Group Benefit Plan of Roper St. Francis Healthcare

SUMMARY PLAN DESCRIPTION

Effective January 1, 2022

Contents

INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, Benefit Booklets), is intended to serve as the Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by Roper St. Francis Healthcare ("Roper St. Francis Healthcare" and/or "RSFH") through the Group Benefit Plan of Roper St. Francis Healthcare (the Plan) for eligible employees and their eligible dependents. This Plan is sponsored by Roper St. Francis Healthcare, but other employers participate in the Plan as well. Generally, all references to Roper St. Francis Healthcare throughout this SPD include Medical Society of South Carolina, as well as any other affiliated groups covered under the Plan.

Roper St. Francis Healthcare also provides employees Health Care, Limited Purpose Health Care and Dependent Care Flexible Spending Accounts and the opportunity to make pre-tax contributions toward certain benefits intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e).

Roper St. Francis Healthcare also offers employees enrolled in the high deductible health plan the option to make pre-tax contributions to a Health Savings Account. The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as Health Care Reform).

Notwithstanding any other provision in this SPD, Roper St. Francis Healthcare intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, Roper St. Francis Healthcare will modify this SPD accordingly and/or provide a Summary of Material Modifications.

Medical, Dental and EAP benefits, and the Flexible Spending Accounts are self-insured and provided under other contracts with service providers. All other benefits are provided under insurance or HMO contracts. All benefits are summarized in this document and in the Benefit Booklets (as defined below).

Medical plan participants may also be eligible to participate in Roper St. Francis Healthcare's wellness benefits. As part of a wellness program Roper St. Francis Healthcare may, from time to time, offer various activities and programs designed to promote wellness. If an employee and/or dependent is eligible to participate in the program, they may receive various incentives or enhanced coverages for doing so. Participation is strictly voluntary and programs may be discontinued or changed at any time.

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). The Benefit Booklets are provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will rule.

The applicable Benefit Booklets describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. An electronic link to a directory of participating network providers will be provided, automatically, at no cost to you. You may also access provider directories on the insurance companies' and HMOs' websites or you can call the insurance companies or HMOs at the phone numbers indicated in the Benefit Booklets. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified in the Administrative Information section.

Roper St. Francis Healthcare reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, Roper St. Francis Healthcare has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by Roper St. Francis Healthcare or to interfere with Roper St. Francis Healthcare's right to discharge any employee at any time.

ELIGIBILITY

ELIGIBILITY FOR BENEFITS

Generally, you are considered an "eligible employee" and are eligible to participate in the Medical (including wellness benefits), Dental, Vision, Flexible Spending Accounts, Health Savings Account, Critical Illness, and Accident benefits under the Plan on the first of the month following 30 days of continuous employment, and in the Short-Term Disability benefits under the Plan the first of the month following enrollment if enrollment occurs prior to the 15th of the month, or the first of the second month if enrollment occurs after that 15th of the month if you are:

- A regular full-time salaried or hourly employee of Roper St. Francis Healthcare regularly scheduled to work at least 20 hours-per-week or more.

- A regular full-time salaried or hourly employee of Roper St. Francis Healthcare who is regularly scheduled to work at least 32 hours-per-week is also eligible to participate in the Life, Supplemental Life and AD&D, Dependent Life, Long-Term Disability, and Permanent Life benefits beginning 90 days from their date of hire.

In the event you are an "eligible employee" as the result of a merger or acquisition, you will be eligible for the benefits upon your date of hire, if you were covered under the merged or acquired company's plan on the date immediately preceding the transaction date, or subject to the waiting periods described above, if you were not covered on the day immediately preceding the transaction date.

Individuals not eligible for Plan benefits

For all Plan benefits, you are not eligible to participate in the Plan if you are:

- regularly scheduled to work fewer than 20 hours-per-week,
- a seasonal or temporary employee,
- a leased employee,
- an independent contractor, or
- a member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

ADDITIONAL ELIGIBILITY FOR MEDICAL, FLEXIBLE SPENDING ACCOUNTS, AND HEALTH SAVINGS ACCOUNT BENEFITS (LOOKBACK METHOD)

If you do not meet the eligibility requirements described above (for example, if your hours vary and you are not regularly scheduled to work 20 hours per week, or you are a seasonal or temporary employee), you may still be eligible for Medical, Flexible Spending Accounts, and Health Savings Account benefits if you satisfy the eligibility standard described below.

You may be eligible for coverage during a particular plan year if you worked an average of 30 hours per week over the course of a measurement period (which is considered to be full-time under the Affordable Care Act) that takes place before the plan year begins. This is called the "Lookback Method"—Roper St. Francis Healthcare looks back at your prior service to determine whether you might be considered full-time and eligible for benefits coverage during the next plan year.

Refer to Appendix B for definitions of the capitalized terms in this section.

For Roper St. Francis Healthcare, the lookback method works like this. To determine whether you are eligible for Medical, Flexible Spending Accounts, and Health Savings Account benefits, Roper St. Francis Healthcare will measure your Hours of Service from October 20 of year 1 through October 19 of year 2. This October 20-October 19 timeframe is called the Standard Measurement Period. If you average at least 30 Hours of Service a week during the Standard Measurement Period, you will be eligible to participate in the Plan's Medical, Flexible Spending Accounts, and Health Savings Account benefits for the Standard Stability Period, which is the plan year beginning January 1st following the end of the Standard Measurement Period. You will be eligible for Medical, Flexible Spending Accounts, and Health Savings Account benefits for the entire Standard Stability Period, even if your hours or wages decrease during the Standard Stability Period, so long as you remain an employee and continue to make any required contributions toward your coverage. [1]

Here is an example of how this will work:

> *Ann has 1642 hours of service from October 20, 2020 through October 19, 2021, which is more than 30 Hours of Service a week on average during the Standard Measurement Period. She is therefore considered full-time for the Plan's Standard Stability Period, and will be eligible for the Plan's Medical*, *Flexible Spending Accounts, and Health Savings Account benefits from January 1, 2022 through December 31, 2022. She will be eligible in 2022 even if her work hours are reduced during 2022.*

In addition to using the traditional definition on the prior page, each year, Roper St. Francis Healthcare will calculate how many Hours of Service you have worked during the Standard Measurement Period and will inform you if you are eligible for Medical, Flexible Spending Accounts, and Health Savings Account benefits prior to the next Standard Stability Period.

If you experience a period of 13 consecutive weeks (or longer) without an Hour of Service—either because you terminate employment or are absent for some other reason—you will have a Break in Service and you will be treated as a New Employee to the extent permitted by law (see the rules that apply to New Employees below). The Plan Administrator may, in its discretion, determine that you have a Break in Service using an alternate "Rule of Parity." Refer to the definition of Break in Service in Appendix B for a description of the Rule of Parity.

[1] *There is one exception for an employee who moves to a new job position during the Standard Stability Period. If the employee has been continuously offered coverage meeting Minimum Value standards since early in his or her employment, and if a new employee hired into the new job position would be classified as a New Part-Time Employee, Roper St. Francis Healthcare may measure the employee's Hours of Service monthly. This may result in a loss of eligibility. You will be informed by Roper St. Francis Healthcare if this applies to you.*

New Employees

You are considered a New Employee for purposes of eligibility for the Plan's Medical, Flexible Spending Accounts, and Health Savings Account coverage benefits if you did not work for the entire Standard Measurement Period before the plan year. When you are hired as a New Employee, Roper St. Francis Healthcare will classify you as either New Full-Time, New Part-Time, Variable Hour, or Seasonal for purposes of eligibility for the Plan's Medical, Flexible Spending Accounts, and Health Savings Account coverage benefits.

New Full-Time Employee

If Roper St. Francis Healthcare reasonably expects you to work at least 20 hours per week on average, Roper St. Francis Healthcare will classify you as a New Full-Time Employee and you will be eligible for Medical, Dental, Vision, Flexible Spending Accounts, Health Savings Account, Critical Illness, and Accident benefits under the Plan on the first of the month following 30 days of continuous employment, and Short-Term Disability benefits under the Plan the first of the month following enrollment if enrollment occurs prior to the 15th of the month, or the first of the second month if enrollment occurs after that 15th of the month. If Roper St. Francis Healthcare reasonably expects you to work at least 32 hours per week on average, you will also be eligible for Life, Supplemental Life and AD&D, Dependent Life, Permanent Life and Long-Term Disability benefits under the Plan 90 days from your date of hire.

Variable Hour/New Part-Time/Seasonal Employee/As-Needed Employee

If Roper St. Francis Healthcare classifies you as a Variable Hour Employee, a New Part-Time Employee, a Seasonal or As-Needed employee, Roper St. Francis Healthcare will measure your Hours of Service over an Initial Measurement Period to determine whether you average over 30 Hours of Service a week. Your Initial Measurement Period will begin on your date of hire, and will end 12 months later.

If you average at least 30 Hours of Service during the Initial Measurement Period, you will be notified that you are eligible for coverage for a period of time following the Initial Measurement Period called the Initial Stability Period, and you will be given an opportunity to elect Medical, Flexible Spending Accounts, and Health Savings Account coverage. If elected, your Medical, Flexible Spending Accounts, and Health Savings Account coverage will begin no later than the first of the month following 13 full calendar months after your date of hire. If your Initial Stability Period spans two plan years, you will be given another opportunity to elect Medical, Flexible Spending Accounts, and Health Savings Account coverage or change your Medical, Flexible Spending Accounts, and Health Savings Account coverage election at annual enrollment along with all other eligible employees.

If you average less than 30 Hours of Service during the Initial Measurement Period, you will not be eligible for Medical, Flexible Spending Accounts, and Health Savings Account coverage during the Initial Stability Period.

Once you have worked an entire Standard Measurement Period, your eligibility will be measured during the Standard Measurement Period as described in the previous section.

What if you change job classifications during the Initial Measurement Period? If you are hired as a new Variable Hour, Seasonal, New Part-Time Employee or As-Needed employee, but during the Initial Measurement Period you are moved to a job classification that, had you been hired into that job classification originally, you would have been a New Full-Time Employee, you will be eligible for

coverage on the first of the fourth month following the job classification change. If you would be eligible sooner during an Initial Stability Period, you will be eligible on the first day of the Initial Stability Period.

See Appendix B for Additional Information

The lookback method for determining eligibility is based on IRS regulations. See Appendix B for definitions related to the lookback method.

Individuals Not Eligible for Medical Benefits, Flexible Spending Accounts and Health Saving Account Benefits

You are not eligible to participate in the Plan's Medical coverage benefits if you are:

- Temporary or Seasonal Employees, except as may be eligible for benefits as described under the Lookback Method;
- a leased employee,
- an independent contractor, or
- a member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan.

Eligibility Determinations are Made by Roper St. Francis Healthcare

It is solely within the authority of the Plan Administrator to determine whether you are eligible for Medical coverage benefits under this Plan. A person the Plan Administrator determines is not an employee and who is later required to be reclassified as an employee will only be eligible prospectively, provided all other eligibility requirements are met.

ELIGIBLE DEPENDENTS

Medical, Dental and Vision

The following dependents are eligible for Medical, Dental and Vision coverage offered under the Plan:

- Your spouse, which means a person recognized as married to you by the state, possession or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession or territory of the United States, regardless of where you live;
- Your children through the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26.

If you are married to another Roper St. Francis Healthcare employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

You are required to provide proof of your dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably

terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Your dependent children are:
- Your biological children,
- Stepchildren,
- Legally adopted children,
- Foster children,
- Children who are placed in your home for adoption, and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Dependents Not Eligible

The following individuals are not eligible for Medical, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A spouse or a child living outside the United States;
- A spouse who is enrolled as an eligible employee under the Plan;
- Your parent or your spouse's parent.

Dependent Life and AD&D

The following dependents are eligible for Dependent Life and Supplemental AD&D coverage offered under the Plan:

- Your legally married spouse, whether or the same or opposite sex;
- Your children until the end of the month in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support.

Please see the applicable Benefit Booklets for additional eligibility requirements.

Health Care FSA and Limited Purpose Health Care FSA

For purposes of the Health Care FSA and Limited Purpose Health Care FSA your dependents include:

- Your spouse, which means a person recognized as married to you by the state, possession or territory of the United States in which you were married, regardless of where you live.
  - If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession or territory of the United States, regardless of where you live;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person

isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes.)

Dependent Care FSA

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code),
- A disabled spouse who lives with you for more than one half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of the employee or any other individual.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets provided by the applicable insurance companies and/or service providers.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. Roper St. Francis Healthcare's procedures governing QMCSO determinations are contained in Appendix C of this SPD, or you may obtain a copy free of charge, by contacting the Plan Administrator at Roper St. Francis Healthcare, 8536 Palmetto Commerce Parkway, Suite 402 Ladson, SC 29456.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

You must Notify the Plan of Certain Events Regarding your Dependents

If you experience a change in status (see Making Changes to Coverage During the Year section), you must notify the Roper St. Francis Healthcare within 31 days in order to make a change in your election during the year. The notice must be in writing and contain the change in status event, the date of the event, and your requested change and must be sent to the Plan Administrator.

In order to preserve your dependent's COBRA rights, you must notify the Plan, as noted above, in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

ENROLLMENT

NEW EMPLOYEES

When you begin working at Roper St. Francis Healthcare, you will receive the information necessary to enroll in the Plan. You are eligible for and will automatically be enrolled in the following:

- Basic Life
- Basic AD&D
- Employee Assistance Plan

You must affirmatively enroll yourself and your eligible dependents within 31 days of your date of hire for:

- Medical and Prescription Drug (including Wellness benefits)
- Dental
- Vision
- Supplemental Life and AD&D
- Dependent Life
- Short-Term Disability
- Long-Term Disability
- Health Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Voluntary Critical Illness Insurance
- Voluntary Accident Insurance
- Voluntary Permanent Life Insurance

If you elect medical coverage under a high deductible health plan and are otherwise eligible, Roper St. Francis Healthcare allows you to make pre-tax contributions towards a Health Savings Account. Roper St. Francis Healthcare may also make a contribution to your Health Savings Account for you if you are enrolled in a high deductible health plan if you participate in certain wellness programs as described in your enrollment materials.

If you and your eligible dependents do not enroll in Medical, Dental, Vision, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account or Dependent Care Flexible Spending Account coverages within 31 days of your date of hire, you will have to wait until the next Open Enrollment period to enroll, unless you experience a change in status.

What Happens if You Don't Enroll When You Are First Eligible?

If you do not enroll for Supplemental Life and AD&D, Dependent Life, Long-Term Disability coverage when you are first eligible, you may enroll mid year but you may have to provide evidence of insurability.

If you do not enroll for Short-Term Disability when you are first eligible, you will have to wait until the next Open Enrollment period.

If you do not enroll for Voluntary Critical Illness Insurance, Voluntary Accident Insurance, or Voluntary Permanent life when you are first eligible, you will have to wait until the next Open Enrollment period. However, if you have a family status change, you can make a change to the coverage tier or benefit amount that corresponds with such family status change.

When Does Coverage Begin?

Your coverage under the Plan will begin the first of the month following 30 days of full-time continuous employment for Medical, Dental, Vision, Flexible Spending Accounts, Critical Illness, and Accident. For Life, Supplemental Life and AD&D, Dependent Life, Permanent Life and Long-Term Disability, coverage becomes effective 90 days from the date of hire. For Short-Term Disability, coverage becomes effective as soon as administrative practicable after your date of hire. If you become eligible for coverage later than your initial hire, your coverage will begin on the first of the month following 30 days of continuous employment from the date you became eligible for Medical, Dental, Vision coverages and the Flexible Spending Accounts, Health Savings Accounts, Critical Illness, and Accident, and within 90 days of the date of the event in which you become newly eligible for coverage for Supplemental Life and AD&D, Dependent Life, and Long-Term Disability. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

If you enroll yourself or a dependent in the Medical, Dental and/or Vision benefits midyear due to a change in status, coverage will be effective the date of the event, but pre-tax payroll contributions will begin prospectively as of the next payroll period following the date the Plan Administrator receives your timely written request for enrollment due to a change in status. However, if you have made a change to your medical coverage due to the birth or adoption of a child, your pre-tax contributions will be effective as of the date of the birth or adoption (or placement for adoption). If you enroll in the Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account or Dependent Care Flexible Spending Account midyear due to a change in status, coverage will be effective as of the next payroll period following the date of your timely written request for enrollment.

If you enroll on time, your coverage will begin on the later of the following: the date you enroll or the date you satisfy the eligibility requirements. Please refer to the applicable Benefit Booklets for additional details on eligibility. Although enrollment may be automatic, coverage may not be automatic.

Open Enrollment for Current Employees

Open Enrollment is held every fall. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You'll receive information, including instructions on how to enroll, before Open Enrollment each year.

HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other non-COBRA coverage). However, you must request enrollment in writing within 31 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other non-COBRA coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must make a written request for enrollment through the electronic benefits portal within 31 days after the marriage, birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your written request for enrollment.

The Plan must allow a HIPAA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to make a written request for enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To make a written request for special enrollment or obtain more information, contact Plan Administrator, Roper St. Francis Healthcare, 8536 Palmetto Commerce Parkway, Suite 402, Ladson, SC 29456, HRBenefitsTeam@rsfh.com.

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

Roper St. Francis Healthcare has established a premium conversion plan under Internal Revenue Code Section 125 so that you will be able to pay your share of certain Plan benefits on a pre-tax basis. You pay your share of the cost of Medical, Dental, and Vision coverage you elect for yourself, your spouse and any tax dependents on a pre-tax basis. The level of contribution is determined by the Company.

Contributions to the Health Care, Limited Purpose Health Care and Dependent Care Flexible Spending Accounts are also on a pre-tax basis. If you wish to enroll, you will be required to agree to have your salary reduced by your elected contribution amount. If you are enrolled in the high deductible health plan you may make pre-tax contributions to a Health Savings Account.

If you are enrolled in Supplemental Life and AD&D, Dependent Life, Short-Term Disability, Long-Term Disability, Voluntary Critical Illness Insurance, Voluntary Accident Insurance, and Voluntary Permanent Life Insurance coverage, you pay the cost for coverage on an after-tax basis. Contributions are deducted from your paychecks based on your elected level of coverage.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to the Plan Administrator at Roper St. Francis Healthcare, 8536 Palmetto Commerce Parkway, Suite 402, Ladson, SC 29456.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following plan year (January 1 through December 31).

CHANGES IN STATUS

Supplemental Life, AD&D and Long-Term Disability Mid-Year Changes

You may make changes to your Supplemental Life and AD&D, Dependent Life, Long-Term Disability coverage mid year but you may have to provide evidence of insurability.

Short-Term Disability Mid-Year Changes

You cannot make changes to your Short-Term Disability coverage during the Plan Year.

Voluntary Benefits Mid-Year Changes

You cannot make changes to your Voluntary Critical Illness Insurance, Voluntary Accident Insurance, or Permanent Life Insurance elections during the Plan Year. However, if you have a family status change, you can change your coverage tier or benefit amount to correspond to such family status change; or if you pay for voluntary benefit coverage on a post-tax basis, you may decrease or cancel you coverage prospectively at any time.

Medical, Dental, Vision and Flexible Spending Account Mid-Year Changes

You may be able to change your Medical, Dental, Vision and Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account or Dependent Care Flexible Spending Account elections during the Plan Year if you experience a change in status.

If you experience one of the events described below and want to make a change to your coverage due to such event, you must notify Roper St. Francis Healthcare in writing within 31 days of the event, or 60 days for certain events as described under HIPAA Special Enrollments in this booklet. If you do not notify Roper St. Francis Healthcare in writing within the 31-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree, etc.). The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment;
- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship, and placement for adoption;
- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or ending employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;

- **Residence:** A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area;
- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA);
- **FMLA leave:** Beginning or returning from an FMLA leave;
- **Reduction in hours of service**: You and your dependents may drop your group health plan coverage under the Plan, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop Roper St. Francis Healthcare coverage.
  - You are not permitted to change your health FSA elections because of a reduction in hours of service.

Consistency Requirements for Changes in Status

Except for election changes due to a HIPAA special enrollment, changes as a result of a reduction in hours of service, and changes because of your enrollment in a health plan offered by the public Marketplace, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all the following requirements:

- **Effect on eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental, Vision and Health Care Flexible Spending Account elections.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

COST OR COVERAGE CHANGE EVENTS

In some instances, you can make elections if the type of coverage or cost of coverage changes. These rules do not apply for purposes of a Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Cost Changes

If Roper St. Francis Healthcare determines there is a significant increase or decrease in the cost of Medical, Dental and Vision coverages, you may be permitted to revoke your election and make a corresponding new election. If you previously declined coverage, you may also make a corresponding new election.

Any change in the cost of your plan option that the Company determines is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Coverage Changes

The following are additional situations in which you may change your current coverage.

Restriction or Loss of Coverage — If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.

Addition to or Improvement in Coverage — If Roper St. Francis Healthcare adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

Changes in Coverage under Another Employer Plan — If your spouse or dependent child(ren) is employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's Open Enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer's open enrollment period, you may request to end your coverage under the Plan.

Loss of Other Group Health Plan Coverage – If you or your spouse or dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll in coverage under this Plan.

Dependent Care Flexible Spending Account Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care Flexible Spending Account if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases or decreases by a provider who is related to you);

- You choose a different dependent care provider who charges a different amount; or
- You make a change to your or your spouse's regular work schedule that increases or decreases your need for dependent care.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, refer to the Benefits Booklet for each specific benefit to determine if and for what period of time active coverage may continue or contact the Plan Administrator at Roper St. Francis Healthcare, 8536 Palmetto Commerce Parkway, Suite 402, Ladson, SC 29456, HRBenefitsTeam@rsfh.com.

FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty or to deal with any qualifying exigency that arises from a family member's active duty or call to active duty in the Armed Forces or a military reserve unit from the National Guard, Military Reserve or retired status in the Armed Forces or Reserve. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact Roper St. Francis Healthcare, 8536 Palmetto Commerce Parkway, Suite 402, Ladson, SC 29456, (843) 720-8400.

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, Employee Assistance Plan and Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by pre-paying for your coverage on a pre-tax basis, paying for coverage during your leave on an after-tax basis, and/or catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your health coverage during the leave.

If your Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account or Dependent Care Spending Account coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to "make up" for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care Flexible Spending Account coverage amount.)

Your Basic Life and AD&D, coverages will continue during an FMLA leave. Your Supplemental Life and AD&D, Dependent Life, Short-Term Disability, Long-Term Disability, Voluntary Critical Illness Insurance, Voluntary Accident Insurance, and Voluntary Permanent Life Insurance coverage will also continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. Your contributions to the Dependent Care Flexible Spending Account will continue during a paid leave, but will be suspended if the leave is unpaid.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return to work at the end of FMLA without any evidence of good health or newly imposed waiting period. If you are granted extended leave after FMLA expires, you may have to show evidence of good health or satisfy a new waiting period upon your return from extended leave. Refer to the Benefits Booklets for each benefit to determine whether you must show evidence of good health or satisfy a new waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave, provided your leave does not extend beyond expiration of FMLA. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see COBRA section below).

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Employee Assistance Plan and Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account coverage for up to 24 months as long as you give Roper St. Francis Healthcare advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from Roper St. Francis Healthcare, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

Basic Life and AD&D coverages will also continue during your military leave. However, all other coverages will terminate, including participation in the Dependent Care Flexible Spending Account.

If you are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA Plan Year.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at Roper St. Francis Healthcare,

you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see COBRA section below). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See COBRA section) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by Roper St. Francis Healthcare;
- The end of the month in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from reduction in hours, leave or termination of active employment, or it may result because you average less than the required hours for eligibility for a particular benefit;
- The date of your death,
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain medical procedures) are described in the Benefit Booklets.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- For your dependent child, for Medical coverage, the end of month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The day on which your legally married spouse or child is no longer considered an eligible dependent (for example, date of divorce);
- The end of the pay period in which you stop making contributions required for dependent coverage; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA

section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, EAP and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by Roper St. Francis Healthcare (such as Life, LTD, or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

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

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event”. After a qualifying event occurs and any required notice of that event is properly provided to the Roper St. Francis Healthcare, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary”. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of Roper St. Francis Healthcare, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of employment with Roper St. Francis Healthcare or
- The termination of your employment with Roper St. Francis Healthcare (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of Roper St. Francis Healthcare, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with Roper St. Francis Healthcare (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with Roper St. Francis Healthcare; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with Roper St. Francis Healthcare (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the FMLA leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform Roper St. Francis Healthcare that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the former employee of Roper St. Francis Healthcare, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Roper St. Francis Healthcare (see Contact Information) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify Roper St. Francis Healthcare within the 31 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO

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

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify Roper St. Francis Healthcare of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify Roper St. Francis Healthcare (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Roper St. Francis Healthcare requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to Roper St. Francis Healthcare at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to Roper St. Francis Healthcare within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to Roper St. Francis Healthcare OR the COBRA Administrator.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected.

However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). When you complete the election form, you must notify Roper St. Francis Healthcare if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care FSA or Limited Purpose Health Care FSA COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account, if elected, will consist of the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-or-lose rule will continue to apply. All qualified beneficiaries who were covered under the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account will be covered together for Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check, money order, ACH debit or on-line credit card payment, or payroll deduction if under special paid severance agreement, as permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. COBRA coverage for the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account cannot be extended under any circumstances. Notwithstanding the previous sentence, a Qualified Beneficiary shall carryover up to $500 or, if less, the unused balance in his or her Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account at the end of the Plan Year, to a subsequent Plan Year. The carryover shall only be available for the duration of the period of COBRA continuation coverage. No premium will be charged for the subsequent Plan Year.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally

18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Trade Act of 2002

The Trade Act of 2002 creates a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

Although it is unlikely that a Roper St. Francis Healthcare employee would qualify, you may contact the Plan Administrator at Roper St. Francis Healthcare (see Contact Information below) for additional information or if you have any questions about these new provisions, or you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-800-829-1040 or visit www.IRS.gov/HCTC. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Roper St. Francis Healthcare no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);

- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee;
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Roper St. Francis Healthcare reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. Roper St. Francis Healthcare, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Are there other coverage options besides COBRA Continuation Coverage?

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

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact

COBRA Administrator:
Wex Health, Inc. d/b/a Wex (formerly Discovery Benefits)
4321 20th Ave SW
Fargo, ND 58103
www.wexinc.com
Direct: (866) 451-3399

Fax: (888) 408-7224
Plan Administrator:
Roper St. Francis Healthcare
8536 Palmetto Commerce Parkway, Suite 402
Ladson, SC 29456
HRBenefitsTeam@rsfh.com
(843) 720-8400

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep Roper St. Francis Healthcare informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to Roper St. Francis Healthcare or the COBRA Administrator.

COVERED AND NON-COVERED SERVICES

Refer to the Benefit Booklets provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

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

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Health Care Flexible Spending Account may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage.

This section explains how the Health Care Flexible Spending Account allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive in health care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the Eligible Dependent section.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than $2,750 (or the amount communicated annually by Roper St. Francis Healthcare) per Plan Year of your own money to your Health Care Flexible Spending Account. For employees hired mid year or enrolling after annual Open Enrollment, the maximum annual contribution is a pro-rated portion of the annual maximum contribution amount based on the number of pay periods remaining in the year.

ELIGIBLE EXPENSES

The Health Care Flexible Spending Account is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, coinsurance, copayments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person’s general health (except menstrual care products, smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses eligible for reimbursement under the Health Care Flexible Spending Account:

- Medical Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the “reasonable and customary” limits
  - Expenses not covered by the terms of the Medical plan
  - Menstrual care products
  - Drugs requiring a doctor’s written prescription that are not covered by insurance
  - Over-the-counter drugs as permitted under applicable law or regulation.
  - Insulin (with or without a prescription)
  - Smoking cessation programs and related medicines

  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by the medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).
- Dental Expenses
  - Deductibles
  - Coinsurance
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by insurance plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

INELIGIBLE EXPENSES

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care Flexible Spending Account:

- Premiums
  - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense. This exclusion does not include menstrual care products
- Long term care expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care Flexible Spending Account.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

USE OR LOSE

IRS regulations stipulate that you must use the full amount of money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year, or forfeit what remains. Your request for reimbursement must be filed by the deadline in the *Filing a Claim* section below. **Any funds, in excess of $500, remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

If you have a balance left in your Health Care Flexible Spending Account after the claim run out period, you may carryover up to $500 of any remaining balance to a Health Care Flexible Spending Account or a Limited Purpose Health Care Flexible Spending Account in the following year. If you have less than $500 remaining, you can carryover up to the amount of your unused balance to a Health Care Flexible Spending Account or a Limited Purpose Health Care Flexible Spending Account in the following year. The unused balance cannot be cashed out. Any amounts in excess of $500 will be forfeited.

You may not use money in your Health Care Flexible Spending Account to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and must be at least $1 or more before reimbursement will be made. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator within 90 days after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care Flexible Spending Account is ConnectYourCare.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Unless you elect to continue your health FSA coverage under COBRA (see *COBRA* section above), your health FSA coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed from your health FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Limited Purpose Health Care FSA may be of interest to you if you are enrolled in the high deductible health plan and have a Health Savings Account.

If you are enrolled in the high deductible health plan and participate in a health savings account, you are not eligible to enroll in the Health Care Flexible Spending Account, but you may enroll in the Limited Purpose Health Care Flexible Spending Account.

The Limited Purpose Health Care FSA covers only medical expenses that are considered to be for dental and/or vision expenses as allowed under Code Section 223.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the Eligible Dependent section.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than $2,750 (or the amount communicated annually by Roper St. Francis Healthcare) per Plan Year of your own money to your Limited Purpose Health Care Flexible Spending Account. For employees hired mid year or enrolling after annual Open Enrollment, the maximum annual contribution is a pro-rated portion of the annual maximum contribution amount based on the number of pay periods remaining in the year.

ELIGIBLE EXPENSES

The Limited Purpose Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" dental and vision care expenses. Expenses must be incurred during the Plan Year and while you were covered under the Plan. Expenses must be incurred during the calendar year and while you are covered under the Limited Purpose Health Care FSA. You may submit bills for any expense for dental and vision care, which you are obligated to pay and which are not covered by any plan.

Below is a partial list of dental and vision expenses eligible for reimbursement under the Limited Purpose Health Care FSA:

- Dental Expenses
- Deductibles
- Coinsurance
- Copayments
- Expenses that exceed the maximum annual amount allowed by your dental plan
- Charges over the “reasonable and customary” limits
- Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
- Vision examinations and treatment not covered by insurance plan
- Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
- Cost of hearing exams, aids and batteries

INELIGIBLE EXPENSES

Below is a partial list of expenses ***not*** eligible for reimbursement under the Limited Purpose Health Care Flexible Spending Account:

- Medical Expenses - Otherwise eligible medical expenses that are not considered dental or vision care
- Premiums
  - Premiums paid by the Employee, a spouse or other Dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for Long Term-Care Insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Over-the-Counter drugs or items without a prescription unless specifically permitted under applicable law or regulation
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.
- Long Term Care Expenses

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Limited Purpose Health Care Flexible Spending Account.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

USE OR LOSE

IRS regulations stipulate that you must use the full amount of money in your Limited Purpose Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year, or forfeit what remains. Your request for reimbursement must be filed within 90 days after the Plan Year in which funds are allocated to your Limited Purpose Health Care Flexible Spending Account for expenses incurred during that Plan Year. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Limited Purpose Health Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year, or you will lose it.

If you have a balance left in your Limited Purpose Health Care Flexible Spending Account after the claim run out period, you may carryover up to $500 of any remaining balance. If you have less than $500 remaining, you can carryover up to the amount of your unused balance. The unused balance

cannot be cashed out. Any amounts in excess of $500 will be forfeited. Any amounts carried over will only be carried over for one year if you do not elect coverage under the Limited Purpose Health Care Spending Account in the next Open Enrollment.

You may not use money in your Limited Purpose Health Care Flexible Spending Account to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and must be at least $1 or more before reimbursement will be made. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a Plan Year must be submitted to the Claims Administrator within 90 days after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Limited Purpose Health Care Flexible Spending Account is ConnectYourCare.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

WHAT HAPPENS WHEN YOUR EMPLOYMENT ENDS?

Unless you elect to continue your limited purpose health care FSA coverage under COBRA (see *COBRA* section above), your limited purpose health care FSA coverage ends on your date of termination of employment. Only claims incurred on or before your date of termination may be reimbursed from your limited purpose health care FSA. See *Eligible Expenses* above for a discussion of when claims are considered to be incurred. All claims must be submitted to the Claims Administrator within 90 days after your date of termination. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work.

This section explains how the Dependent Care Flexible Spending Account allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes.

QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed in the Eligible Dependent section.

CONTRIBUTION LIMITS

The IRS limits the amount you may contribute to your Dependent Care Flexible Spending Account. There is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). For employees hired mid year or enrolling after annual Open Enrollment, the maximum annual contribution is a pro-rated portion of $5,000 based on the number of pay periods remaining in the year. But another limitation also applies. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During the calendar year, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care Flexible Spending Account will be limited to $3,600. She can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse’s actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse’s actual income (if any) or $500 a month.

ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Plan include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you – or if you’re married, you and your spouse – to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the Plan Year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

INELIGIBLE EXPENSES

You cannot use the money in your Dependent Care Flexible Spending Account to pay for:

- General “baby-sitting” other than during work hours
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return
- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible
- Expenses for which you claim IRS child care credit when you file your tax return

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Flexible Spending Account.

USE OR LOSE

It is important that you not contribute more than the dependent care expenses than you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year, or forfeit what remains. You must incur eligible expenses by December 31 in order for them to be eligible for reimbursement. Your request for reimbursement must be filed the deadline in the *Filing a Claim* section below. **Any funds remaining in your Account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Set aside only as much as you expect to claim during the Plan Year or you will lose it.

You may not use money in your Dependent Care Flexible Spending Account to pay health care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and must be at least $1 or more before reimbursement will be made. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a Plan Year must be submitted to the Claims Administrator within 90 days after the Plan Year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Dependent Care Flexible Spending Account is ConnectYourCare.

SPECIAL RULES AFFECTING DEPENDENT CARE ACCOUNTS

Several special rules apply to Dependent Care Spending Accounts. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted – dollar for dollar – by any reimbursements you receive from your Dependent Care Flexible Spending Account. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care Flexible Spending Account. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care Spending Account must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

CLAIMS AND APPEAL PROCESS

FILING A CLAIM

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. In general, any participant or beneficiary under the Plan may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets.

You may designate an authorized representative to handle the claim, or any subsequent appeal, on your behalf. To designate an authorized representative to act on a participant's or beneficiary's behalf with respect to a benefit claim, you (or your spouse or child) must submit a written request on a form approved by the Plan Administrator, which the participant or beneficiary signs and which authorizes the representative to act on their behalf with respect to the benefit claim. If a party is not properly designated as an authorized representative under Plan, the Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of a participant's or beneficiary's rights under the Plan. With respect to any urgent, pre-service, or concurrent care claim (discussed below), a participant's or beneficiary's treating physician or other health care professional may act as an authorized representative in exercising a participant's or beneficiary's rights under the Plan. The Plan will also recognize a court order giving a person authority to submit claims on a participant's or beneficiary's behalf. Any attempted assignment of benefits by a participant or beneficiary to a health care provider is void, and does not constitute a designation of an authorized representative for purposes of the Plan.

Claims Administrators – Fully Insured

Roper St. Francis Healthcare provides the following benefits under the Plan through contracts with the insurance companies listed below. The Plan benefits listed below are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Vision	Physicians Eye Care Plan 1-800-368-9609
Basic, Supplemental & Dependent Life and Accidental Death and Dismemberment (AD&D)	The Hartford 888-755-1503
Short-Term Disability	Manhattan Life, administered by The Farmington, an Aon Company 800-621-0067
Long-Term Disability	The Hartford 888-755-1503
Voluntary Critical Illness Insurance	The Hartford 866-547-4205
Voluntary Accident Insurance	The Hartford 866-547-4205
Voluntary Permanent Life Insurance	Transamerica Life Insurance Company 888-763-7474

Claims Administrators – Self-Insured

The Plan benefits listed below are self-insured and the Employer has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Medical	Blue Cross and Blue Shield of South Carolina Claims Service Center PO Box 100300 Columbia, SC 29202 888-314-5059
Pharmacy	Express Scripts, Inc. 844-730-1971
Dental	Delta Dental 800-335-8266
Employee Assistance Plan	Empathia 800-634-6433
Flexible Spending Accounts	Optum Financial (formerly ConnectYourCare) 844-973-3919

This section provides general information about the claims and appeals procedure applicable to certain Plan benefits under ERISA. (The *Administrative Information* section of this SPD identifies which Plan benefits are *not* subject to ERISA. These claims and appeals rules do not apply to those benefits.) Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. See the Benefit Booklets for more information.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules will not apply to dental or vision claims or health care flexible spending account claims.

CLAIM-RELATED DEFINITIONS

Claim

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

An adverse benefit determination disability claims or for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

INITIAL CLAIM DETERMINATION

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;

- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

In the event of an adverse benefit determination for a claim under health benefits, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

In the event of an adverse benefit determination for a disability claim, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- A statement that reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits are available free of charge, upon request.

For Medical claims, the notice will include information sufficient to identify the claim involved. This includes:

- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Health Care FSA and Limited Purpose Health Care FSA claims are considered non-urgent "post-service" claims.

	Medical, Dental, Vision, EAP & Health Care FSA Benefits				Short-Term & Long-Term Disability Benefits	Life, AD&D, Voluntary Critical Illness, Voluntary Accident, & Voluntary Permanent Life Benefits
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, Dental, Vision, EAP & Health Care FSA Benefits				Short-Term & Long-Term Disability Benefits	Life, AD&D, Voluntary Critical Illness, Voluntary Accident, & Voluntary Permanent Life Benefits
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A	N/A	

	Medical, Dental, Vision, EAP & Health Care FSA Benefits				Short-Term & Long-Term Disability Benefits	Life, AD&D, Voluntary Critical Illness, Voluntary Accident, & Voluntary Permanent Life Benefits
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The appeals processes of fully insured health plans may vary somewhat. Please see your Benefit Booklets for more information on fully insured health benefits.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the appropriate Claims Administrator as listed in the Filing a Claim section. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

For disability claims and for medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

For disability claims and for Medical claims, prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or

generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

For a disability claim, if the Plan fails to strictly adhere to all the requirements of the disability claims and appeals process with respect to your disability benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. If a court rejects your demand for immediate review based on the exceptions above, your claim will be considered as refiled on appeal upon receipt of the court's decision, and the plan will notify you of the resubmission.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described in the Time Frames for Appeals Process section. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For adverse benefit determinations under a health benefit under the Plan, the notice will also include:

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims); and

- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims).

For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

For adverse benefit determinations on disability claims, the notice will also include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - the views of medical or vocational experts obtained by the plan, without regard to whether the advice was relied upon for the adverse benefit determination; and
  - any Social Security Administration disability determination regarding the claimant presented to the Plan;
- A description of any applicable contractual limitations period, including the date on which the claim expires;
- Either the specific rule, guideline, protocol, standards, or other similar criteria relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

External Review

For Medical benefits, you may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer; a coverage rescission; or, in the event there is a question as to whether the claim should have been subject to surprise billing protections, as required by the No Surprises Act provisions of the CAA. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your request for an external review

is determined eligible for such a review, an independent organization will review the Claims Administrator's decision and provide you with a written determination, as described in the Benefits Booklets.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment, coverage rescission, or a determination whether the claim should have been subject to surprise billing protections.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical, Dental, Vision, EAP & Health Care FSA Plans			Short-Term & Long-Term Disability	Life, AD&D, Voluntary Critical Illness, Voluntary Accident, & Voluntary Permanent Life
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

COORDINATION OF BENEFITS

Coordination with Other Plans

Unless otherwise specified in the applicable Benefit Booklet, the Plan will coordinate benefits with any other health plan that covers you or your eligible dependents under the rules below.

Other health plans with which the Plan will coordinate include:

- Group or nongroup coverage, whether insured or uninsured, including HMOs
- The medical care component of long-term care contracts, such as skilled nursing care;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under federal government programs, except that coverage under a federal government program may be limited to hospital, medical, and surgical benefits of the government program. Coverage does not include Medicare supplemental policies or Medicaid policies; and
- The medical benefits coverage in group or individual automobile “fault” or “no-fault” coverage.

Order of Benefit Determination

The rules below determine whether this Plan or another plan will pay primary (first) or secondary. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this Plan.

- COB/Non-COB Provision: The benefits of a plan which does not contain a coordination of benefits (COB) provision always shall be determined before the benefits of a plan which does contain a COB provision.
- No Fault Auto Insurance: The benefits of the plan which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to this Plan, regardless of whether the no-fault policy has been selected as secondary.
- Non-Dependent/Dependent: The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent (unless “Medicare Coordination” below applies).
- Dependent Child/Parents not Separated or Divorced: When this Plan and another plan cover the same child as a dependent of different persons, called “parents”:

    (1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

    (2) if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits. For a dependent who has coverage under either or both parents and also has coverage as a dependent under a spouse's plan, see "Longer-Shorter Length of Coverage" below applies.

- Dependent Child/Separated or Divorced Parents: If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

    (1) first, the plan of the parent with custody of the child;

    (2) then, the plan of the spouse of the parent with custody of the child;

    (3) the plan of the parent not having custody of the child, and

    (4) finally, the plan of the spouse of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year starting before the Plan is given notice of the court decree.

  This Plan will not cover the expenses of any child who does not meet the definition of dependent as defined in this Plan except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

- Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Continuation Coverage: If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

    (1) First, the benefits of a plan covering the person as an employee or retiree (or as the dependent of an employee or retiree);

    (2) Second, the benefits of coverage under the continuation plan.

  If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer-Shorter Length of Coverage: If none of the above rules determines the order of benefits, the benefits of the plan which has covered the person longer are determined before those of the plan which has covered that person for the shorter time.

- Medicare Coordination

(1) Employees and/or Spouses Entitled to Medicare Due to Age: Unless an active employee entitled to Medicare due to age gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving his or her right to Plan benefits, the Plan is primary. With respect to the spouse of an active Employee who is entitled to Medicare due to the spouse's age, unless the employee gives the Plan notice (in the form and manner requested by the Plan Administrator) waiving Plan benefits, the Plan is primary.

(2) Medicare Disabled Covered Persons: If required by law, the Plan is primary with respect to a covered person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

(3) Covered Persons with End-Stage Renal Disease: For the period required by law, if any, the Plan is primary with respect to a covered person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

Disagreement on Order of Benefits

If the Plan and the other health plan cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the Plan shall immediately pay half of the claim and will determine its liability following payment, except that the Plan shall be required to pay no more than it would have paid had it been the primary plan.

Facility of Payment

If another health plan provides or pays benefits that should have been provided or paid under this Plan, the Plan has the right to pay to the other plan the amount the Plan Administrator determines is necessary to satisfy this coordination of benefit provision. These amounts are considered benefit payments under this Plan and will operate to discharge the Plan from liability to the extent of such payments.

ACTS OF THIRD PARTIES

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made on your behalf by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator.
- Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator.
- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the "Acts of Third Party" provisions in this SPD conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the “Acts of Third Party” provisions in this SPD will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plan or the right to assert legal or equitable rights, including an administrative claim, action under state law or lawsuit against any of the following: the Plan, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company and any Participating Employers, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plan to any other party, including any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal or equitable rights (including but not limited to claims for breach of fiduciary duty or the right to bring an injunction) or to bring any administrative claim, action under state law or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

MISSTATEMENT OF FACT

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage,

changing your existing coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	Group Benefit Plan of Roper St. Francis Healthcare
Plan Number	501
Plan Sponsor	Roper St. Francis Healthcare 8536 Palmetto Commerce Parkway, Suite 402 Ladson, SC 29456
Employer Identification Number	57-0831165
Plan Administrator	Roper St. Francis Healthcare 8536 Palmetto Commerce Parkway, Suite 402 Ladson, SC 29456 HRBenefitsTeam@rsfh.com (843) 720-8400
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the following types of benefits: ▪ Medical and Prescription Drug (including Wellness benefits) ▪ Dental ▪ Vision ▪ Employee Assistance Plan ▪ Short-Term Disability ▪ Long-Term Disability (LTD) ▪ Basic Life Insurance ▪ Supplemental Life and AD&D Insurance ▪ Dependent Life Insurance ▪ Accidental Death and Dismemberment (AD&D) ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Voluntary Critical Illness Insurance ▪ Voluntary Accident Insurance ▪ Voluntary Permanent Life Insurance Although the Dependent Care Flexible Spending Account and Health Savings Account benefits are described in this SPD, they are **not** ERISA plans.

Source of Contributions	Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from Roper St. Francis Healthcare, contributions by the employee, or will be shared by Roper St. Francis Healthcare and the employee. The cost of Medical, Dental and Long-Term Disability coverage is shared by Roper St. Francis Healthcare and its employees enrolled in those coverages. Roper St. Francis Healthcare pays 100% of the cost of the EAP, Basic Life and AD&D coverages. Employees pay 100% of the Vision, Supplemental Life and AD&D, Dependent Life, Short-Term Disability, Voluntary Critical Illness Insurance, Voluntary Accident Insurance, and Voluntary Permanent Life Insurance coverages and contributions to the Health Care, Limited Purpose Health Care and Dependent Care Flexible Spending Accounts. Where Roper St. Francis Healthcare and employees share the cost of coverage, Roper St. Francis Healthcare shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. Roper St. Francis Healthcare, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse Roper St. Francis Healthcare for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

Roper St. Francis Healthcare reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Roper St. Francis Healthcare reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Roper St. Francis Healthcare also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Roper St. Francis Healthcare will be done in accordance with Roper St. Francis Healthcare's normal operating procedures. Amendments will be effective at such date as Roper St. Francis Healthcare determines, or upon the date of execution or adoption if no effective date is given. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Roper St. Francis Healthcare, the Plan shall terminate unless the Plan is continued by a successor to Roper St. Francis Healthcare

If a benefit under the Plan is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Roper St. Francis Healthcare to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document. If the entire Plan terminates, plan assets will be used for the benefit of participants and beneficiaries or to defray reasonable administrative expenses.

PLAN ADMINISTRATION

Roper St. Francis Healthcare is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. Roper St. Francis Healthcare has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Roper St. Francis Healthcare will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Roper St. Francis Healthcare will be liable in any manner for any determination made in good faith.

Roper St. Francis Healthcare may designate other organizations or persons to carry out specific fiduciary responsibilities for Roper St. Francis Healthcare in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Roper St. Francis Healthcare will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

POWER AND AUTHORITY OF THE INSURANCE COMPANY

Certain benefit programs (identified in the Filing a Claim section of this SPD) under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Roper St. Francis Healthcare and an insurance company. With respect to fully insured benefits, claims for

benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not Roper St. Francis Healthcare.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan;
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan;
- The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Office of Outreach, Education, and Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A — BENEFIT BOOKLETS

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as Benefit Booklets) provided by the insurance companies and service providers.

The Benefit Booklets are intended to describe the Roper St. Francis Healthcare benefits available to you as an employee of Roper St. Francis Healthcare, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Benefit Booklets for details of Plan benefits.

For additional information or for copies of the Benefit Booklets, please contact the Plan Administrator.

Coverage	Benefit Booklet Name
Medical	BCBS RSFH Health Alliance Prime, Flex, Save, or Out of Area
Prescription Drug	Express Scripts, Inc. Benefits Booklet
Dental	Delta Dental Silver
Vision	Roper St. Francis Healthcare Vision Program
Employee Assistance Plan	Roper St. Francis Healthcare Employee Assistance Program
Basic Life Insurance	Hartford Life AAFT or Hartford Life Executives
Supplemental Life Insurance	Hartford Life AAFT or Hartford Life Executives
Dependent Life Insurance	Hartford Life AAFT or Hartford Life Executives
Short-Term Disability	The Farmington, an Aon Company short term disability
Long-Term Disability	Hartford LTD AAFT, Hartford LTD Physicians, Hartford LTD Executives
Accidental Death and Dismemberment	Hartford Life AAFT or Hartford Life Executives
Supplemental AD&D	Hartford Life AAFT or Hartford Life Executives
Voluntary Critical Illness Insurance	Hartford Critical Illness
Voluntary Accident Insurance	Hartford Accident
Voluntary Permanent Life Insurance	Transamerica Universal Life

APPENDIX B — ADDITIONAL INFORMATION ABOUT THE LOOKBACK METHOD

GLOSSARY OF DEFINED TERMS RELATED TO THE LOOKBACK METHOD

Break in Service. A Break in Service occurs when you do not have an Hour of Service for a period of 13 consecutive weeks or longer. The Plan Administrator, at its discretion, may also determine whether you have had a Break in Service using the Rule of Parity. Under the Rule of Parity, you will be considered to have had a Break in Service if you have a period of at least four weeks during which you do not have an Hour of Service, if the period without an Hour of Service is greater than your immediately preceding period of employment.

Hours of Service. Hours of Service means any hour for which you are paid, or entitled to payment, for (1) the performance of duties for Roper St. Francis Healthcare, or (2) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. An Hour of Service does not include:

- Hours for which your compensation is considered non-US source income.
- Hours worked as a volunteer
- Hours worked as part of a Federal Work-Study Program.

An hour of overtime counts as one hour of service, regardless of the rate you are paid.

Initial Measurement Period. Initial Measurement Period means the period beginning on your start date and ending 12 months later.

Initial Stability Period. Initial Stability Period means the period of time beginning on first of the month following the end of your Initial Measurement Period, and ending twelve (12) months later.

Minimum Value. This is a concept in the Affordable Care Act. A plan that meets minimum value standards pays at least 60% of the total allowed costs of benefits provided under the plan.

New Employee. You are considered a New Employee for purposes of the Lookback Eligibility Definition if you did not work for the entire Standard Measurement Period before the plan year.

New Full-Time Employee. If Roper St. Francis Healthcare reasonably expects, at the time it hires you or at the time you return to work after a Break in Service, you to work at least 30 hours per week on average during the Initial Measurement Period, Roper St. Francis Healthcare will classify you as a New Full-Time Employee for purposes of Medical coverage and Flexible Spending Accounts and Health Savings Account benefits.

New Part-Time Employee. If Roper St. Francis Healthcare reasonably expects, at the time it hires you or at the time you return to work after a Break in Service, you to average less than 30 Hours of Service a week during the Initial Measurement Period, Roper St. Francis Healthcare will classify you as a New Part-Time Employee for purposes of Medical coverage and Flexible Spending Accounts and Health Savings Account benefits.

Seasonal Employee. If Roper St. Francis Healthcare hires you in a position customarily six months or less, beginning at approximately the same time annually, Roper St. Francis Healthcare will classify you as Seasonal for purposes of Medical coverage benefits.

Standard Measurement Period. Standard Measurement Period means the 12 month period beginning each October 20th and ending the next year on October 19th.

Standard Stability Period. Standard Stability Period means the plan year immediately following the end of a Standard Measurement Period.

Variable Hour Employee. If Roper St. Francis Healthcare can't reasonably know when you are hired or when you return to work after a Break in Service whether you will average at least 30 Hours of Service per week over the Initial Measurement Period, Roper St. Francis Healthcare will classify you as a Variable Hour Employee.

Appendix C — Qualified Medical Child Support Order (QMCSO) Procedures

The Employer's Group Health Plan shall pay Covered Expenses in accordance with the applicable requirements of any Qualified Medical Child Support Order.

1. Procedural Requirements

a. Timely Notifications and Determinations

In the case of any Medical Child Support Order received by the Employer's Group Health Plan:

i. The Employer as the Plan Administrator shall promptly notify the Employee and each Alternate Recipient of the receipt of the Medical Child Support Order and the Corporation's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and,

ii. Within a reasonable period after receipt of such Qualified Medical Child Support Order, the Employer shall determine whether such order is a Qualified Medical Child Support Order and notify the Employee and each Alternate Recipient of such determination.

b. Establishment of Procedures for Determining Qualified Status of Orders

The Employer as the Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of Covered Expenses under such qualified orders. The Employer's procedures:

i. Shall be in writing;

ii. Shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive Benefits under the Plan of Benefits (at the address included in the Medical Child Support Order) of the Employer's procedures promptly upon receipt by the Plan Administrator of the Medical Child Support Order; and,

iii. Shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

c. Actions Taken by Fiduciaries

If a Plan fiduciary for the Employer's Group Health Plan acts in accordance with these procedural requirements in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Employer's Group Health Plan obligation to the Member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

2. Treatment of Alternate Recipients

a. Under ERISA

A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a beneficiary under the Employer's Group Health Plan for purposes of any provisions of ERISA, as amended, and shall be treated as a participant under the reporting and disclosure requirements of ERISA.

b. Direct Provision of Benefits Provided to Alternate Recipients

Any payment for Covered Expenses made by the Employer's Group Health Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

c. Plan Enrollment and Payroll Deductions

If an Employee remains covered under the Employer's Group Health Plan but fails to enroll an Alternate Recipient under the Plan of Benefits after receiving notice of the Qualified Medical Child Support Order from the Employer, the Employer shall enroll the Alternate Recipient and deduct the additional Premium from the Employee's paycheck.

d. Termination of Coverage

Except for any coverage continuation rights otherwise available under the Employer's Group Health Plan, the coverage for the Alternate Recipient shall end on the earliest of:

i. The date the Employee's coverage ends;

ii. The date the Qualified Medical Child Support Order is no longer in effect;

iii. The date the Employee obtains other comparable health coverage through another insurer or Plan to cover the Alternate Recipient; or,

iv. The date the Employer eliminates family health coverage for all of its Employees.