLLMENT

FAQs

Ardent Health

Table of contents

Table of contents

Choose well, live well

When is annual enrollment?

Annual enrollment for the 2026 plan year will be Monday, Nov. 3 through Friday, Nov. 21, 2025 (website closes at midnight CT).

Do I need to enroll for 2026?

Yes, annual enrollment is active this year. That means you are required to elect your benefits Nov. 3–21 if you want coverage for 2026, even if you don't plan to make any changes. Your **2025 elections will not roll over automatically**. If you don't enroll, you and your dependents will not have medical, dental or vision coverage, or spending accounts, through Ardent in 2026.

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 2026. You will also be able to view the Benefits Guide, medical plan comparison charts, FAQs and plan documents.

Are the team member premiums changing?

Bi-weekly medical plan contribution rates for **part-time** team members will increase by approximately 25%. This helps ensure Ardent can continue offering coverage options that support the needs of you and any dependents, while also aligning more closely with current market standards.

Many other team member premiums are not changing. Plan costs will be displayed when you make your selections online.

Important changes for 2026

Medical (changes only for team members who live within 50 miles of an Ardent hospital)

- We are moving to value-based pricing (VBP) for all medical plans. This approach places a ceiling on the amount covered, rather than having the provider determine the cost.
- Some networks will no longer be available. Providers and facilities that aren't part of the network will be subject to the VBP model.

Prescription drug

- EmpiRx Health is replacing OptumRx as our pharmacy benefits manager. Your prescriptions may be subject to new criteria, such as prior authorization or other requirements for specialty medications. You'll receive additional information if you're impacted; be sure to engage with the vendor and complete the next steps the vendor requests so there's no disruption to your care.
- You will receive a new ID card, combined for medical and pharmacy.

Life and accidental death and dismemberment (AD&D) insurance

- Securian Financial is replacing New York Life as our life and AD&D insurance vendor.
- For 2026 annual enrollment only, Evidence of Insurability (EOI, or proof of good health) is waived for optional life insurance. This means you can enroll or increase coverage up to the guaranteed limit ($500,000) for yourself, and enroll or add one $5,000 increment of coverage up to the guaranteed limit ($100,000) for your spouse or domestic partner.

Increases to flexible spending account (FSA) and health savings account (HSA) contribution limits

- Dependent Care FSA: $7,500 ($1,800 for highly-compensated employees)
- HSA (available if you enroll in the high deductible health plan): $4,400 for self coverage and $8,750 for any other coverage level (combined for both you and Ardent)

Details can be found in the Benefits Guide online at **getardentbenefits.com**

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 **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 2026. 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 2025.

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 **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 **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 Nov. 21, 2025, IRS regulations require you to keep your elections through Dec. 31, 2026, 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 Nov. 21, 2025, 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 Jan. 1, 2026, and will remain in effect for the 2026 plan year (which ends on 12/31/26) 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 end on your termination date.

Who 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 plans from which to choose. Eligibility is assigned based on the proximity of your home address to an Ardent hospital.

	High Deductible Health Plan	PPO Premier Plan	EPO Basic Plan	OAP Open Access Plan
If you live within 50 miles of an Ardent hospital and are within the UT Health East Texas Market	x	x		x
If you live within 50 miles of an Ardent hospital but are not in the UT Health East Texas market	x	x		x
If you live 50 miles or more away from an Ardent hospital	x	x	x	

What are the different networks?

If you live within 50 miles of an Ardent hospital and are within the UT Health East Texas Market

- **Ardent Network:** The Ardent Network is made up of facilities and providers that are part of our company. Your out-of-pocket costs for care are lowest when you see Ardent Network providers.
- **Access Direct Platinum Network:** The Access Direct Platinum Network offers a choice of providers and facilities and covers nine counties: Smith, Cherokee, Rush, Panola, Henderson, Van Zandt, Wood, Camp, and Gregg. Certain services not available at UT Health can be covered at Children's Medical Center or UT Southwestern.
- **Open Access Network:** The Open Access Network gives you flexibility to see any provider with built-in price protection through value-based pricing. (Read more about value-based pricing on the following pages.)

If you live within 50 miles of an Ardent hospital but are not in the UT Health East Texas market

- **Ardent Network:** The Ardent Network is made up of facilities and providers that are part of our company. Your out-of-pocket costs for care are lowest when you see Ardent Network providers.
- **Open Access Network:** The Open Access Network gives you flexibility to see any provider with built-in price protection through value-based pricing. (Read more about value-based pricing on the following pages.)

If you live 50 miles or more away from an Ardent hospital

- **Choice Plus Network:** The Choice Plus Network is a national UnitedHealthcare network available to you because you don't have access to Ardent providers and facilities or other local networks. Your out-of-pocket costs for care are lowest when you use this network.
- **Out-of-Network:** If you enroll in the HDHP or PPO Premier Plan, you can see providers outside of the Choice Plus Network, but your out-of-pocket costs will be higher. If you enroll in the EPO Basic Plan, out-of-network care is not available, except for emergency services.

Is coverage excluded at any facility?

Yes, coverage is excluded at the following locations:

- Northwest Texas Healthcare System (TX) except for emergency, mental health and alcohol/drug treatment.
- Presbyterian Health Services (NM) except for emergency, mental health and alcohol/drug treatment.
- Ascension St. John (OK) except for emergency, mental health, alcohol/drug treatment, and colorectal services.
- St. Francis Health System (OK) except for emergency, mental health, alcohol/drug treatment and pediatric services (for members under age 17).
- Akumin Amarillo/Preferred Imaging (TX).
- CHRISTUS Trinity Mother Frances Health System except for emergency services.
- Texas Spine and Joint except for emergency services and Ear, Nose & Throat (ENT) procedures.

What is a High Deductible Health Plan?

A High Deductible Health Plan (HDHP) has lower premiums in exchange for higher deductibles. With the exception of certain preventive services which are covered at 100%, when you receive care, you pay all costs up to the deductible. Then you and the plan share costs through coinsurance. You have the freedom to see any provider you wish—no referral required—but you'll pay less out of pocket when you use in-network providers.

If you elect the HDHP, you can enroll in a Health Savings Account (HSA) to pay for eligible health care expenses with tax-free dollars. Ardent matches your HSA contribution—up to $500 for individual coverage and up to $1,000 for all other coverage levels.

What is a PPO Plan?

A Preferred Provider Organization—or PPO—Plan has higher premiums in exchange for lower deductibles. With the exception of certain preventive services which are covered at 100%, when you receive care, you either pay a flat copay or you pay all costs up to the deductible (depending on the type of services you receive). After you meet the deductible, you and the plan share costs through coinsurance. You have the freedom to see any provider you wish—no referral required—but you'll pay less out of pocket when you use in-network providers.

What is an EPO Plan?

An Exclusive Provider Organization—or EPO—Plan covers in-network services only. Out-of-network care is not covered, unless it's an emergency. With the exception of certain preventive services which are covered at 100%, when you receive care, you either pay a flat copay or you pay all costs up to the deductible (depending on the type of services you receive). After you meet the deductible, you and the plan share costs through coinsurance.

With an EPO Plan, it's especially important to know which providers are in-network, since services received from out-of-network providers aren't covered. Quantum Health can help you find in-network providers.

Visit **ardentcarecoordinators.com** or call **888-295-9299** for help finding network providers.

What is an OAP Open Access Plan?

An OAP Open Access Plan has a similar structure to a PPO Plan. With the exception of certain preventive services which are covered at 100%, when you receive care, you either pay a flat copay or you pay all costs up to the deductible (depending on the type of services you receive). After you meet the deductible, you and the plan share costs through coinsurance. You have the freedom to see any provider you wish—no referral required—but you'll pay less out of pocket when you use in-network providers.

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 a set amount. This ensures that patients receive quality care at a more affordable cost, while paying the providers a fair payment for their services.

With value-based pricing, you have the freedom to see any 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.

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

Will I receive new ID cards?

All team members enrolled in an Ardent medical plan will receive new ID cards, combined for both your medical and pharmacy benefits.

Quantum Health

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 dependents 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.

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.

How can care coordinators help?

Quantum Health care coordinators can help you with anything related to your medical 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 to resolve the issue.

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 **ardentcarecoordinators.com** or call Quantum at Quantum at **888-295-9299**.

More about the transition to EmpiRx Health for prescription drugs

Will I have to change my pharmacy?

EmpiRx Health partners with nearly all retail chains and most independent pharmacies. In most cases, that means you won't need to change your pharmacy.

I receive my maintenance medications by mail. Can I continue that through EmpiRx Health?

Yes, your valid prescription will transfer automatically to EmpiRx Health's mail-order pharmacy. Starting in January 2026, contact EmpiRx Health Member Services at **877-814-2303** to verify the transfer. You'll need to verify your mailing address and payment method. You can do this when you call member services or via the EmpiRx Health member portal.

Do I need a new prescription from my provider?

No, if you have refills remaining on a prescription, you don't need a new one.

What does this mean for my current medications?

EmpiRx Health is reviewing all current prescriptions to ensure they align with its clinical guidelines. In some cases, EmpiRx may contact you or your dependents by mail with recommendations—such as switching to a different medication (if yours isn't covered) or enrolling in a step therapy program. EmpiRx may also require **prior authorization** to continue your current medication. EmpiRx will work directly with your healthcare provider to support any suggested changes and ensure continuity of care. **Your provider will always have the final say in determining your treatment plan.** If a clinical review is appropriate for you and your provider agrees with EmpiRx's recommendations, any new EmpiRx requirements will start April 1, 2026.How do I check which tier my medication is in?

How do I check which tier my medication is in?

You can verify the tier (generic, preferred brand, non-preferred brand or specialty) for any medication by checking EmpiRx Health's **formulary list***. We expect most medications will remain in the same tier through EmpiRx as they were through Optum Rx. However, your doctor can often direct you to a lower-tier medication for your condition if your medication has moved to a higher tier.

*Note: This is the 2025 formulary list; it may be updated for 2026.

Is financial assistance available for my prescription?

Possibly. For certain non-specialty medications, EmpiRx Health partners with a company called Luna Health to obtain copay assistance from drug manufacturers, helping lower your out-of-pocket costs. If your medication is eligible, you'll receive a letter or call from Luna Health following your first fill in 2026.

I take a prescription specialty medication. What does the transition to EmpiRx Health mean for me?

Certain specialty medications have new coverage requirements beginning January 1, 2026.

EmpiRx Health partners with a company called Payer Matrix to help members obtain **defined specialty medications*** at little or no cost. If you take one of these medications, you will receive a letter from Payer Matrix in late November, followed by a phone call in early December. Payer Matrix will request certain financial information, such as a W-2 or paystub, so it can work with the drug manufacturer to access the maximum subsidy available for your prescription. **Important: If you receive a call or letter from Payer Matrix, it's critical that you review in detail and promptly follow the requested next steps. If you don't, your first fill after Jan. 1 will be denied at the pharmacy as not covered.**

*Note: This is the Q4 2025 specialty medications list; it may be updated for Q1 2026.

How can I learn more?

Watch your mail later this year for information from EmpiRx Health. Then, beginning in January, visit the EmpiRx Health **member portal** or download the EmpiRx Health app to access your digital ID card, find in-network pharmacies, review covered and preferred medications, compare drug pricing and find lower-cost alternatives, check prescription coverage and costs, check the status of a clinical review, update your shipping address for medications you receive by mail, request refills for mail-order prescriptions and more.

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. Your 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?

No, you won't receive new dental or vision ID cards for 2026.

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 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 if I choose a different medical plan?

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.

Who contributes to an HSA? How much?

You and Ardent both contribute to your HSA. In 2026 the IRS contribution limit is $4,400 if you elect individual coverage, and $8,750 for all other coverage levels. These limits include both your and Ardent's contributions. If you are age 55+, you can contribute an extra $1,000. Ardent deposits its matching contribution to your Ardent HSA after the first pay period of the calendar year. The amount depends on whether you enroll in individual coverage or another coverage level.

Can I change my HSA contribution during the year?

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 (DCFSA) 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 you elect the HDHP and open an HSA, IRS regulations prohibit you from participating in a Health Care FSA. However, you can participate in a Limited-Purpose Flexible Spending Account (LPFSA), where your 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 $3,300 per year to pay for eligible out-of-pocket expenses. The Health Care FSA is not available if you enroll in the HDHP.

Limited-Purpose FSA – you may set aside up to $3,300 per year to pay for eligible dental and vision expenses only. The Limited-Purpose FSA is only available if you enroll in the HDHP.

Dependent Care FSA – you may set aside up to $7,500 per year used to pay for eligible expenses.

Notice for Highly Compensated Employees

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

For Ardent to provide our team members 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 2026 plan year if your total compensation was at least $160,000 in 2025.

We have determined that a cap limiting the maximum election amount for Highly Compensated Employees is required in 2026 for the plan to continue to qualify to provide tax-advantaged benefits. Therefore, Highly Compensated Employees' DCFSA elections will be capped at $1,800 for the 2026 plan year.

Disability

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 a team member 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 team members 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 Insurance

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 enroll 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 you receive your treatment for the accident 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.

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. The 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 Legal 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.

What does ID WatchDog's identity monitoring do?

- 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 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.

Additional Programs

Carrot

How does Carrot work?

Carrot provides team members with personalized support for a variety of benefits, at no cost.

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

Need help enrolling or have questions about your benefits?

For medical questions:
Call a Quantum Health Care Coordinator at
888-295-9299, Monday to Friday from 7:30 a.m. to 9 p.m. CT.

For general benefits and enrollment questions:
Contact the Ardent Benefits Service Center at 855-787-0668,
Monday to Friday from 8 a.m. to 6 p.m. CT.

* 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,

Ardent Health