Benefits Handbook

S8/2020

CARING IN A BETTER WAY DAY BY DAY

The Partner Benefit Plans described in this Handbook are Plans sponsored by your employer for your benefit.

Throughout the history of NHC, new partner benefit plans have been added and old ones have been refined as a result of your input.

Our motto, "Care Is Our Business", relates to the company-sponsored Partner Benefit Plans, as well as, to the services that we, as partners provide. Your employer cares about you and your needs.

Whether it is through your Supervisor, Administrator, or a Partner Satisfaction Survey, NHC wants you to have an opportunity to voice your opinion about how your employer is satisfying your needs as a partner, as an individual and as a family member.

When you receive a Partner Satisfaction Survey, please take a few minutes to complete the survey. Your opinion is important to your employer.

NHC cares about your needs, just as you care about the needs of those you serve daily.

CARE IS OUR BUSINESS

Mission Statement

NHC is committed to being the industry leader in customer and investor satisfaction.

This handbook contains all applicable Summary Plan Descriptions.

If there is any discrepancy between the Summary Plan Description and the Plan Document, the Plan Document will control.

Produced and Published by National HealthCare Corporation

Printed in the United States of America

Nondiscrimination Statement

As a recipient of Federal financial assistance, National HealthCare Corporation (NHC) complies with applicable Federal Civil Rights laws and does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, religion, sex, gender, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments to patients, whether carried out by NHC directly or through a contractor or any other entity with which NHC arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, 91, and 92.

NHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact the Section 1557 Coordinator listed below.

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, you may do so in person or by mail, fax or email by contacting the Compliance Department at:

Mailing Address:	100 East Vine St. Murfreesboro, TN 37130	Telephone Number:	(615) 890-2020
Email Address:	klocke@nhccare.com	Fax Number:	(615) 278-1232
		TDD or State Relay Number:	7-1-1

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-615-890-2020 (TTY: 7-1-1). (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-615-890-2020 (TTY：7-1-1）。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-615-890-2020 (TTY:7-1-1). (Vietnamese)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-615-890-2020 (TTY:7-1-1)번으로 전화해 주십시오. (Korean)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-615-890-2020 (TTY:7-1-1). (Tagalog)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-615-890-2020 (телетайп:7-1-1). (Russian)

ةظوحلم: اذإ تنك ثدحت ركذا ال لغة، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لص تا مقرب 1-615-890-2020 (مقر

ف تاهصلا مكبلاو: (TTY 7-1-1). (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-615-890-2020 (TTY:7-1-1). (French –Creole)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-615-890-2020 (ATS :7-1-1). (French)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-615-890-2020 (TTY:7-1-1). (Portugese)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-615-890-2020 (TTY:7-1-1). (German)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-615-890-2020（TTY:7-1-1）まで、お電話にてご連絡ください。(Japanese)

هجوت: گار هب ابزن یسراف گتفگو یم ینکد، الیهست ینابز صبت رو اگیارن ی ارب امش
فمهار یمشابد. اب (TTY:7-1-1) 1-615-890-2020 امتس یری گبد. (Persian)

ध्यान द: यद आप ह दी बी□लते ह त□ आपकी ि◌ीलए मी□ फ्त म भीाषीा सहीायतीा सी वाएं उपलब्ध ह। 1-615-890-2020 (TTY: 7-1-1) पर की□ल कर। (Hindi)

ચ ના: જો તમે ુજરાતી બોલતા હો, તો િન:ુલક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે.ફોન કરો 1-615-890-2020 (TTY: 7-1-1). (Gujarati)

ማስ ታወሻ: የ ሚና ገ ሩት ቋንቋ ኣ ማርኛ ከሆነ የ ትርጉም እ ርዳታ ድርጅቶች፣ በነ ጻ ሊያ ግዝዎት ተዘ ጋጀተዋል፡ ወደ ሚከተለ ውቁ ጥር ይደውሉ 1-615-890-2020 (ማስ ማት ለ ተሳና ቸው: 7-1-1). (Amharic)

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Acknowledgment of Receipt

National Health Corporation
Benefits Handbook

I acknowledge that I have received a copy of the National Health Corporation Benefits Handbook (the "Handbook"), that I have consulted, or have had the opportunity to consult, with my legal and/or tax advisors regarding the benefits described in the Handbook and that I understand and acknowledge that the Handbook describes important information about the benefit plans available through my employer which apply to me and/or my dependent(s), if applicable.

I further understand that any benefits I and/or my dependent(s), if applicable, may be eligible for are regulated as described in this Handbook.

I also understand and acknowledge that, in order to avail myself and my dependent(s) of benefits described in the Handbook, I have an obligation to read, understand and familiarize myself with the benefit coverages and enrollment and/or election procedures relating to each and all applicable benefits and that my eligibility for, and participation in, benefit plans or programs described in the Handbook will be based on compliance with the required applicable enrollment and/or election procedures.

I further understand that my employer may, at any time, and from time to time, amend or eliminate any and/or all of the provisions of the benefit plans or programs, or any plan or programs in their entirety, described in this Handbook to the extent allowable by law, and that my employer intends to advise me within the time period that may be applicable by law of any such amendment or elimination of benefit.

_____ _____

Partner's Signature Date

__XXX__ /__XX___ / _____

Partner's Social Security Number (last 4 digits)

_____

Partner's Name (Please Print)

Partner Benefits Package

NHC and Affiliated Companies

Pay Related Incentives	▪ PEP ▪ PIE ▪ Safety Award	
Service Awards	▪ Service Pins	
Time Off	**PAID LEAVE**	**UNPAID LEAVE**
	▪ Earned Time Off ▪ Sick Leave ▪ Perfect Attendance ▪ Bereavement ▪ Jury Duty	▪ FMLA ▪ Medical ▪ Personal ▪ Military Duty ▪ Witness Duty
Insurance Plans	▪ Health ▪ Dental ▪ Vision ▪ Life - Partner - Dependent ▪ Short Term Disability	
Flexible Spending Account Plans	▪ Health Care Reimbursement Account ▪ Dependent Care Reimbursement Account	
Retirement Plan	▪ 401(k) ▪ ESOP (NHC owned companies only)	
Stock Purchase Plan	▪ Partner Stock Purchase Plan	
Education Plan	▪ Tuition Reimbursement	
Financial Services	▪ Direct Deposit of Paycheck ▪ Local Credit Union Membership	
Partner Discounts	▪ Entertainment, Retail & Other Discounts	

Employer-sponsored benefits require a period of time before you will be eligible for participation in each benefit plan. This is referred to as an eligibility waiting period. The eligibility date is the 1st day of the month following the end of the eligibility waiting period. Eligibility dates vary depending on the benefit plan.

Partner Benefit Eligibility

Based on Regularly Scheduled Hours

STATUS	ELIGIBLE FOR		
FULL Full-time, regularly scheduled 37.50 hours or more each week (75 hours or more each pay period). Eligible for full benefit package.	▪ PEP ▪ PIE ▪ Safety Award ▪ Service Pins ▪ Health ▪ Dental ▪ Vision ▪ Life	▪ Short Term Disability ▪ Flexible Spending Account Plans - Health Care Reimbursement Account - Dependent Care Reimbursement Account ▪ Paid Leave (ETO/Sick/PA) ▪ Unpaid Leave	▪ 401(k) ▪ ESOP (NHC Owned Locations Only)* ▪ Stock Purchase Plan ▪ Tuition Reimbursement ▪ Credit Union ▪ Partner Discounts
IPAR Part-time, regularly scheduled 30 hours or more but less than 37.50 each week (60 hours or more but less than 75 hours each pay period).	▪ PEP ▪ PIE ▪ Safety Award ▪ Service Pins ▪ Health ▪ Dental ▪ Vision ▪ Life	▪ Short Term Disability ▪ Flexible Spending Account Plans - Health Care Reimbursement Account - Dependent Care Reimbursement Account ▪ Unpaid Leave	▪ 401(k) ▪ ESOP (NHC Owned Locations Only)* ▪ Stock Purchase Plan ▪ Tuition Reimbursement ▪ Credit Union ▪ Partner Discounts
PART Part-time, regularly scheduled 29 hours or less each week (or 58 hours or less each pay period), for an indefinite period of time.	▪ PEP ▪ PIE ▪ Safety Award ▪ Service Pins ▪ Health** ▪ Dental*** ▪ Vision***	▪ Short Term Disability*** ▪ Flexible Spending Account Plans - Health Care Reimbursement Account** - Dependent Care Reimbursement Account ▪ Unpaid Leave	▪ 401(k) ▪ ESOP (NHC Owned Locations Only)* ▪ Stock Purchase Plan ▪ Tuition Reimbursement ▪ Credit Union ▪ Partner Discounts
PRN Part-Time, used only on an as needed basis regardless of number of hours worked per week.	▪ PEP ▪ PIE ▪ Safety Award ▪ Service Pins ▪ Health**	▪ Flexible Spending Account Plans - Health Care Reimbursement Account** - Dependent Care Reimbursement Account	▪ 401(k) ▪ ESOP (NHC Owned Locations Only)* ▪ Stock Purchase Plan ▪ Tuition Reimbursement ▪ Credit Union ▪ Partner Discounts
TEMPORARY Working Full or Part-time hours for a limited period of time and typically working on a short term basis.	▪ PEP ▪ Safety Award ▪ Tuition Reimbursement ▪ Partner Discounts ▪ Credit Union		

**Plan frozen 12/14/2009 - participation is closed to new participants.*

***Partners must be eligible to participate in the NHC Health Benefit Plan as determined by the Affordable Care Act (ACA).*

****Eligibility requires a regular schedule of 20 or more hours each week.*

The intent of the NHC-sponsored benefit plans is to provide a complete benefits package in compliance with the provisions of all applicable benefit laws and regulations.

Excellence Programs

Most employers offer two excellence programs whereby you may be rewarded for exceptional contributions made by you and your co-workers in providing customer satisfaction and achieving company goals.

A safety awareness cash award is also available to honor partners who help maintain a safe work environment.

Partner Excellence Program (PEP)

PEP was created with the belief that individual partner performance must excel if NHC is to continue to have satisfied customers.

Customers can recognize partners' performance by completing a PEP card. Customers can include patients, family members and patient visitors. Supervisors and partners can also award cards for specific exceptional service.

Customer satisfaction activity is identified and reported on PEP cards that are available throughout your worksite.

In addition to PEP cards, each center will sponsor a monthly PEP drawing for a cash award. Partners receiving PEP cards during the one month immediately prior to the drawing are eligible for participation.

Partners Incentive for Excellence (PIE)

PIE is a financial bonus paid at eligible NHC locations. The PIE bonus may be awarded to partners who have achieved NHC's excellence goals. Regardless of length of service, you are eligible to receive the bonus when: (a) you are actively employed on the date that the PIE bonus checks are distributed from your employer, and (b) you were employed during the six months upon which the bonus is based (the first 6 month period ends on June 30 and the second 6 month period ends on December 31). A pro-rated PIE Bonus is paid to partners who were hired within the 6 month bonus period. The bonus is paid twice each year, on or about September 1 (for period ending June 30) and on or about March 1 (for period ending December 31).

Safety Awareness Cash Awards

Safety award drawings are held to recognize partners of qualified employers where no partners miss work because of an on the job injury in a specified 30 day period.

All partners are included in the drawing. Each winner receives $20.00 in cash at the time of the drawing.

Service Awards

Partners are awarded service awards for their loyalty to the company. Partners who have achieved one or more years of service with NHC are awarded a service pin that represents the years of service they have completed with NHC.

Years of service include only those years employed by an NHC affiliated company. Prior service with an unaffiliated owner is excluded.

NHC years of service that contain a break of employment can be added together in order to receive a service pin representing total service with NHC.

NHC ABSENCE / LEAVE FORM

Partner Name: _____

Employer Name: _____

All partners (Full, Part, IPAR, etc.) must complete this section if you have an absence:

ABSENCE _____ _____ _____
Beginning Date Ending Date Total Days/Hours

My absence was planned/scheduled at least 24 hours in advance, or was an approved exception:

_____ _____
Yes No

Complete the following request for Benefit Payment:

	Beginning Date	Ending Date	Total Days/Hours Requested
☐ **ETO**	_____	_____	_____
☐ **Sick**	_____	_____	_____
	Outpatient Treatment or Hospital Admission (circle if applicable)		
☐ **PA**	_____	_____	_____
	Personal Medical or Family Medical Purpose (circle one)		

	Beginning Date	Ending Date	Total Days/Hours Requested	
☐ **Bereavement**	_____	_____	_____	_____ Relationship
☐ **Jury/Witness Pay**	_____	_____	_____	_____ Amount Received from Court Attach Receipt

NOTE: COMPLETE A FORM FOR EACH ABSENCE (IF DAYS ARE NOT CONSECUTIVE)

Partner Signature: _____ **Date:** _____

Approved By: _____ **Date:** _____
Initials Title

Earned Time Off (ETO)

Holidays and vacation days are added together to establish your Earned Time Off (ETO) account. ETO allows you to take time off at the time most convenient for your personal needs as long as patient care is not affected. Your ETO plan is flexible and allows you to decide when, how much, and the purpose for which you want time off. Another benefit is that ETO can be taken in 2 hour increments (hourly partners only), 1/2 day increments, 1 day increments or several days at a time. Exempt partners must contact their employer for policy compliance.

ETO Eligibility and How ETO Is Earned

You must have at least 3 full months of full-time service and be a full-time partner to be eligible for ETO. **Your ETO balance must appear on your paycheck stub prior to the pay period in which you wish to use your ETO.** ETO earnings begin with date of full-time employment. **Part-time, IPAR, PRN or Temporary Partners are not eligible for ETO.**

To earn ETO Days each month you must be an active partner and be paid a minimum of 125 hours (excluding overtime) in a month with 2 payroll ending dates or 187.50 hours (excluding overtime) in a month with 3 payroll ending dates. Earnings occur on the last pay period of each month. Updated ETO account balances appear on your check stub each pay period.

Your ETO account includes a maximum account balance available to be taken off with pay. Once your account reaches the maximum applicable to you, based on your years of full-time service, the available ETO balance will remain the same (with no increase in balance) until you have used enough ETO days to bring your balance below the allowable maximum.

ETO ACCOUNT EARNING AND BALANCES

Length of Full-time Service	ETO Days Earned Each Year	ETO Days Earned Monthly	Maximum Account Balance
1 through 12 Months	15	1.250	15
13 through 36 Months	20	1.667	27
37 through 60 Months	21	1.750	27
5 Years to 10 Years	22	1.834	27
10 Years to 15 Years	23	1.917	27
15 Years and Over	24	2.000	27

ETO Scheduling

Time off must be pre-approved by your supervisor. This ensures that quality patient care will continue in your absence. We cannot guarantee that your ETO request for a specific time may be granted. However, every effort will be made to approve reasonable ETO requests.

Requests for ETO near and during Thanksgiving and Christmas may be difficult to accommodate since there are high numbers of requests for time off during the holiday season. Only one ETO day should be requested during the seven days before Thanksgiving Day and seven days after Thanksgiving Day. Only two days should be requested during the period seven days prior to Christmas Day and seven days after New Year's Day. This helps to honor many more requests for time off, while also meeting patient care needs during the traditional holiday season.

NHC Absence/Leave Form must be submitted to your supervisor for approval of the requested days. The form will also be used as a request for payment for all applicable paid leave days.

ETO Pay

For pay purposes, ETO days are equivalent in length to your normal work-day. If your normal work-day is 7 1/2 hours, your ETO day will also equal 7 1/2 hours. A 12 hour shift partner should submit an ETO request for 1.50 days to be paid 12 hours of ETO.

Any partner who works a scheduled shift on one of the five designated holidays (New Year's Day, Independence Day (July 4), Labor Day, Thanksgiving Day, or Christmas Day) may elect to be paid for earned ETO in addition to being paid for time worked.

Holiday Premium

Hourly partners will be paid a holiday premium of 1/4 times all hours worked on Thanksgiving Day (7:00 AM to 7:00 AM) and/or Christmas Day (7:00 AM to 7:00 AM). The holiday premium will be posted as "Other Pay" on your check stub.

The holiday premium will also be available in addition to your approved request for a paid ETO day, in accordance with the policy, while working on either of the 2 designated holidays.

Status Changes

If you change from full-time status to IPAR, Part-time, PRN or Temporary status, your ETO balance will remain until full balance has been used, but the ETO earnings will stop. When returning to a full-time status, all periods of full-time service will count towards benefit days earnings and eligibility.

If you terminate from employment no further additions will be made to your ETO account after your last day work. You may be paid your ETO account balance (subject to 2 hour or half day increments) when you meet the following conditions, subject to state and federal law:

(1) Your introductory period has ended;

(2) Six months of full-time employment have been completed;

(3) A voluntary resignation has been given in writing with at least 14 calendar days' notice. Licensed professionals and salaried, or "exempt", partners should provide a 30-calendar day notice.

(4) You have not been terminated for gross misconduct, violation of workplace rules or gross neglect of duties.

Your supervisor must approve all terminal ETO pay.

At your employer's discretion, ETO days may be applied to your notice of resignation period.

If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of earned benefits.

Sick Leave Benefits

NOTE: Specific Sick Leave Benefits for Massachusetts partners begin on page 7.

Temporary absences from work because of your own illness may be paid from your Sick Leave Account. Sick Leave is available for illnesses that are severe enough to result in your temporary inability to come to work.

Sick Leave Eligibility and How Sick Leave is Earned

You must have at least 6 months of full-time service and be a full-time partner to be eligible for Sick Leave. Your Sick Leave balance must appear on your paycheck stub prior to the pay period in which you wish to use your Sick Leave. IPAR, Part-time, PRN or Temporary Partners are not eligible to earn Sick Leave Days. For pay purposes, Sick Leave Days are equivalent in length to your normal work-day. Sick Leave can be used in increments as small as 15 minutes. Exempt partners must contact their employer for policy compliance.

To earn Sick Days each month, you must be an active partner and be paid a minimum of 125 hours (excluding overtime) in a month with 2 payroll ending dates or 187.50 hours (excluding overtime) in a month with 3 payroll ending dates. Earnings occur on the last pay period of each month. Updated Sick Leave account balances appear on your check stub each pay period.

Your Sick Leave Account includes a maximum account balance available to be taken off with pay for your own illness (except as required by state law). Once your account reaches the maximum applicable to you, based on your years of full-time service, the available Sick Leave Days will remain the same (with no increase in the balance) until you have used enough Sick hours or days to bring your balance below the allowable maximum.

SICK LEAVE ACCOUNT EARNINGS AND BALANCES

Length of Full-time Service	Sick Leave Days Earned Each Year	Sick Leave Days Earned Monthly	Maximum Account Balance
1 through 12 Months	5	.417	5
13 through 24 Months	9	.750	14
25 through 36 Months	9	.750	23
37 months to 15 Years	9	.750	30
16 Years	9	.750	31
17 Years	9	.750	32
18 Years	9	.750	33
19 Years	9	.750	34
20 Years and Over	9	.750	35

If you are admitted to a hospital, excluding emergency room treatment, on your first day of absence, the balance in your sick leave account is available for the duration of the illness or until the balance is exhausted, whichever comes first. Hospital admission includes outpatient surgery, outpatient procedures and outpatient treatment, such as chemotherapy, rehabilitation, radiation, etc.

Except as required by state law, if you have an illness without a hospitalization, your Sick Leave can start on the 2nd consecutive scheduled work day of illness (after 1 day without sick pay) and continue until either your Sick Leave Account is exhausted or your illness ends, whichever comes first.

Perfect Attendance Days (PA Days) are designed to be available for day 1 of your illness or to pay after your Sick Days have been exhausted. If PA days are not available, you may use days from your ETO account.

An NHC Absence/Leave From must be submitted to your supervisor for approval of the absence. The form will also be used as a request for payment for all applicable paid leave days.

You may be required to provide a doctor's certification to establish the need for Sick Leave. It may also be necessary for you to submit to a medical examination by a physician chosen by the company to decide if Sick Leave should be granted. When you are ready to return to work, your supervisor may require a doctor's certification stating that you are capable to come back to work.

Because you work closely with patients, it is necessary that whenever you become ill at work, you notify your supervisor to determine whether you should continue to work. It is also critical that if you become ill at home, and your doctor tells you that you have an infectious disease, you must notify your supervisor so that any necessary precautions to protect other partners and patients can be taken. If your supervisor decides that you are too ill to work, you will be prevented from working due to medical reasons and your absence will be considered a Sick Day under this policy and subject to established waiting periods as defined in the Sick Leave policy.

Unused Sick Leave Days are not payable, and no longer available, upon your termination from employment or if you change status from Full-time to IPAR, Part-time, PRN or Temporary.

If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of earned benefits.

Massachusetts Partners: Subject to Code of Massachusetts – Title 940, Chapter 33.00
Effective July 1, 2015

Sick Leave Benefits for Massachusetts Partners

Temporary absences from work may be paid from your Sick Leave Account for Qualifying Absences defined as; 1) your own illness, 2) illness of your child, spouse, parent or parent of your spouse, 3) routine medical appointment for you, your child, spouse, parent or parent of your spouse, 4) psychological, physical or legal effects of domestic violence and 5) travel related to the above.

For the purposes of this policy, "child" means a biological, adopted, foster child, stepchild, a legal ward or a child of the partner who has assumed the responsibilities of parenthood. "Parent" means a biological, adoptive, foster or step-parent of a partner or of a partner's spouse, or another person who assumed the responsibilities of parenthood when the partner or partner's spouse was a child.

Sick Leave Eligibility and How Sick Leave is Earned

All Massachusetts partners are eligible to earn Sick Leave. Earnings will be based on your length of employment service and subject to the Code of Massachusetts – Title 940, Chapter 33.00 and NHC Sick Leave Earnings & Usage policy.

Full-Time partners with one year or less of employment service and non-Full-Time partners will earn one (1) hour of Sick Leave for each 30 hours paid up to a maximum of 40 hours.

Full-Time partners with more than one year of employment service will earn Sick Leave in accordance with NHC Sick Leave Earnings and Usage policy as stated within this section.

Earnings occur on the last pay period of each month. Updated Sick Leave account balances appear on your check stub each pay period.

Your Sick Leave Account includes a maximum account balance available to be taken off with pay for Qualifying Absences. Once your account reaches the maximum applicable to you, based on your length of employment service, the available Sick Leave will remain the same (with no increase in the balance).

SICK LEAVE ACCOUNT EARNINGS AND BALANCES
(Full-Time Massachusetts Partners)

Length of Full-time Service	Sick Leave Days Earned Each Year	Sick Leave Earned Monthly	Maximum Account Balance
1 through 12 Months	5	1 hour for each 30 hours paid	5
13 through 24 Months	9	.750/day	14
25 through 36 Months	9	.750/day	23
37 through to 15 Years	9	.750/day	30
16 Years	9	.750/day	31
17 Years	9	.750/day	32
18 Years	9	.750/day	33
19 Years	9	.750/day	34
20 Years and Over	9	.750/day	35

SICK LEAVE ACCOUNT EARNINGS AND BALANCES (IPAR, Part-Time, PRN & Temporary Massachusetts Partners)			
Length of Employment Service	**Sick Leave Days Earned Each Year**	**Sick Leave Earned Monthly**	**Maximum Account Balance**
1 Month and Over	5	1 hour for each 30 hours paid	5

Sick Leave Usage

You must have at least 90 days of employment service to be eligible to use Sick Leave. Your Sick Leave balance must appear on your paycheck stub prior to the pay period in which you wish to use your Sick Leave. For pay purposes, Sick Leave Days are equivalent in length to your normal work-day. Sick Leave can be used in increments as small as 15 minutes. Exempt partners must contact their employer for policy compliance.

Massachusetts Sick Leave

Up to and Including the First 40 Hours of Massachusetts Sick Leave Used:

If you have a Qualifying Absence, your Sick Leave can start on the first scheduled work-day of that absence.

NHC Sick Leave

***After* the First 40 Hours of Massachusetts Sick Leave Used:**

If you have a Qualifying Absence, your NHC Sick Leave will start on the 2nd consecutive scheduled work day of the absence (after 1 day without Sick pay) and continue until either your NHC Sick Leave Account is exhausted or the Qualifying Absence ends, whichever occurs first.

In the event of a hospitalization (excluding emergency room treatment) for yourself, your child, spouse, parent or parent of your spouse, your NHC Sick Leave Account balance is available on the first day of absence and for the duration of the illness or until the balance is exhausted, whichever occurs first. Hospital admission includes outpatient surgery, outpatient procedures and outpatient treatment, such as chemotherapy, rehabilitation, radiation, etc.

Additional Guidelines Applicable to both Massachusetts & NHC Sick Leave

If you are a Full-Time partner, NHC Perfect Attendance Days (PA Days) are designed to be available for day 1 of your illness or to pay after your Sick Leave has been exhausted. If PA days are not available, you may use days from your ETO account to supplement your Sick Leave Days.

An NHC Absence/Leave Form must be submitted to your supervisor for approval of any absence resulting from a Qualifying Absence. The form will also be used as a request for payment for all applicable paid leave days.

You may be required to provide a doctor's certification to establish the need for Sick Leave. It may also be necessary for you to submit to a medical examination by a physician chosen by the company to decide if Sick Leave should be granted. When you are ready to return to work, your supervisor may require a doctor's certification stating that you are capable to come back to work.

Because you work closely with patients, it is necessary that whenever you become ill at work, you notify your supervisor to determine whether you should continue to work. It is also critical that if you become ill at home, and your doctor tells you that you have an infectious disease, you must notify your supervisor so that any necessary precautions to protect other partners and patients can be taken. If your supervisor decides that you are too ill to work, you will be prevented from working due to medical reasons and your absence will be considered a Sick Day under this policy and subject to established waiting periods as defined in the NHC Sick Leave policy.

If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another

person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of earned benefits.

If your employment status changes from Full-time to IPAR, Part-time, PRN or Temporary status, your Sick Leave balance will remain in your account until the balance is used. Future Sick Leave earnings are subject to Code of Massachusetts – Title 940, Chapter 33.00.

Unused Sick Leave Days are not payable upon termination of employment.

Massachusetts Break In Service Rules

- Following a break in service of up to 4 months, unused Sick Leave earned before the break in service will be reinstated. The maximum that can be reinstated is 40 hours.
- Following a break in service between 4 and 12 months, unused Sick Leave earned before the break in service will be reinstated if the balance of unused sick time equals or exceeds 10 hours. The maximum that can be reinstated is 40 hours.
- Following a break in service of up to 12 months, you will not be required to restart the 90-day waiting period.

Perfect Attendance Days (PA Days)

You can earn Perfect Attendance (PA) Days as a reward for planning and communicating your work schedule interruptions to your supervisor at least 24 hours in advance. You may earn the equivalent of 2 bonus days each year.

You must have at least 6 months of full-time service and be a full-time partner to be eligible for PA Days. Your PA balance must appear on your paycheck stub prior to the pay period in which you wish to use your PA days. IPAR, Part-time, PRN or Temporary Partners are not eligible to earn PA Days.

PA Days are earned monthly based on your lack of unscheduled or unplanned absences from your scheduled work times. There may be times when some unavoidable incident will cause an unplanned/unscheduled absence. For months in which these unplanned absences occur, you would not earn any portion of a PA day. A distinction should be made between scheduled and approved absences. The fact that an absence was approved will not change the fact that it may have been unscheduled.

For pay purposes, PA days are equivalent in length to your normal work-day. PA days can be used in increments as small as 15 minutes. Exempt partners must contact their employer for policy compliance.

To earn PA Days each month you must be an active partner and be paid a minimum of 125 hours (excluding overtime) in a month with 2 payroll ending dates or 187.50 hours (excluding overtime) in a month with 3 payroll ending dates. Earnings occur on the last pay period of each month. Updated PA account balances appear on your check stub each pay period.

Your PA account has a 4 day maximum balance. When your account reaches 4 days, all future earnings are added to your ETO balance. This movement from PA days to ETO days will continue as long as your PA balance remains at 4.

PERFECT ATTENDANCE LEAVE ACCOUNT EARNINGS AND BALANCES

Length of Full-time Service	PA Days Earned Each Year	PA Days Earned Monthly	Maximum Account Balance
All	2	.167	4

An NHC Absence/Leave Form must be submitted to your supervisor for approval of the absence. The form will also be used as a request for payment of all applicable paid leave days.

PA Days are designed to supplement your Sick Leave Account. They can be used to pay for the first day of absence due to your illness or after all Sick Leave Days have been paid. They can also be used for all family medical needs.

PA Days are not payable, and no longer available, upon termination from employment or changes from Full-Time to IPAR, Part-time, PRN or Temporary.

If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of earned benefits.

Additional Paid and Unpaid Time Off

You may be eligible for the following types of special paid leave or unpaid leave after proper notification to and approval by your supervisor. Leave periods may impact your benefit eligibility to include insurance coverage.

Bereavement Leave (Paid Leave)

You must be full-time and have completed your introductory period to be eligible for Bereavement Leave.

This paid leave of absence of up to 3 scheduled working days is available to help ease the hardship caused by the death of an immediate family member (spouse, child, father, mother, brother or sister). Partners working 12 hour shifts can receive up to 2 scheduled working days.

One (1) scheduled working day of Bereavement Leave is available for time lost associated with the death of a partner's mother-in-law, father-in-law, grandparent or grandchild.

In the event of the death of an eligible family member, bereavement leave will be available to full-time partners who are on an active FMLA leave. Partners on FMLA may request the appropriate bereavement leave provided above based on their typical scheduled work-day (i.e., 7.5, 8 or 12 hour shifts). Partners on any other leave of absence are excluded from bereavement leave eligibility.

You must submit your request for Bereavement Leave on the NHC Absence/Leave Form.

Jury Duty Leave (Paid Leave)

You should notify your supervisor as soon as possible if you receive a jury summons. If you are required to serve on a jury during normally scheduled work-days you will not have your total pay reduced or lost. When permitted by law, you will be entitled to a jury duty differential. This means that you will be paid the difference between your normal scheduled hours of straight time pay and the payments received from the government for jury duty service. To receive jury duty differential, you must submit your jury duty pay record, and an NHC Absence/Leave Form, to your Supervisor or the Business Office so that your pay can be adjusted accordingly.

Family and Medical Leave Act - FMLA (Unpaid Leave)

FMLA allows partners who have worked for the company for at least 12 months (not required to be consecutive) and for at least 1,250 hours during the preceding 12 month period to request FMLA leave. If you are eligible, you are entitled to up to 12 (normally scheduled) workweeks of unpaid leave in a 12 month period. The 12 month period is calculated on a rolling basis starting on the first day of your first FMLA leave. You should contact your employer to determine if there are any state laws that may have an impact on your FMLA leave time.

If you are eligible, you are entitled to:

- Twelve workweeks of leave in a 12-month period for:
  - the birth of a child and to care for the newborn child within one year of birth;
  - the placement with you of a child for adoption or foster care and to care for the newly placed child within one year of placement;
  - to care for your spouse, child, or parent who has a serious health condition;
  - a serious health condition that makes you unable to perform the essential functions of your job;
  - any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered military member on "covered active duty;" **or**
- Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if you are the service member's spouse, child, parent, or next of kin (military caregiver leave).

You may use more than one FMLA-qualifying reason during a 12-month period as long as it does not exceed 12 workweeks, with the exception of military caregiver leave. The regulations provide you to be entitled to a combined total of 26 workweeks of military caregiver leave and leave for any other FMLA-qualifying reason in this "single 12-month period," provided that you may not take more than 12 workweeks of leave for any other FMLA-qualifying reason during this period. For example, in the single 12-month period you could take 12 weeks of FMLA leave to care for a newborn child and 14 weeks of military caregiver leave, but could not take 18 weeks of leave to care for a newborn child and 8 weeks of military caregiver leave.

Intermittent leave or reduced schedule leave may be included in the total FMLA available. Intermittent leave is taken in separate blocks of time due to a single illness or injury. Intermittent or reduced leave requires medical necessity certification. Intermittent leave for your own personal illness is limited solely to times scheduled for treatment, or for recovery from either illness or treatment. Your employer has the right to temporarily transfer you to an alternative position that better accommodates the recurring leave.

Notice of Need for FMLA Leave

When your need for FMLA is foreseeable, you are required to give 30 days' advance written notice of the dates of the leave, and you should contact your supervisor about filling out an Application for Family Medical Leave. Failure to provide the required 30-day notice may result in your leave being delayed. When your need for FMLA is not foreseeable, you are still required to give as much notice as possible and complete the appropriate application for FMLA leave. Leave certification forms must be completed and returned to your employer before the leave begins or within 15 calendar days from the date the forms are received, or your leave may be denied. You will be notified by your employer whether the request is approved and whether the leave will be designated as FMLA leave.

During leave, you must keep your supervisor informed of the estimated duration of leave and your intended date to return from leave. You may be required to submit re-certification of the serious health condition on a reasonable basis during your leave.

Illness Related FMLA Leave Documentation

If you wish to take FMLA leave for your own or your spouse's, child's or parent's serious health condition you are required to provide a medical certification form completed by a relevant health care provider to document your reason for FMLA. Medical certification forms must be returned to your employer before the leave begins or within 15 calendar days from the date the forms are received, or your leave may be denied. At the company's expense, a second opinion may be required. If the second opinion differs, a third opinion may be required from a mutually agreeable health care provider (at the company's expense), which is considered final and binding.

You may be required to submit re-certification for serious health conditions during your FMLA leave. Your employer may request reasonable periodic reports about your status and your intention to return to work. When FMLA is for your own serious health condition, you will be required to present a written fitness for duty statement from a health care provider that certifies you can return to work. Your fitness for duty statement must be received before you return to work.

Pay and Benefits During FMLA Leave

You will continue to receive your health benefits (if applicable) while on FMLA leave as long as you continue to pay your portion of the premium. Please refer to the Insurance Plan section of this Handbook for further detail. All other benefit earnings (i.e. ETO and employment start date) remain the same during your FMLA leave. During your FMLA leave you will not lose any benefits already accrued.

FMLA is unpaid. However, during FMLA leave for your own serious health condition, you may choose to take any earned PA, Sick or ETO days. During FMLA leave for any other reason than your own serious health condition, you may choose to take earned ETO and PA days (Except as required by state law, sick days may only be taken for your own illness). Paid leave time counts toward your 12 week FMLA leave.

Partner Reinstatement after FMLA Leave

If you return to work as scheduled from an approved FMLA leave, you will be reinstated to the same or an equivalent position. If you do not return as scheduled from an approved FMLA leave, you will be considered to have voluntarily resigned your employment.

You should contact your supervisor as soon as possible if you are unable to return to work following your FMLA leave to discuss your options. You can submit a written request for a Personal Leave of Absence which can only be granted with supervisor approval. The other option is to terminate your employment and re-apply when your situation is suitable for the position for which you are qualified.

Medical Leave of Absence (Unpaid Leave)

If you have an illness that extends beyond your earned Sick Leave, a Medical Leave of Absence may be available to you.

In order to be eligible for the Medical Leave of Absence, you must be regularly scheduled full-time hours and have completed your introductory period and not be eligible for FMLA Leave.

The Medical Leave of Absence is available only for your own illness. You will be required to complete a medical certification form to document your need for the leave. In some instances, you may even be asked to get a 2nd opinion as to the need of the leave.

Your health benefits will be maintained up to 60 calendar days and you will be responsible for paying your normal portion of the monthly premium. Please refer to the Insurance Plan section of this Handbook for further detail.

Your Medical Leave of Absence is limited to 60 calendar days. Medical Leave of Absence makes no guarantee that you will be returned to your same job or that a job will be available when you are ready to return to work.

You should contact your supervisor as soon as possible if you are unable to return to work by the end of the 60 calendar day leave to discuss your options. You can submit a written request for a Personal Leave of Absence which can only be granted with supervisor approval. The other option is to terminate your employment and re-apply when your situation is suitable for the position for which you are qualified.

Personal Leave of Absence (Unpaid Leave)

Personal situations sometimes occur that necessitate extended time off from work. Personal Leaves of Absence are available for those situations.

Personal Leaves of Absence allow you to protect your prior service time with your employer while on leave.

You must be a regularly scheduled full-time or regularly scheduled part-time partner to be eligible for a Personal Leave of Absence.

Personal Leave of Absence is available to partners who otherwise are not eligible for FMLA because of the circumstances necessitating the leave or not meeting prior service and work hours requirements, or who have exhausted the leave period under FMLA or unpaid medical leave plans.

You must apply for a Personal Leave of Absence in writing as far in advance as possible. Your written request must contain the purpose for the leave and the projected amount of time off required to satisfy your need. Each request is considered on a case-by-case basis weighing such factors as patient care needs, partner performance records, urgency and legal requirements.

During the leave, ETO, Sick, PA and other benefits will not accumulate. To determine the effect of Personal Leave on your insurance benefits, please see the Insurance section of this Handbook for further detail.

You will be required to keep your supervisor updated as to the accuracy of this original projected return date. All changes to the anticipated return date must be approved by your supervisor.

There is no guarantee that you will be assigned to the same position or shift or that a position will be available at the time you are available to return to work.

Military Leave (Unpaid Leave)

The company recognizes that some partners may be called upon to serve in the military. Your employer grants military leaves of absence provided you submit written verification of a call to duty from the appropriate military authority, and the cumulative period of military service with your employer does not exceed five years.

The company also grants you unpaid time off to meet your training obligations in the Active Reserves. If you are involved in periodic reserve training, you are not required to use ETO, but may choose to do so if you desire pay for hours on military duty.

Witness Duty Leave (Unpaid Leave)

If you are required by law to appear in court as a witness, you may take unpaid time off for such purpose provided you give the company reasonable advance notice.

You must make a request for Witness Leave in writing and provide the request to your supervisor together with evidence of the requirement to serve as a witness. Leave will be unpaid except where otherwise required by law.

Witness Duty Leave (Paid Leave)

If you appear as a witness on behalf of the company, you will receive your regular pay with evidence of the requirement to serve as a witness.

Workers' Compensation Leave

For information related to Workers' Compensation Leave, please refer to your NHC Partner Handbook.

Insurance Plans

All insurance plans sponsored by NHC and its affiliated companies are effective on your initial eligibility date, if you choose to participate. Your initial eligibility date is the first of the month following 60 days of eligible employment status.

You must elect or waive insurance benefits online at https://nhcpartnerbenefits.com within 45 days of your date of employment.

From your initial eligibility date forward, you will have an annual opportunity to enroll online in each plan or make changes to your plan participation.

If you chose not to enroll when you first became eligible, annual enrollment may carry with it some late entry penalties. Each plan varies as to the specific applicable penalty.

If you enroll in a plan or plans or you choose not to enroll in a plan or plans, you will have only one opportunity each year (January 1) to change your enrollments.

For example, this means that if you enroll in the Health Benefit Plan, you cannot drop or change your coverage until January 1 of the following year (with one exception). The same would be true if you choose not to enroll in the Health Benefit Plan, you would not be eligible to enroll again until January 1 of the following year (also with one exception).

The exception is if you experience a change in status, you may be eligible to change your enrollment in the company-sponsored insurance plans.

A change in status is defined in the Summary Plan Description of each insurance benefit.

Request for a participation change based on a change in status must be made within 31 days of the status change.

When enrolling, you should consider that your only opportunity to start coverage, stop coverage, or change coverage will be January 1 of the following year unless you experience a status change.

Termination or job abandonment of employment, as defined in the NHC Partner Handbook, may result in forfeiture of insurance benefits.

NHC

2020 ENROLLMENT FORM

Partner Information

Location: _____ Job Title: _____

Name: _____ Date of Birth: _____

Address: _____ Date of Hire: _____

City, ST, Zip: _____ Social Security #: _____

Home Phone: _____ Gender: ☐ *Male* ☐ *Female*

Status: ☐ *Full-time* ☐ *IPAR* ☐ *Part-time* ☐ *PRN* Marital Status: ☐ *Single* ☐ *Married*

PLAN ADMINISTRATOR USE ONLY: BENEFIT LEVEL CODE | EMP. STATUS DATE | EFFECTIVE DATE | CLASS CODE | TERMINATION DATE | INITIAL ELIG./LATE APP.

Before-Tax Benefit Options

Fill in contribution of your choice

HEALTH BENEFIT PLAN — *Medical*

	PARTNER ONLY	PARTNER PLUS SPOUSE	PARTNER PLUS CHILD(REN)	PARTNER PLUS FAMILY
☐ No Change to Current Coverage				
HSA Value	☐ **$46.25**	☐ **$186.00**	☐ **$176.25**	☐ **$200.25**
Value	☐ **$50.00**	☐ **$198.75**	☐ **$188.25**	☐ **$215.00**
Premier	☐ **$76.00**	☐ **$256.75**	☐ **$236.75**	☐ **$292.00**

☐ Waive Medical Coverage Reason:_____

$_____ *(1st & 2nd pay period)*

DENTAL — *Dental*

	PARTNER ONLY	PARTNER PLUS SPOUSE	PARTNER PLUS CHILD(REN)	PARTNER PLUS FAMILY
☐ No Change to Current Coverage				
Dental High	☐ **$28.54**	☐ **$64.68**	☐ **$69.69**	☐ **$83.84**
Dental Low	☐ **$15.62**	☐ **$36.92**	☐ **$39.87**	☐ **$48.12**

☐ Waive Dental Coverage Reason:_____

$_____ *(1st pay period)*

VISION — *Vision*

	PARTNER ONLY	PARTNER PLUS SPOUSE	PARTNER PLUS CHILD(REN)	PARTNER PLUS FAMILY
☐ No Change to Current Coverage				
Vision Coverage	☐ **$7.95**	☐ **$17.53**	☐ **$18.86**	☐ **$22.61**

☐ Waive Vision Coverage Reason:_____

$_____ *(2nd pay period)*

FLEXIBLE SPENDING ACCOUNT (FSA) — *FSA*

Health Care FSA (Health Care Reimbursement Account or HCRA)
Maximum $2,700. Not to exceed the lesser of stated IRS maximum, your salary, your spouse's salary or your expenses.
Not available if participating in the HSA Value Option.
Calculation based on 2 deductions each month.

Health Care Deduction
$_____ *(1st & 2nd pay period)*

Dependent Care FSA (Dependent Care Reimbursement Account or DCRA)
Maximum $5,000. Not to exceed the lesser of stated IRS maximum, your salary, your spouse's salary, or your expenses.
Calculation based on 2 deductions each month.

Dependent Care Deduction
$_____ *(1st & 2nd pay period)*

After-Tax Benefit Options

Fill in contribution of your choice

SHORT TERM DISABILITY — *Short Term Disability*

☐ No Change to Current Coverage	WEEKLY BENEFIT	MONTHLY PREMIUM	WEEKLY BENEFIT	MONTHLY PREMIUM	WEEKLY BENEFIT	MONTHLY PREMIUM	WEEKLY BENEFIT	MONTHLY PREMIUM	WEEKLY BENEFIT	MONTHLY PREMIUM	WEEKLY BENEFIT	MONTHLY PREMIUM
	☐ $100	**$6.02**	☐ $450	**$27.09**	☐ $800	**$48.16**	☐ $1,150	**$69.23**	☐ $1,500	**$90.30**	☐ $1,850	**$111.37**
	☐ $150	**$9.03**	☐ $500	**$30.10**	☐ $850	**$51.17**	☐ $1,200	**$72.24**	☐ $1,550	**$93.31**	☐ $1,900	**$114.38**
	☐ $200	**$12.04**	☐ $550	**$33.11**	☐ $900	**$54.18**	☐ $1,250	**$75.25**	☐ $1,600	**$96.32**	☐ $1,950	**$117.39**
☐ Waive Short Term Disability	☐ $250	**$15.05**	☐ $600	**$36.12**	☐ $950	**$57.19**	☐ $1,300	**$78.26**	☐ $1,650	**$99.33**	☐ $2,000	**$120.40**
	☐ $300	**$18.06**	☐ $650	**$39.13**	☐ $1,000	**$60.20**	☐ $1,350	**$81.27**	☐ $1,700	**$102.34**		
	☐ $350	**$21.07**	☐ $700	**$42.14**	☐ $1,050	**$63.21**	☐ $1,400	**$84.28**	☐ $1,750	**$105.35**		
	☐ $400	**$24.08**	☐ $750	**$45.15**	☐ $1,100	**$66.22**	☐ $1,450	**$87.29**	☐ $1,800	**$108.36**		

Choose any amount between $100-$2,000, not to exceed 70% of Basic Weekly Income (excluding bonuses, overtime and any extra compensation other than commissions). If you choose an amount greater than 70% of your Basic Weekly Income, benefit amount will be reduced at time of claim. Premium adjustment in these situations will be made only for the prior 12 months.

$_____ *(2nd pay period)*

BASIC TERM LIFE AND AD&D INSURANCE — *Term Life*

Your Basic Term Life and AD&D Insurance amount is based on your years of service. *A beneficiary form MUST be completed.*

COMPANY PAID

PARTNER AND DEPENDENT TERM LIFE INSURANCE — *Partner & Dependent Term Life*

A beneficiary form MUST be completed. Spouse may not exceed 50% of covered partner's amount; Child(ren)may not exceed 25% of covered partner's amount.

Partner	*Spouse*	*Child(ren)*
☐ No Changes to Current Coverage	☐ No Change to Current Spouse Coverage	☐ No Change to Current Child(ren) Coverage
☐ **$10,000** ☐ **$75,000** ☐ **$125,000**	☐ **$5,000** ☐ **$37,500** ☐ **$62,500**	☐ **$2,500** ☐ **$18,750**
☐ **$25,000** ☐ **$100,000** ☐ **$150,000**	☐ **$12,500** ☐ **$50,000** ☐ **$75,000**	☐ **$6,250** ☐ **$25,000**
☐ **$50,000**	☐ **$25,000**	☐ **$12,500**
☐ Waive Voluntary Term Life Insurance	☐ Waive Spouse Term Life Insurance	☐ Waive Child(ren) Term Life Insurance

$_____ *(each pay period)*

Dependent Information

In order to be an Eligible Dependent, a person must be enrolled by the Partner and meet at least ONE of the following criteria: 1) Be the Eligible Partner's current spouse while not divorced or legally separated who is a legal US citizen or a non-citizen lawfully residing in the US. The term "spouse" does not include the following: (a) a common law spouse or (b) any domestic relationship other than a marriage that is legally recognized as such by the State of the Eligible Partner's residence; 2) Be the Eligible Partner's (a) natural child; (b) legally adopted child (including children placed for the purpose of adoption); (c) step-child(ren); or (d) children for whom the Eligible Partner is the legal guardian who are less than 26 years old, regardless of financial or marital status; 3) Be a child of the Eligible Partner for whom a Qualified Medical Child Support Order has been issued or 4) Be an Incapacitated Child of the Eligible Partner or the Eligible Partner's spouse. The Plan Administrator reserves the right to require proof of eligibility including, but not limited to marriage certificate, birth certificate, legal adoption or legal custody/guardianship documents and/or a certified copy of any Qualified Medical Child Support Order.

**For Dependent Term Life Insurance, an unmarried child, step-child or legally adopted child up to age 26 is eligible for coverage provided they depend on you for 50% or more of their support and are living with you in a regular parent-child relationship. If any unmarried child over age 26 is 1) Incapable of self-sustaining employment because of mental retardation, developmental disability or physical handicap; and 2) Depends on the Employee for 50% or more of his support; that child will continue to be a Dependent under this Policy for as long as these two conditions exist.*

NAME	SSN	DATE OF BIRTH	RELATIONSHIP*	GENDER	RESIDES WITH & SUPPORTED BY PARTNER	MEDICAL	DENTAL	VISION	DEPENDENT TERM LIFE
				M F	Y N	☐	☐	☐	☐
				M F	Y N	☐	☐	☐	☐
				M F	Y N	☐	☐	☐	☐

*Relationship – please use one of the following codes: **S** = Spouse **C** = Child **SC** = Stepchild **AC** = Legally Adopted Child

Partner Name _____ **Social Security #:** _____

Partner Information – PLEASE READ CAREFULLY

If you do NOT want the health benefit plan, dental or vision coverage, you may waive coverage by placing an X next to the "waive coverage" option and state the reason under each benefit. Even if you want to waive coverage, it is very important for you to read the remainder of this section because you will lose any valuable special enrollment period rights you or your dependent(s) may have by failing to fully complete and submit this enrollment form. If you waive coverage now, then you cannot enroll in the health benefit plan, dental or vision plan until a future annual election period for an immediately following January 1 effective date.

Notice of Limited Special Enrollment Rights – PLEASE READ CAREFULLY

I acknowledge and understand if the reason that I decline enrollment for myself and my dependent(s) is because of other health, dental or vision coverage (including COBRA coverage) and I and my dependent(s) lose this other coverage because of divorce or legal separation, disability, death or loss of coverage by my spouse, then I may in the future be able to enroll myself and my dependent(s) in the health benefit plan, dental or vision coverage during a special enrollment period, provided that I request enrollment within 31 days after such other coverage ends. But in order to be eligible for this special enrollment period, I acknowledge and understand I must indicate on this enrollment that I and my dependent(s) are declining coverage because I and my dependent(s) had this other coverage (including COBRA coverage). Otherwise, I acknowledge and understand that this special enrollment period will not apply or be available to me and my dependent(s). In addition, if a new dependent relationship forms as a result of my marriage, birth, adoption or placement for adoption, I acknowledge and understand that I may be able to enroll myself and my new dependent(s) during a special enrollment period provided that I request enrollment within 31 days after such marriage, birth, adoption or placement for adoption.

Other Special Enrollment Notice

I further acknowledge and understand that I may also be able to enroll myself or my dependent(s) in the health benefit plan within 60 days of the loss of Medicaid or Child Health Insurance Program (CHIP) coverage as a result of loss of eligibility or within 60 days of myself or my dependent(s) becoming eligible for a premium assistance subsidy under Medicaid or CHIP.

Other Health Coverage Information (This Section MUST be completed if there is other CURRENT coverage or Medicare.)

On the day your Health Benefit Plan coverage is to begin, will you or any family members enrolling in this Health Benefit Plan be covered by other Non-Medicare group health coverage or Medicare? ☐ Yes ☐ No. If yes, fill out the remainder of this Section.

LIST OTHER NON-MEDICARE GROUP HEALTH COVERAGE INFORMATION BELOW

COVERAGE TYPE:	SPONSOR'S NAME, ADDRESS & PHONE # OTHER COVERAGE IS THROUGH	POLICY # (IF COVERAGE IS THROUGH INSURANCE)
☐ Medical Insurance		
☐ Other Medical Coverage (name):		

COVERAGE DATE	NAME OF PERSON COVERAGE IS THROUGH	DOB FOR SUCH PERSON	NAMES AND RELATIONSHIPS OF FAMILY MEMBERS COVERED BY OTHER NON-MEDICARE COVERAGE
____ to ____			

LIST MEDICARE COVERAGE INFORMATION BELOW

NAMES OF FAMILY MEMBERS COVERED BY MEDICARE	MEDICARE PART A EFFECTIVE DATE	MEDICARE PART B EFFECTIVE DATE	IS MEDICARE ELIGIBILITY DUE TO
			☐ Kidney failure (ESRD) ☐ Disability ☐ Retirement
			☐ Kidney failure (ESRD) ☐ Disability ☐ Retirement
			☐ Kidney failure (ESRD) ☐ Disability ☐ Retirement

Previous Health Coverage Information (This Section MUST be completed if you had PREVIOUS coverage.)

MUST BE COMPLETED if you and, if applicable, your Dependent(s) had prior health coverage during the previous 12 months. Please submit to the Health Benefit Plan the Certificate of Creditable Coverage which should be provided by the previous health plan.

NAME OF HEALTH PLAN	SPONSOR OF PLAN	FROM	TO

Authorization / Signature *(REQUIRED)*

I understand that I have made an election for my benefits package for the entire plan year and agree that the information provided by me is accurate and that any dependent or beneficiary information provided is subject to the eligibility provisions of the plan documents.

- I hereby authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above.
- I authorize the collection and/or filing of a lawsuit for recovery of monies paid for benefits when a third party is responsible for the injuries or illnesses.
- I understand the benefit elections I have made may only be altered due to a special enrollment right or change in status as defined and permitted under the plan. I understand that if I decline any coverage — other than health coverage — and apply at a later date, I may be required to show evidence of insurability.
- I understand that inaccurate information provided by me could result in the denial of benefits.
- I understand that any dishonesty, misrepresentation or false statements related to enrolling dependents in any insurance plan may result in disciplinary action, up to and including termination of employment.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal penalties. (not enforceable in OR or VA)
- I may enroll, apply for additional coverage, or request a change to all insurance benefits only during a scheduled enrollment period.
- I understand, that for STD coverage:
  - If I am not Actively at Work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of Actively at Work.
  - If I am eligible for state-mandated temporary disability benefits, or any employer-sponsored income replacement plan, the combination of my state mandated benefit or other income benefit and my STD weekly benefit may not exceed 70% of my basic weekly income.
  - New plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA). If my earnings are based in whole or in part on commissions, commissions will be averaged over the 12-month period prior to the date disability begins.
- By signing this Enrollment Form, I hereby state, certify and represent that the information provided is true, accurate, complete and not misleading. I acknowledge, understand and agree that any omissions, or false, inaccurate, incomplete or misleading statements made by me may invalidate my coverage and, if applicable, the coverage of my Dependent(s). I understand that any person who knowingly and with intent to injure, defraud or deceive files a statement of claim or an application containing false, inaccurate, incomplete or misleading information, may be guilty of a punishable crime. I understand that coverage will become effective only on the date specified after enrollment has been approved and after I have paid my share of the first full Premium due.

Partner Signature _____ **Date** _____

Signature Required *Date Required*

NHC
NATIONAL HEALTHCARE CORPORATION

Health Savings Account (HSA) Individual Enrollment Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:

Address: **NHC Partner Insurance**
P.O. Box 7036, Murfreesboro, TN 37133-7036

Fax: 615.278.1241

Eligibility

To determine whether or not you are eligible to open an HSA, please answer the following questions.

☐ YES ☐ NO Are you covered by any other non-qualified health plan, including Medicare?

☐ YES ☐ NO Are you claimed as a dependent on another individual's tax return?

☐ YES ☐ NO Do you have access to dollars in a flexible spending account (FSA), such as NHC's Nontaxable Benefit Plan, that can pay for any medical expenses before the required deductible is met, including a spouse's FSA?

If you answer YES to any of these questions, you are NOT eligible for the NHC HSA Value option. You must elect another plan.

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Health Benefit Plan Coverage – NHC HSA Value Option

Coverage Effective Date	Coverage Type
	☐ Partner Only ☐ Partner Plus Spouse ☐ Partner Plus Child(ren) ☐ Partner Plus Family

Contribution Amount

An HSA allows you to make pre-tax contributions to an FDIC-insured savings account. The best way to make contributions into your account is through payroll contributions so that you avoid payroll taxes on those dollars. As long as you use the money to pay for medical expenses, you never pay taxes or penalties on those dollars. If you are actively employed and eligible to contribute to a HSA account, your employer will cover the monthly administration fee ($2.50) and will contribute the annual amount listed in the table below into your HSA. The employer contribution will be deposited into your HSA account in $25 increments, based on the 24 pay periods that correspond with the medical premium deductions. For newly hired partners, the amount will be pro-rated based on the month in which your coverage is effective.

If you do not participate in the HSA Value option for the entire year or you change your coverage during the tax year, special contribution limits may apply. See a professional tax preparer to avoid possible penalties and income tax consequences.

Coverage Tier	2020 Tax Year Annual Maximum Contribution Amount			
	Employer	Partner	Total	55 or Over*
Partner Only	$600	$2,950	$3,550	$4,550
Partner Plus Spouse	$600	$6,500	$7,100	$8,100
Partner Plus Child(ren)	$600	$6,500	$7,100	$8,100
Partner Plus Family	$600	$6,500	$7,100	$8,100

**If you are age 55 or older, you may also make an additional catch-up contribution up to $1,000.*

Annual amount you wish to contribute:

$_____

You may elect to contribute $0.00 and still receive the employer contribution. After your benefit is active, you can log into My Benefits and change your HSA contribution throughout the calendar year.

Authorization and Certification

- I accept the terms of this HSA enrollment form and the HSA Custodial Agreement. The HSA Custodial Agreement is available on the HealthEquity member portal by looking under Health Account Forms and Agreements.
- In compliance with the USA PATRIOT Act, HealthEquity must verify the identity of all customers seeking to open an HSA. As part of this identity verification process, you may be asked to provide additional information and/or documentation before your account can be established.
- I assume complete responsibility for:
  1) Determining that I am eligible for an HSA each year I make a contribution.
  2) Making a yearly contribution election for each year that I wish to participate in the HSA.
  3) Insuring that all contributions I make are within the limits set forth by the tax laws.
  4) The tax consequences of any contribution (including rollover contributions) and distributions.
  5) Determining whether my spouse, if applicable, is eligible to participate in the plan.

Print Name	Signature	Date

The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), subject to applicable deposit limits.

FDIC

866.346.5800

Revised 10/2017

NHC Health Benefit Plan Premiums

Effective 1/1/2020

PLAN OPTION	Coverage Level	Deduction *Taken Twice Monthly*
HSA Value	Partner Only	$46.25
	Partner + Spouse	$186.00
	Partner + Child(ren)	$176.25
	Partner + Family	$200.25
Value	Partner Only	$50.00
	Partner + Spouse	$198.75
	Partner + Child(ren)	$188.25
	Partner + Family	$215.00
Premier	Partner Only	$76.00
	Partner + Spouse	$256.75
	Partner + Child(ren)	$236.75
	Partner + Family	$292.00

Dental and Vision Premiums

Monthly, Effective 1/1/2020

	Coverage Level	High Plan	Low Plan
DENTAL	Partner Only	$28.54	$15.62
	Partner + Spouse	$64.68	$36.92
	Partner + Child(ren)	$69.69	$39.87
	Partner + Family	$83.84	$48.12
VISION	Partner Only	$7.95	
	Partner + Spouse	$17.53	
	Partner + Child(ren)	$18.86	
	Partner + Family	$22.61	

Partner & Dependent Term Life Insurance w/AD&D Premiums

Bi-Weekly, Effective 1/1/2020

Rates illustrated below are the bi-weekly payroll deduction amount for each applicable benefit amount. Premiums are deducted each pay period of every month..

PARTNER							
Age	**$10,000**	**$25,000**	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**
<25	$0.32	$0.81	$1.62	$2.42	$3.23	$4.04	$4.85
25-29	$0.37	$0.92	$1.85	$2.77	$3.69	$4.62	$5.54
30-34	$0.46	$1.15	$2.31	$3.46	$4.62	$5.77	$6.92
35-39	$0.54	$1.35	$2.70	$4.05	$5.40	$6.75	$8.10
40-44	$0.78	$1.96	$3.92	$5.88	$7.85	$9.81	$11.77
45-49	$1.24	$3.09	$6.18	$9.28	$12.37	$15.46	$18.55
50-54	$2.08	$5.19	$10.38	$15.58	$20.77	$25.96	$31.15
55-59	$3.13	$7.83	$15.67	$23.50	$31.34	$39.17	$47.01
60-64	$4.23	$10.57	$21.14	$31.71	$42.28	$52.85	$63.42
65-69	$6.72	$16.80	$33.60	$50.40	$67.20	$84.00	$100.80
70-74	$17.94	$44.84	$89.68	$134.52	$179.35	$224.19	$269.03
75+	$31.00	$77.49	$154.98	$232.48	$309.97	$387.46	$464.95

SPOUSE							
Age	**$5,000**	**$12,500**	**$25,000**	**$37,500**	**$50,000**	**$62,500**	**$75,000**
<25	$0.16	$0.40	$0.81	$1.21	$1.62	$2.02	$2.42
25-29	$0.18	$0.46	$0.92	$1.38	$1.85	$2.31	$2.77
30-34	$0.23	$0.58	$1.15	$1.73	$2.31	$2.88	$3.46
35-39	$0.27	$0.68	$1.35	$2.03	$2.70	$3.38	$4.05
40-44	$0.39	$0.98	$1.96	$2.94	$3.92	$4.90	$5.88
45-49	$0.62	$1.55	$3.09	$4.64	$6.18	$7.73	$9.28
50-54	$1.04	$2.60	$5.19	$7.79	$10.38	$12.98	$15.58
55-59	$1.57	$3.92	$7.83	$11.75	$15.67	$19.59	$23.50
60-64	$2.11	$5.28	$10.57	$15.85	$21.14	$26.42	$31.71
65-69	$3.36	$8.40	$16.80	$25.20	$33.60	$42.00	$50.40
70-74	$8.97	$22.42	$44.84	$67.26	$89.68	$112.10	$134.52
75+	$15.50	$38.75	$77.49	$116.24	$154.98	$193.73	$232.48

CHILD(REN)	$2,500	$6,250	$12,500	$18,750	$25,000
Premium includes coverage for all current & future eligible children	$0.46	$1.15	$2.31	$3.46	$4.62

Group Term Life Limitations and Exclusions

As is standard with most term life insurance plans, coverage amounts will be reduced at certain ages in order to prevent premium increases. In addition, death by suicide is covered only after the Partner has been insured for two years. Therefore, if death results from suicide, no benefit will be payable for any Term Life coverage that became effective within two years of the date of death.

Other exclusions apply to the Accidental Death & Dismemberment amounts of your coverage. Refer to your certificate.

Complete coverage information is in the Certificate of Insurance booklet issued to each insured individual.
Please read it carefully and keep it in a safe place with your other important papers.

Short Term Disability Premiums

Monthly, Effective 1/1/2020

Weekly Benefit	Monthly Premium
$100	$6.02
$150	$9.03
$200	$12.04
$250	$15.05
$300	$18.06
$350	$21.07
$400	$24.08
$450	$27.09
$500	$30.10
$550	$33.11
$600	$36.12
$650	$39.13
$700	$42.14
$750	$45.15
$800	$48.16
$850	$51.17
$900	$54.18
$950	$57.19
$1,000	$60.20
$1,050	$63.21

Weekly Benefit	Monthly Premium
$1,100	$66.22
$1,150	$69.23
$1,200	$72.24
$1,250	$75.25
$1,300	$78.26
$1,350	$81.27
$1,400	$84.28
$1,450	$87.29
$1,500	$90.30
$1,550	$93.31
$1,600	$96.32
$1,650	$99.33
$1,700	$102.34
$1,750	$105.35
$1,800	$108.36
$1,850	$111.37
$1,900	$114.38
$1,950	$117.39
$2,000	$120.40

Your weekly benefit may not exceed 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions).

Health Benefit Plan

NHC offers the Health Benefit Plan ("Plan") to all Eligible Partners and their Eligible Dependents. The terms and conditions of the Plan are described in this booklet. The following are highlights of those terms and conditions:

1. If you are a full-time Partner or an IPAR (generally scheduled between 30.00 and 37.50 hours each week) and you have completed your waiting period, you are eligible to enroll in the Plan during your initial and/or during the Plan's annual enrollment period. If you enroll, you will be required to pay a portion of the cost of the coverage that you elect (the "premium"). Information regarding your premiums for coverage under the Plan will be provided during the applicable enrollment periods.
2. If you enroll, you may also enroll your Eligible Dependents. In order to enroll your Eligible Dependents, you will be required to provide certain information regarding your dependents that verifies their eligibility for the Plan (including but not limited to their taxpayer identification number). You will be required to pay a premium for your Eligible Dependent's coverage as well.
3. You must request enrollment during your initial enrollment period or during the annual enrollment period. The booklet provides more detail on the initial and annual enrollment periods. The election that you make during the applicable enrollment periods (including an election to waive coverage) cannot be changed for the remainder of the plan year unless you experience one of the specific events described in the Summary Plan Description and you timely submit your request to change your election. For example, if you choose no coverage during the initial enrollment period but you have a child during the plan year, you may enroll yourself and your child if you timely request enrollment. The Summary Plan Description provides more detailed information regarding permissible changes to your election, including a list of permissible events.
4. The Plan is self-insured, which means that NHC has not paid an insurance carrier to take the risk. NHC has, however, engaged Blue Cross Blue Shield of Tennessee ("BCBST") to administer the claims.
5. If you properly enroll, prior to the month that coverage begins, you will receive a medical identification card from BCBST and a prescription drug card from EmpiRx Health. Identification cards must be presented to all of your providers at the time services are received. If you enrolled but do not receive an ID card from either BCBST or EmpiRx, you should contact them to obtain a card. The contact information for each is provided in the Summary Plan Description.
6. The plan uses Preferred Provider Networks (PPOs) for most services including pharmaceuticals. The Plan's benefits for services provided by a network provider are greater than service or treatments provided by a non-network provider. The Summary Plan Description includes phone numbers and web sites to help you determine if your provider is a member of the network.
7. Premiums are payable through payroll deduction (if you are receiving a paycheck) and are withheld/paid for the current month's coverage. Your portion of the premium is deducted from your check monthly. Half is deducted on the 1st pay period of the month with the balance (1/2) deducted on the second pay period of the month. The premiums are automatically excluded from income.
8. Coverage will generally end at the end of the month in which you or your dependent's cease to be eligible; however, if coverage is lost due to a "qualifying event" you or your dependents may elect to continue that coverage pursuant to a federal law called "COBRA" for up to 18, 29, or 36 months (depending on the type of qualifying event) so long as you make a timely election and pay the COBRA premium, which is 102% of the total cost of the coverage that is typically shared by you and NHC.
9. If you have any questions about your rights and obligations under the Plan and are unable to find the answers in the booklet, please contact the Plan Administrator or the claims administrator. The contact information for both can be found in the booklet.

Please pay particular attention to the limitations on and exclusions for services or treatments.

Contact Information for Medical Benefits	
Insured Inquiries (medical)	1-877-892-8288
Provider Inquiries	1-800-924-7141

Contact Information for EmpiRx Prescription Drug Benefits	
All Inquiries	1-888-363-3939

Throughout this document, BCBST or BCBS is used and refers to Blue Cross Blue Shield of Tennessee or the Blue Cross Blue Shield Association throughout the United States. BCBST and BCBS may be used interchangeably.

NATIONAL
HEALTH CORPORATION
Health Benefit Plan Summary Plan Description and Booklet

Effective January 1, 2020

Table of Contents

Introduction

National Health Corporation ("NHC") has established the Health Benefit Plan ("Plan") to make certain health care benefits available to eligible employees (partners) and their eligible dependents. The terms of the Plan are set forth in this Summary Plan Description, which may also be referred to as the "SPD" or "Booklet". NHC is the Plan Sponsor and the Plan Administrator of the Plan.

NHC has engaged BlueCross BlueShield of Tennessee ("BCBST") to provide day-to-day administration of the claims payments and reimbursement under the terms of this Plan for medical expenses (e.g. hospitalization, doctor's visits), and to provide other services as contracted with NHC. NHC has also engaged EmpiRx to provide day-to day-administration of prescription drug claim payments and reimbursements under the terms of this Plan, and to provide other services as contracted with NHC. Neither BCBST nor EmpiRx assume any financial risk or obligation with respect to Plan claims. Neither BCBST nor EmpiRx is the Sponsor, Plan Administrator or a Fiduciary, as those terms are defined in the Federal law called the Employee Retirement Income Security Act ("ERISA"). BCBST and EmpiRx are referred to herein collectively as the "claims administrators."

This SPD describes the terms and conditions of your Coverage through the Plan effective as of the date identified on the cover. It replaces and supersedes any SPD or description of benefits with a prior effective date. If there is a conflict between this SPD and any other documents or materials that describe eligibility for benefits and/or the benefits provided by the Plan (e.g. enrollment material booklets), this SPD will control.

The Plan is also maintained pursuant to an official plan document. This SPD is incorporated into and made a part of that plan document so that both the plan and the SPD constitute the "plan document" that is required by ERISA. You may request a copy of the plan document by contacting the Plan Administrator.

Please read this entire SPD carefully. Certain services are not Covered by the Plan; other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care Provider recommends or orders the service or treatment.

In order to make it easier to read and understand this SPD, defined words are capitalized. Those words are defined in the Definitions section of this Plan.

If you have any questions when reading this SPD, you should contact the applicable claims administrator or the Plan Administrator. You will find the applicable contact information in this SPD. You can also find each claims administrator's contact information on the ID card each issued to you. The representatives are also available to discuss any other matters related to your Coverage under the Plan.

Independent Licensee of The BlueCross BlueShield Association

BCBST is an independent corporation operating under a license from the BlueCross BlueShield Association (the "Association"). That license permits BCBST to use the Association's service marks within its assigned geographical location. BCBST is not a joint venture, agent or representative of the Association nor any other independent licensee of the Association.

Eligibility

If you are an Eligible Partner, you may request enrollment for yourself and your Eligible Dependents in the Plan.

NOTE: You will be required to pay a Premium for the coverage you elect and that premium will be withheld from your pay on a pre-tax basis in accordance with NHC's Section 125 plan.

A. Eligible Partner Defined:

An Eligible Partner is any Employee who satisfies the following requirements:

1. You are an Employee who is eligible to work in the United States legally as confirmed by the USCIS (United States Citizenship Immigration Services) I-9; and
2. You are designated by your Employer as a Full-Time or IPAR Partner or
3. You are a Qualifying Part-Time Partner (described below) or an Eligible Ongoing Partner as described in the Qualifying Partner appendix attached to this SPD.

B. Eligible Dependents Defined:

An Eligible Dependent is any person who satisfies at least ONE of the following requirements:

1. The person is an Eligible Partner's current Spouse.
2. The person is an Eligible Partner's Child who is under age 26, regardless of marital status.
3. The person is a Child, regardless of age, who is incapacitated and satisfies the additional eligibility requirements for Incapacitated Children.

C. Incapacitated Children

If a Covered Dependent Child is incapacitated on the date the Child turns age 26, coverage for such Child will continue beyond the age of 26 so long as the following requirements are satisfied:

1. You provide written notice to BCBST of the incapacity prior to the date the child turns age 26; and
2. You provide sufficient documentation (as determined by BCBST) supporting the Child's incapacity.

A child is considered "incapacitated" if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

D. Proof of Eligibility and Other Information; Appeals

If you request enrollment for a dependent, you will be required to provide the Plan Administrator (or its designee) with information the Plan Administrator deems necessary to verify eligibility, including but not limited to a marriage certificate, tax return, birth certificate, legal adoption or legal custody/guardianship documents and/or a certified copy of any Qualified Medical Child Support Order. You are also required to provide the federally issued taxpayer identification number for each dependent for whom you request enrollment. Your dependent's enrollment in the Plan is conditioned on the timely provision of all such information.

If you request to enroll in the Plan but the Plan Administrator determines that you are not eligible for the Plan, you will receive written notice from the Plan Administrator that you are not eligible. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

Enrollment

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent's enrollment in the Plan is conditional pending the Plan Administrator's timely receipt of the requested information verifying your dependent's eligibility. You may only enroll during one of the enrollment periods described below.

It is very important for you to timely enroll in the Plan during the applicable enrollment periods. There are two general enrollment periods---the Initial Enrollment Period and the Annual Enrollment Period.

A. Initial Enrollment Period

If you are a newly hired Eligible Partner or you have recently become an Eligible Partner and you wish to request enrollment, you must request enrollment for yourself and any Eligible Dependents within the Initial Enrollment Period identified by the Plan Administrator.

If you timely request enrollment, and your enrollment is approved or conditionally approved, coverage will take effect for you and any Eligible Dependent that you enroll at that time on the first day of the month following 60 days of continuous employment.

B. Annual Enrollment Period

Each year, the Plan Administrator conducts an Annual Enrollment Period during which you may request enrollment for yourself or your Eligible Dependents or you may make changes to your current elections. You will be notified in advance of the Annual Enrollment Period each year. If you request enrollment or make changes during the Annual Enrollment Period, your coverage (or changes) will be effective the following January 1 if you are still an Eligible Partner at that time. If you fail to enroll or make any changes during the Annual Enrollment Period, your prior coverage elections (including your prior election to waive coverage) in effect on the last day of that Plan Year will continue during the next Plan Year.

C. Mid-Year Enrollment Period—Changes in Coverage

Generally, you cannot change your coverage elections under the Plan during the Plan Year except as follows.

First, your election for Coverage is revoked by operation of the Plan's terms as of the date you or any other Covered Person ceases to be an Eligible Person in accordance with the Plan's terms. **NOTE:** You are still required to provide timely notice of an event that results in loss of eligibility for you and/or your Covered Dependents (e.g. divorce). In other words, your failure to provide prompt notice of such an event does not operate to extend eligibility or Coverage under the Plan. See the "When Eligibility for Coverage Ends" section of this SPD for more details.

Next, you may voluntarily change your elections to participate (or not to participate) during the Plan Year if you satisfy the following conditions (prescribed by federal law):

1. You experience one of the following Status Changes and the change you wish to make satisfies the Consistency Rule, described below; or
2. You experience a significant Cost or Coverage Change; and
3. You complete your enrollment change online within 31 days of the date you experience the event (or within any longer period specifically identified below). If you do not change your election prior to the enrollment deadline, you will not be permitted to make a change to your benefit elections until the next Annual Enrollment Period.

D. Status Changes

The following status changes will allow you to change your enrollment election during the plan year:

1. *Marital Status*. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. *Change in Number of Dependents*. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with you for adoption, or death of a Dependent. See also "Special Enrollment" below.
3. *Change in Dependent Eligibility*. Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.
4. *Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan*. You, or your Eligible Dependent experiences a change in employment status due to one of the following events:
    a. Termination or commencement of employment;
    b. A strike or lockout;
    c. Commencement or return from an unpaid leave of absence;
    d. A change in employment status, *e.g.*, unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
    e. A change in worksite; and
    f. Any other change in employment status that affects benefits eligibility.
5. *Change in Residence that Affects Eligibility*. You or your eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for medical coverage or becomes eligible for medical coverage.

You can only change your elections on account of a Status Change if the requested change is on account of and corresponds with the Status Change event, as determined by the Plan Administrator. This is called the "Consistency Rule" and it is a rule required by the IRS. As a result of the IRS's Consistency Rule, you may experience a Status Change event that does not let you change your benefit elections.

Under the Consistency Rule, the Status Change has to affect you or your Eligible Dependent's eligibility for medical coverage under an employer's health plan. For example, if your Spouse gains employment but does not become eligible for health plan coverage offered by his or her new employer, no election change under this Plan is permitted. A Status Change also affects eligibility for medical coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must satisfy the following specific requirements in order to change your election based on a Status Change:

1. *Loss of Dependent Eligibility.* If the event is divorce, legal separation, annulment, death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements and you are enrolled in medical coverage, you may not cancel the coverage for any other covered Person.

    Example. Pat is unmarried and has one married child. Pat elects family medical coverage. Pat's Child turns 26 and therefore loses eligibility for coverage under the Plan. Pat's coverage will automatically change to single coverage. Pat cannot, however, cancel coverage for herself.

2. *Gaining Eligibility Under Another Employer Plan.* For a Status Change in which you or your Spouse or Dependent gains eligibility for coverage under another employer's medical plan as a result of a change in marital status or a change in your spouse's or Dependent's employment status, an election to cancel coverage for that individual under this Plan would correspond with that Status Change only if medical coverage for that individual becomes effective or is increased under the other employer's plan.

    Example: Employee Chris elects Partner only medical coverage. Chris marries. Chris's wife elected employee only medical coverage from her employer's medical plan prior to their marriage. Chris may either cancel medical coverage under the NHC Health Benefit Plan if he certifies that he and his wife

will be covered under her employer's plan, or Chris's wife may cancel coverage under her plan and become covered under the NHC Health Benefit Plan.

3. *Gaining Coverage Under Another Plan Providing Minimum Essential Coverage*. You may also cancel your coverage if you change employment status during the year to a position that is expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Covered Partner ceasing to be eligible under the group health plan (e.g. you are enrolled during a Stability Period) so long as the cancellation corresponds to the intended enrollment of the Covered Partner and any Covered Dependent in another plan that provides minimum essential coverage and that will be effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

E. Cost or Coverage Changes

You may also make changes due to cost or coverage changes. The applicable cost or coverage changes are:

1. *Change in Cost of Coverage*. If your share of the premium for medical coverage you elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another benefit plan option under the NHC Health Benefit Plan may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your premiums will automatically be adjusted to reflect the insignificant cost change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.
2. *Entitlement to or Loss of Entitlement to Medicare or Medicaid*. You or your eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.
3. *Governmental Plan Coverage Change*. You or your Eligible Dependent loses coverage under a group medical plan sponsored by a governmental or educational institution.
4. *New Benefit Option Added*. You are eligible for a new or improved medical coverage option.
5. *Court Ordered Coverage*. You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order ("QMCSO") that requires medical coverage for your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child you have enrolled in the Plan and such coverage is actually provided by the other plan. **NOTE:** If a QMCSO expires, you will only be allowed to drop coverage for the Covered Child as permitted under the Code Section 125 rules and regulations.
6. *Reductions in Coverage*. If coverage under an option is significantly curtailed, you may elect to revoke your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.
7. *Change under another Employer Plan*. You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:
    a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or
    b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Health Benefit Plan.

Example: Jean, an NHC Partner, is married and has two unmarried children. At annual enrollment, Jean elects not to participate in the Plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, the cost of the medical coverage provided by Tom's employer significantly increases and there is no other similar benefit package option available to him. As a result, his employer's plan allows him to cancel his family medical coverage. Because Tom has experienced a Status Change under his employer's plan that allows him to drop his family medical coverage, Jean may elect family medical coverage under the NHC Health Benefit Plan.

F. HIPAA Special Enrollment

There are three categories of "special enrollment" events, under the Health Insurance Portability and Accountability Act ("HIPAA") that will allow a midyear enrollment election change.

1. New Dependent Special Enrollment

   If an Eligible Partner marries, has a Child, adopts a Child or a Child is placed with the Eligible Partner for adoption (Dependent Event), the Eligible Partner will be permitted to enroll (i) the Eligible Partner only, (ii) the Eligible Partner and the Eligible Partner's Spouse only, (iii) the Eligible Partner and the newly acquired eligible Dependent only, or (iv) the Eligible Partner, his or her Spouse, and newly acquired Eligible Dependent.

   If a Covered Partner experiences a Dependent Event, the Covered Partner may enroll (i) the Spouse only (ii) the newly acquired Eligible Dependent or (iii) the Spouse and any newly acquired Eligible Dependents.

   The Eligible or Covered Partner (as applicable) must request enrollment within 31 days of the Dependent Event in order to qualify for special enrollment. If properly enrolled, coverage will begin on the date of the Dependent Event in the case of a birth, adoption or placement for adoption and on the first day of the month following the date the enrollment is processed in the case of marriage.

2. Loss of Other Coverage Special Enrollment (Not applicable to Retirees)

   If an Eligible Partner initially refused coverage on behalf of the Eligible Partner and/or his/her Eligible Dependents because of other group health coverage or health insurance and the Eligible Partner or Eligible Dependent experiences a "loss of eligibility" for that other group health coverage, the Eligible Partner may enroll (i) the Eligible Partner only, (ii) the Eligible Partner and any Eligible Dependents who lost eligibility for coverage. If a Covered Partner initially refused coverage for an Eligible Dependent because of other group health coverage and the Eligible Dependent experiences a "loss of eligibility" for that other group health coverage, the Covered Partner may enroll any Eligible Dependents who lose eligibility for other coverage. The Eligible Partner or Covered Partner (as applicable) must request enrollment within 31 days of the date of the loss of eligibility for other group coverage in order to qualify for special enrollment.

   A "loss of eligibility" results if any of the following occurs:

   a. Loss of eligibility for reasons other than failure to pay premiums or fraud if you elect COBRA Continuation Coverage, you must exhaust the maximum continuation period in order to qualify for special enrollment.

   b. Reaching a lifetime limit on all benefits.

   c. Cessation of all employer contributions.

   d. Moving out of an HMO service area if the other plan does not offer other coverage.

   e. Ceasing to be a "Dependent," as defined in the other plan.

   f. Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time Employees).

3. Loss of Eligibility for CHIP or MEDICAID

   You may enroll the eligible Employee and/or an eligible Dependent Child in if either of the following conditions is satisfied:

   a. You or your Eligible Dependent Child loses eligibility for Medicaid or a state Child health plan; or

   b. You or your Eligible Dependent Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state Child health Plan.

   NOTE: Unlike the other special enrollment events, you have 60 days to request enrollment for Loss of Eligibility for Medicaid or eligibility for premium assistance as described above.

G. Qualified Medical Child Support Order

An Eligible Dependent Child may be enrolled in the Plan pursuant to a Qualified Medical Child Support Order in accordance with ERISA Section 609. If the Plan Administrator receives a medical child support order that requires coverage under the Plan for your Eligible Dependent Child, you are an Eligible Partner, and the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order as defined by ERISA, the Eligible Dependent Child will become covered as of the first day of the month following the date that the Plan Administrator approves the order. You may be automatically enrolled involuntarily in order for the Plan Administrator to comply with the Qualified Medical Child Support Order. In order for a medical child support order requiring coverage to be a "Qualified Medical Child Support Order", the order must satisfy the requirements under ERISA Section 609 (and the regulations). Generally, ERISA requires the order to clearly identify all of the following:

1. The name and last known mailing address of the Covered Person;
2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
3. A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
4. The period to which the order applies.

H. Effective Date of Enrollment Changes

Except as noted above, election changes are typically effective on the first day of the month following the date the Plan Administrator receives the request to change coverage (if the request is approved).

I. Denial of Requested Enrollment Changes

If the Plan Administrator rejects your request to make an election change during the year, you will receive written notice of that decision. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

When Eligibility for Coverage Ends

A previously Eligible Person will cease to be eligible when any of the events occur and, if covered when one of these events occurs, coverage will end as indicated below. **NOTE**: we rely on you to notify us in many instances that a Covered Person is no longer eligible. If Coverage would end under the Plan (as indicated below) prior to the date notice is provided, you may be required to repay any claims paid by the Plan after the person ceased to be eligible. Contact the Plan Administrator as soon as possible after a Covered Person ceases to be an Eligible Person:

For the Partner:

Event	When Coverage Ends
You cease to be an Eligible Person (e.g. your employment status changes from Full-time Partner to Part-time Partner (other than a Qualifying Part-Time Partner).	The end of the month in which you cease to be an Eligible Partner. **NOTE**: you may still be an Eligible Person if you satisfy as a Qualifying Part-time Partner or Ongoing Partner. See the Qualifying Partner Appendix.
You terminate employment	The end of the month in which you terminate employment.
You fail to pay a required premium	The last day of the last month for which a complete and timely premium was paid.

For a Dependent:

Event	When Coverage Ends (if covered)
You cease to be an Eligible Person (e.g. your employment status changes from Full-time Partner to Part-time Partner (other than a Qualifying Part-Time Partner).	The end of the month in which you cease to be an Eligible Partner
You terminate employment	The end of the month in which you terminate employment.
You fail to pay a required premium	The last day of the last month for which a complete and timely premium was paid.
The Dependent ceases to be an Eligible Dependent	The last day of the month in which Dependent ceases to be an Eligible Dependent.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the date that coverage under the Plan ends for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys' fees, expenses and court costs (as permitted by applicable law).

If a Covered Person loses coverage due to a Qualifying Event, the Covered Person may be eligible to continue coverage under the Plan in accordance with a federal law called "COBRA". See the COBRA Continuation of Coverage section in this booklet for more information.

Extended Medical Plan

Covered Persons have an opportunity to extend their medical coverage if they meet certain requirements. The Extended Medical Plan option, defined below, is not available in addition to COBRA Continuation of Coverage, but in lieu of COBRA Continuation Coverage. Covered Partners and their Covered Dependents meeting all of the below described eligibility requirements will receive information regarding both options and will need to determine which option works best for their individual situation.

A. Eligibility Requirements

1. The Covered Partner leaves the Employer between age 55 and 65.
2. The Covered Partner has at least 15 years or more of cumulative employment service with (1) National Health Corporation, (2) National Healthcare Corporation ("NHC") or (3) Affiliated Employer.
3. The Covered Partner (and any Covered Dependents) has a minimum of 3 consecutive years of Coverage in this Health Benefit Plan immediately prior to leaving the employment of an Employer.
4. In the case of Partner death, Covered Partner must have a minimum of 3 consecutive years in this Health Benefit Plan immediately prior to death. Any Eligible Covered Dependents must have a minimum of 1 year in the Health Benefit Plan immediately prior to the Partner's death.

B. Extended Medical Plan Provisions

If the Covered Partner or Covered Dependent meets the above requirements, the following Extended Medical Plan provisions will apply:

1. Coverage may be continued under the Extended Medical Plan in the medical Plan option (Value, HSA Value and Premier) that the Covered Partner is enrolled in at the time of employment termination.
2. Credit will be given for any prior Deductible or Out-of-Pocket met in the current Calendar Year in which the event occurred.
3. The Extended Medical Plan Coverage terminates at the earlier of the Covered Person's Medicare eligibility date (currently age 65 or disability) except where coverage is required to be continued for ESRD or when the Covered Person chooses to terminate coverage or the Covered Person discontinues Premium payment.
4. Covered Dependents may continue on the Extended Medical Plan option until the earlier of the Covered Dependent's Medicare eligibility date (currently age 65 or disability) or when the Covered Dependent ceases to be an Eligible Dependent as defined within this Plan.
5. The Employer will contribute 2% of the total premium (as determined by the Plan Administrator) for each year of the Partner's credited employment service toward the Covered Person's total monthly Premium.
6. Maximum length of Employer contribution toward Eligible Dependent Coverage will be the earliest of the person's no longer meeting the definition of an Eligible Dependent as defined within this Plan, reaching Medicare eligibility age (currently age 65 or disability) or having a total of 10 years of Extended Medical Plan Coverage.
7. All other Health Benefit Plan provisions, guidelines and limitations set forth herein will apply to the Extended Medical Plan.

C. Plan's Right to Waive Eligibility

1. Eligibility for the Extended Medical Plan may be waived by the Plan Sponsor in cases of partner gross misconduct, violation of workplace rules or gross neglect of duties. Acts of gross misconduct include intentional, wanton, willful, deliberate, reckless or deliberate indifference to an employer's interest.
2. The termination of a sponsoring Affiliated Employer relationship between the NHC Health Benefit Plan and any sponsoring Affiliated Employer voids eligibility to the Extended Medical Plan for all

Partners of the sponsoring Affiliated Employer. If the sponsoring Affiliated Employer has former Partners covered by the Extended Medical Plan on the date of the termination of the sponsoring Affiliated Employer relationship, the Extended Medical Plan coverage for the former Partners will end on the last day of the month following 60 days from the relationship termination or the last day of the calendar year following the relationship termination, whichever is longer in duration. COBRA will be offered to all Partners covered on the termination date and to former Partners who lose coverage under the Extended Medical Plan as a result of the termination of the relationship.

General Notice of COBRA Continuation Coverage Rights

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and/or your Dependent children could each become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a covered Partner, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced,
2. Your employment ends for any reason other than your gross misconduct,

NOTE: if you take an FMLA qualifying leave of absence and you choose not to continue coverage, you have not experienced a qualifying event by virtue of the leave. However, if you fail to return from leave as required by FMLA, then your qualifying event date will be the date the FMLA period ends (if your coverage is ending because you took an FMLA leave).

If you are the covered Spouse of a Covered Partner, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

1. The Covered Partner dies;
2. The Covered Partner's hours of employment are reduced;
3. The Covered Partner's employment ends for any reason other than his or her gross misconduct;
4. The Covered Partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

If you are the Covered Dependent child of a Covered Partner, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happen:

1. The Covered Partner dies;
2. The Covered Partner's hours of employment are reduced;
3. The Covered Partner's employment ends for any reason other than his or her gross misconduct;
4. The Covered Partner becomes entitled to Medicare benefits (Part A, Part B, or both);
5. Your parents become divorced or legally separated; or
6. You cease to be eligible for coverage under the Plan as a "Dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Partner, commencement of a proceeding in bankruptcy with

respect to the Employer, or the Partner's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the qualifying event.

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 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).

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Partner and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the COBRA Administrator within 60 days after the date that coverage is lost as a result of the qualifying event or the date the qualifying event occurs, which is later.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Partners may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their minor children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Partner, the Partner's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Partner's hours of employment, thus resulting in a loss of coverage, and the Partner became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Covered Partner lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Partner becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment, reduction of the Partner's hours of employment, thus resulting in a loss of coverage, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, each covered qualified beneficiary may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the COBRA Administrator before the expiration of the 60-day notice period or the 18-month period, whichever ends first. The 60-day notice period ends on the latest of the following to occur: (i) the qualifying event (ii) the date coverage is lost as a result of the qualifying event and (iii) the date you receive notice from the Social Security Administration indicating that you are determined to be disabled.

Second qualifying event during 18 or 29-month period of continuation coverage

If a qualified beneficiary other than the Covered Partner experiences another qualifying event during the 18 (or, if applicable, the 29) month COBRA continuation coverage period, the qualified beneficiary (other than the Covered Partner) can get up to 36 months of COBRA continuation coverage measured from the date of the original qualifying event, if notice of the second qualifying event is properly given to the Plan. This extension

may be available to a qualified beneficiary Spouse and/or any qualified beneficiary Dependent children receiving continuation coverage if the Partner or former Partner dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Failure to provide written documentation of any of the above events, within the required 60 days will result in loss of continuation rights.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, coverage will be provided which is identical to the coverage provided under the Plan to similarly situated Partners or family members.

The law also provides that your continuation coverage may be cut short for any of the following reasons:

1. The Company or any of its subsidiaries no longer provides group health coverage to any of its Partners;
2. The premium for your continuation coverage is not paid in a timely fashion;
3. You become covered by another employer's group health plan;
4. **NOTE**: If you become covered by another group health plan and that plan contains a Pre-Existing Condition limitation that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's Pre-Existing Condition rule does not apply to you by reason of credit for prior coverage, your group health coverage may be terminated.
5. You become entitled to Medicare;
6. You extended coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

A child that is born or placed for adoption with the Covered Partner during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with terms of the group health care coverage and the requirements of Federal Law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator within 31 days of the birth or adoption.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay all or a part of the premium for your continuation coverage. You will have a grace period of 45 days to pay any retroactive premium for the period from the date continuation coverage starts until the date you choose continuation coverage. You will have a grace period of 30 days to pay any subsequent premiums.

If you have any questions about the law, please contact the COBRA Administrator identified in the General COBRA notice you received when you first became enrolled (or contact the Plan Administrator identified in this SPD).

Relationship with Network Providers and Participating Pharmacies

Medical

Independent Contractors

Network Providers are not employees, agents or representatives of Blue Cross Blue Shield of Tennessee ("BCBST"). Such Network Providers contract with BCBST, which has agreed to pay them for rendering Covered Services to you. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Covered patients. National Health Corporation and BCBST do not make medical treatment decisions under any circumstances.

BCBST's participation agreements permit Network Providers to dispute the Coverage decisions if they disagree with those decisions. If your Network Provider does not dispute a Coverage decision, you may request reconsideration of that decision as explained in the ERISA Benefit Claim Grievance Procedure section of this Plan. The participation agreement requires Network Providers fully and fairly explain Coverage decisions to you, upon request, if you decide to request reconsideration of a Coverage decision.

BCBST has established various incentive arrangements to encourage Network Providers to provide Covered Services to you in an appropriate and cost effective manner. You may request information about your Network Provider's incentive arrangement with BCBST by contacting BCBST's customer service department.

Termination of Providers' Participation

BCBST or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Covered Person's that he, she or it will accept as patients during the term of the contract with BCBST. BCBST does not promise that any specific Network Provider will be available to render Covered Services while you are Covered.

Provider Directory

You may check to see if a Provider is in your Plan's Provider Network by going online to www.bcbst.com.

Prescription Drug

You should use a participating pharmacy whenever possible. Show your EmpiRx Health ID card to the pharmacist and pay your retail copay each time you fill a new prescription.

To find a participating retail pharmacy near you:

- Online: Through the member portal at www.empirxhealth.com/members/
- By phone: Call Member Services toll-free at 1-888-363-3939, 24 hours a day, 7 days a week, 365 days.

As with the network providers, participating pharmacies are not employees, agents or representatives of EmpiRx. Such pharmacies contract with EmpiRx, which has agreed to pay them for rendering Covered Services to you. Participating pharmacies are solely responsible for deciding whether to issue a prescription drug to you in consultation with their Covered customers. Neither NHC nor EmpiRx make decisions regarding which drugs to prescribe to you and/or whether a prescribed drug should be issued under the circumstances. For convenience sake, both Network Providers and participating pharmacies will be referred to herein as "Network Providers."

BlueCard/BlueCard PPO Program

When you are in an area where Network Providers are not available and you need health care services or information about a BlueCross BlueShield PPO Provider or Hospital, just call the BlueCard/BlueCard PPO Network Provider and Hospital Information Line at 1-800-810-BLUE (2583). BCBST will help you locate the nearest BlueCard/BlueCard PPO Network Provider.

If you call 1-800-810-BLUE (2583) and go to a BlueCard/BlueCard PPO Network Provider or Hospital, your benefits will be Covered as In-Network Benefits, and your out-of-pocket expenses will be less than if you go to a non- BlueCard/BlueCard PPO Network Provider or Hospital. In the BlueCard/BlueCard PPO Program, the term "Host Plan" means the BlueCross BlueShield Plan that provides access to service in the location where you need health care services.

Show your Health Plan ID Card (that has the "PPO in a suitcase" logo) to any BlueCard/BlueCard PPO Network Provider. The BlueCard/BlueCard PPO Network Provider can verify your participation, eligibility and Coverage with this Plan. When you visit a BlueCard/BlueCard PPO Network Provider, you should not have claim forms to file. After you receive Covered Services, your claim is electronically routed to BCBST, which processes it and sends you a detailed explanation of benefits. You are responsible for any applicable Copayments or your Deductible and Coinsurance Coverage payments (if any.) If the Plan pays such amounts to a health care Provider on your behalf, BCBST may collect those cost-sharing amounts directly from you.

The calculation of your liability for claims incurred outside the BCBST service area that are processed through the BlueCard/BlueCard PPO Network Program will typically be at the lower of the Provider's Billed Charges or the negotiated price BCBST pays the Host Plan.

The negotiated price BCBST pays to the Host Plan for Covered Services provided through the BlueCard/BlueCard PPO program may represent either: (a) the actual price paid by the Host Plan on such Covered Service claims; (b) an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount BCBST pays is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield to use a basis for calculating Covered Person liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if you receive Covered Services in these states, your liability for Covered Services will be calculated using these states' statutory methods.

Remember: You are responsible for receiving Prior Authorization. If Prior Authorization is not received your benefits may be reduced or denied. Call the 1-800 number on your Health Plan ID Card for Prior Authorization. No other entity may provide such information. In case of an emergency, you should seek immediate care from the closest health care Provider.

BLUECARD WORLDWIDE: Through the BlueCard Worldwide Program, you also have access to a participating Hospital network and referrals to doctors in major travel destinations throughout the world. When you need to locate a Hospital or doctor, you can call the BlueCard Worldwide Service Center at 1-800-810-BLUE, or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.

You can also visit the website: https://www.bluecardworldwide.com/, or you can call BCBST. When you need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer you to a participating Hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance Coverage). In an Emergency, you should go to the nearest Hospital and call the BlueCard Worldwide Service Center if you are admitted. You still have the choice of using non-BlueCard Worldwide Hospitals; however, you may have to pay the Hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but you will have to pay the Provider and then file the claim for reimbursement.

Claims and Payment

When you receive Covered Services, either you or the Provider must submit a claim form to BCBST. BCBST will review the claim against the terms of the Plan and let you or the Provider know if the Claims Administrator needs more information before the claim is paid or denied. The Claims Administrators follows their own internal administration procedures when adjudicating claims in accordance with the terms of this Plan. If these procedures differ from those required by the ERISA claims regulations, the ERISA claims regulations shall control.

A. Claims

Federal regulations use several terms to describe a claim: pre-service claim, post-service claim, and a claim for Urgent Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to you. Only post-service claims can be billed to the Plan, or you.
3. Urgent Care is defined as medical care or Treatment for injury or condition, not so severe as to require Emergency Room Care, that, if delayed or denied, could seriously jeopardize (1) the life or health of the claimant, or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or Treatment. A claim for denied Urgent Care is always a pre-service claim.

See the Claims and Appeals section for more information regarding the different time periods the Claims Administrators have for notifying you of an adverse benefit determination (i.e. a denial of benefits in whole or part) and the rights and obligations you have regarding appeals of those adverse benefit determinations.

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Covered Person Payments. The Network Provider will submit the claim directly to the Plan.
2. You may be charged or billed by an Out-of-Network Provider or Non-contracted Provider for Covered Services rendered by that Provider. If you use an Out-of-Network Provider or Non-contracted Provider, you are responsible for the difference between Billed Charges and the Allowed Amount for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including obtaining Prior Authorization of such Covered Services, when necessary).

   If you are charged or receive a bill, in order to be reimbursed, you must submit the claim on a timely basis, but no later than July 1 following the year in which expenses were incurred. If you do not submit a claim within the above stated time period, it will not be paid. If it is not reasonably possible to submit the claim within the stated time period, the claim will not be invalidated or reduced.
3. You may request a claim form from BCBST's customer service department. BCBST will send you a claim form within 15 days. You must submit proof of your own payment to BCBST for the Covered Service. BCBST may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
4. If you use a non-participating pharmacy, you may pay the entire cost of the prescription, and then submit a claim form to EmpiRx. You will be reimbursed up to the Allowed Amount if the drug is a

covered drug. Claims forms may be obtained via the EmpiRx Health Member Portal at empirxhealth.com or by contacting Member Service at 1-888-363-3939.

5. A Network Provider or an Out-of-Network Provider may refuse to render a service, reduce or terminate a service that has been rendered, or require you to pay for what you believe should be a Covered Service. If this occurs, you may submit a claim to the Claims Administrator to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide you with a prescribed medication; or (2) requires you to pay for that prescription, you may submit a claim to obtain a Coverage decision about whether it is Covered by the Plan.

6. Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on their contract with the Claims Administrator. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

C. Payment

1. If you received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to the Claims Administrator's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the In-Network Benefit level.

2. If you received Covered Services from an Out-of-Network Provider or Non-Contracted Provider, you must submit, in a timely manner, a completed claim form for Covered Services with the Claims Administrator. If the claim does not require further investigation, the Plan will reimburse you. The Plan may make payment for Covered Services either to the Provider or to you, at its discretion. The Plan's payment fully discharges its obligation related to that claim.

   The In-Network Benefit level shown in the Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers because there are no in-network providers that provide that type of service. Non-contracted Providers are otherwise treated the same as Out-of-Network Providers and any reference to "Out-of-Network Provider" in this SPD includes a reference to Non-contracted Provider. For example, you are responsible for the difference in the Billed Charge and the Allowed Amount for that Covered Service. The Plan's payment fully discharges its obligation related to that claim.

3. The Claims Administrator will pay benefits according to the Plan's terms after it receives a claim form that is complete (typically within 30 days). Claims are processed in accordance with current industry standards and based on the information at the time the Claims Administrator receives the claim form. The Plan, the Plan Administrator, the Employer and the applicable Claims Administrator are not responsible for over or under payment of claims if your claim information is not complete or is inaccurate. Reasonable efforts will be made to obtain and verify relevant facts when claim forms are submitted.

4. When a claim is paid or denied, in whole or part, an explanation of benefits ("EOB" for short) will be sent to you. This will describe how much was paid to the Provider, and lets you know if you owe an additional amount to that Provider. The EOB for medical services will be available to you at www.bcbst.com or by calling the customer service department at the number listed on your Health Plan ID Card.

5. You are responsible for paying any applicable Copayments, Deductible, Coinsurance or Penalty amounts to the Provider. If the Plan pays such amounts to a health care Provider on your behalf, we may collect those cost-sharing amounts directly from you.

Reimbursement for Covered Services is more fully described in the Schedule of Benefits.

D. Complete Information

Whenever you need to file a claim yourself (e.g. a claim with a non-contracted provider), it can be processed for you more efficiently if you complete a claim form. This will ensure that you provide all the

information needed. Most Providers will have claim forms, or you can request them by calling the customer service department at the number listed on the Health Plan or prescription drug (as applicable) ID Card.

Mail all claim medical claim forms to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

Mail all prescription drug claims to:

EmpiRx Health
PO Box 1339
Mechanicsburg, PA 17055

Prior Authorization, Care Management, Medical Policy and Patient Safety

BlueCross BlueShield of Tennessee ("BCBST") provides services to help manage your care including, performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of Hospital Services, discharge planning, lifestyle and health counseling, low-risk case management, catastrophic medical and transplant case management and the development and publishing of Medical Policy.

Neither BCBST nor the Plan makes medical treatment decisions under any circumstances. That is up to you. You may always elect to receive services that do not comply with BCBST's Care Management requirements or Medical Policy but doing so may affect the Coverage of such services.

A. Prior Authorization

BCBST must Authorize some Covered Services in advance in order for those Covered Services to be paid at the Allowed Amount without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the Plan must be satisfied before Coverage for services will be provided.

Services that require Prior Authorization include, but are not limited to

1. Inpatient Hospital stays (except maternity admissions),
2. Skilled nursing facility and rehabilitation facility admissions,
3. Certain outpatient Surgeries and/or procedures,
4. Durable Medical Equipment (DME), Prosthetics and Orthotics greater than $500,
5. certain Specialty Drugs, and
6. certain Prescription Drugs.

Other services not listed at the time of printing may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made available via the BCBST website and newsletters. You may also call the customer service department at the phone number on your Health Plan ID Card to find out which services require Prior Authorization.

Refer to the Schedule of Benefits for details on benefit Penalties for failure to obtain Prior Authorization. Network Providers in Tennessee will request Prior Authorization for you.

If Prior Authorization is required, you are responsible for requesting Prior Authorization when using medical Providers outside Tennessee and any Out-of-Network Providers (including out of network pharmacies), or benefits will be reduced or denied. Network Providers will request prior authorization on your behalf.

For the most current list of medical services that require Prior Authorization, call customer service or visit BCBST website at www.bcbst.com. For a current list of prescription drugs that require prior authorization, contact EmpiRx at 1-888-723-6001.

BCBST may authorize some services for a limited time. BCBST must review any request for additional days or services.

The following only applies to medical services and items administered by BCBST:

Network Providers in Tennessee are required to comply with all of BCBST's medical management programs. You are held harmless (not responsible for Penalties) if a Network Provider in Tennessee fails to comply with Care Management program and Prior Authorization requirements, unless you agreed that the Provider should not comply with such requirements.

The Covered Person is not held harmless if

1. a Network Provider outside Tennessee (known as a BlueCard PPO Network Provider) fails to comply with Care Management program and Prior Authorization requirements, or
2. an Out-of-Network Provider fails to comply with Care Management program and Prior Authorization requirements.

If you use an Out-of-Network Provider, or a Provider outside Tennessee, such as a BlueCard PPO Network Provider outside of Tennessee, you are responsible for ensuring that the Provider obtains the appropriate Authorization prior to treatment.

Failure to obtain the necessary authorization may result in additional Covered Person charges and reduced Plan reimbursement. Contact the customer service department for a list of Covered Services that require Prior Authorization.

B. Care Management

A number of Care Management programs are available to Covered Persons, including those with low-risk health conditions, potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries.

Lifestyle and Health Education – Lifestyle and health education is for healthy Covered Persons and those with low-risk health conditions that can be self-managed with educational materials and tools. The program includes: (1) wellness, lifestyle, and condition-specific educational materials; (2) an on-line resource for researching health topics; and (3) a toll-free number for obtaining information on more than 1,200 health-related topics.

Low Risk Case Management – Low risk case management, including disease management, is performed for Covered Persons with conditions that require a daily regimen of care. Registered nurses work with health care Providers, the Covered Person, and primary care givers to coordinate care. Specific programs include: (1) Pharmacy Care Management for special populations; (2) Emergency services management programs; (3) transition of care program; (4) condition-specific care coordination program; and (5) disease management.

Catastrophic Medical and Transplant Case Management - A Covered Person with terminal illness, severe injury, major trauma, cognitive or physical disability, or a Covered Person who is a transplant candidate may be served by the catastrophic medical and transplant case management program. Registered nurses work with health care Providers, the Covered Person, and primary caregivers to coordinate the most appropriate, cost-efficient care settings. Case managers maintain regular contact with Covered Persons throughout treatment, coordinate clinical and health plan Coverage issues, and help families utilize available community resources.

After evaluation of the Covered Person's condition, it may be determined that alternative treatment is Medically Necessary and Medically Appropriate.

In that event, alternative benefits for services not otherwise specified as Covered Services in this Plan Document may be offered to the Covered Person. Such benefits shall not exceed the Allowed Amount specified and will be offered only in accordance with a written case management or alternative treatment plan agreed to by the Covered Person's attending Physician and BCBST.

Emerging Health Care Programs - Care Management is continually evaluating emerging health care programs. These are services or technologies that demonstrate reasonable potential improvement in access, quality, health care costs, efficiency, and the Covered Person satisfaction. When an emerging health care program, is approved by the Plan Administrator, services provided through that program are Covered, even though they may normally be excluded under the Plan.

Care Management services, emerging health care programs and alternative treatment plans may be offered to Covered Persons on a case-by-case basis to address their unique needs. Under no circumstances does a Covered Person acquire a vested interest in continued receipt of a particular level of benefits.

C. Medical Policy

Medical Policy, as defined below, looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

Medical policies are based on an evidence-based research process that seeks to determine the scientific merit of a particular medical technology. Determinations with respect to technologies are made using technology evaluation criteria. The term "technologies" means devices, procedures, medications and other emerging medical services.

Medical policies state whether or not a technology is Medically Necessary, Investigational or Cosmetic. As technologies change and improve, and as a Covered Person's needs change, The Medical Director may reevaluate and change medical policies without formal notice. You may check medical policies at www.bcbst.com. Enter "medical policy" in the search field. These Medical Policies are made a part of this Plan by reference.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy differs from a definition in this Plan, the medical policy definition controls.

D. Patient Safety

If you have a concern with the safety or quality of care you received from a Network Provider, please call us at the number on the Health Plan ID Card. Your concern will be noted and investigated by BCBST's Clinical Risk Management department.

Coordination of Benefits

This Plan includes the following Coordination of Benefits ("COB") provision, which applies when a Covered Person has coverage under another Health Care Arrangement and this Plan. Rules of this section determine whether the benefits available under this Plan are determined before or after those of that Health Care Arrangement. In no event, however, will benefits under this Plan be increased because of this provision.

If this COB section applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan's benefits are determined before or after those of another Health Care Arrangement.

A. Definitions

The following terms apply to this provision:

1. Other Health Care Arrangement means any form of medical or dental coverage with which coordination is allowed. An other "Health Care Arrangement" includes:
    a. group, blanket or franchise insurance;
    b. group BlueCross Plan, BlueShield Plan;
    c. group or group-type coverage through HMOs or other prepayment, group practice and individual practice Plans;
    d. coverage under labor management trust plans or Partner benefit organization plans;
    e. coverage under government programs to which an Employer contributes or makes payroll deductions;
    f. coverage under a governmental Plan or coverage required or provided by law;
    g. medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type coverages;
    h. coverage under Medicare and other governmental benefits; and
    i. any other arrangement of health coverage for individuals in a group.
2. "Plan" does not include individual or family
    a. insurance contracts;
    b. Partner subscriber contracts;
    c. coverage through Health Maintenance Organizations (HMO) organizations;
    d. coverage under other prepayment, group practice and individual practice Plans;
    e. public medical assistance programs (such as TennCare);
    f. group or group-type Hospital indemnity benefits of $100 per day or less; or
    g. school accident-type coverages.

    Each contract or other arrangement for coverage is a separate Health Care Arrangement. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Health Care Arrangement.
3. Primary Plan/Secondary Plan
    a. The order of benefit determination rules state whether this Plan is a "Primary Plan" or "Secondary Plan" as to another Health Care Arrangement covering you.
    b. When this Plan is a Primary Plan, its benefits are determined before those of the other Health Care Arrangement. This Plan does not consider the other Health Care Arrangement's benefits.

c. When this Plan is a Secondary Plan, its benefits are determined after those of the other Health Care Arrangement and may be reduced because of the other Health Care Arrangement's benefits.

d. When there are two or more Health Care Arrangements covering the person, this Plan may be a Primary Plan as to one or more other Health Care Arrangements and may be a Secondary Plan as to a different Health Care Arrangement.

e. This Plan in no event pays a benefit, when considered together with the benefit paid by another Health Care Arrangement, exceeding in total the Allowed Expense as defined herein.

4. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by this Plan or another Health Care Arrangement covering the Covered Person for whom the claim is made.

   a. When this Plan or another Health Care Arrangement provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

   b. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private Hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically covered by the Plan.

   c. The Plan Administrator, in its sole discretion, will determine only the benefits available under this Plan. You are responsible for supplying the Plan Administrator with information about other Health Care Arrangements so the Plan Administrator can act on this provision.

5. "Claim Determination Period" means a calendar year. However, it does not include any part of a calendar year during which you have no coverage under this Plan or any part of a year prior to the date this COB section or a similar provision takes effect.

B. Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules that applies.

1. Non-Dependent/Dependent

   The benefits of the plan that covers the person as an employee, insured, or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent, except that

   a. if the person is also a Medicare Beneficiary; and

   b. if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Health Care Arrangement of the person as a dependent of an active covered employee, then the order of such benefit payment determination of benefits shall be

      (i) benefits of the Health Care Arrangement of an active employee covering the person as a dependent;

      (ii) Medicare;

      (iii) benefits of the Health Care Arrangement of the person as an employee, insured, or subscriber.

2. Dependent Child/Parents Not Separated or Divorced

   Except as stated in Paragraph (3) below, when this Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called "parents," the following applies:

   a. The benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year.

b. If both parents have the same birthday, the benefits of the Health Care Arrangement that has covered one parent longer are determined before those of the Health Care Arrangement of the other parent.

However, if the other Health Care Arrangement does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result there is a disagreement on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

3. Dependent Child/Separated, Divorced or Unmarried Parents

If there is more than one Health Care Arrangement covering a person as a Dependent child of divorced, separated or unmarried parents, benefits for the child are determined in this order:

a. first, the Health Care Arrangement of the parent with custody of the child;

b. then, the Health Care Arrangement of the spouse of the parent with the custody of the child;

c. finally, the Health Care Arrangement 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 Health Care Arrangement of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. The Health Care Arrangement of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Health Care Arrangement of the child shall follow the order of benefit determination rules outlined in Paragraph B (2), Dependent Child/Parents Not Separated or Divorced.

4. Active/Inactive Partner

The benefits of the Health Care Arrangement of a person as an employee who is neither laid off or retired are determined before those of a Health Care Arrangement which covers that person as a laid off or retired employee. If the other Health Care Arrangement does not have this rule, and if, as a result, there is a disagreement on the order of benefits, this Rule is ignored.

5. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement that has covered an employee or Covered Person longer are determined before those of the Health Care Arrangement of that person for the shorter term.

a. To determine the length of time a person has more than one Health Care Arrangement, two Health Care Arrangements shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

b. The start of the new Health Care Arrangement does not include

(i) a change in the amount or scope of a Health Care Arrangement's benefits;

(ii) a change in the entity that pays, provides, or administers the Health Care Arrangement's benefits; or

(iii) a change from one type of Health Care Arrangement to another (such as, from a single employer Health Care Arrangement to that of a multiple employer Health Care Arrangement).

c. The claimant's length of time covered under a Health Care Arrangement is measured from the claimant's first date of coverage under that Health Care Arrangement. If that date is not readily available, the date the claimant first became a Covered Person of the Plan shall be used as the

date from which to determine the length of time the claimant's coverage under the present Health Care Arrangement has been in force.

If the other Health Care Arrangement does not contain provisions establishing the order of benefit determination rules, the benefits under the other Health Care Arrangement will be determined first.

6. Health Care Arrangements with Excess and Other Non-conforming COB Provisions

Some Health Care Arrangements declare their benefits "in excess" to all other Health Care Arrangements, "always Secondary," or otherwise not governed by COB rules. Such Health Care Arrangements are called "non-complying plans."

This Plan coordinates its benefits with a non-complying plan as follows:

a. If this Plan is the Primary Plan, it will provide its benefits on a primary basis.

b. If this Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of this Plan will be limited to the benefits of a Secondary Plan.

c. If the non-complying plan does not provide information needed to determine this Plan's benefits within a reasonable time after it is requested, this Plan will assume that the benefits of the non-complying plan are the same as the benefits of this Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying plan.

d. If

(i) the non-complying Plan reduces its benefits so that a Covered Person receives less in benefits than he or she would have received had the complying plan paid, or provided its benefits as the Secondary Plan, and the non-complying plan paid or provided its benefits as the Primary Plan; and

(ii) governing State law allows the right of subrogation set forth below;

then the complying plan shall advance to you or on your behalf an amount equal to such difference. However, in no event shall the complying plan advance more than the complying plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the complying plan shall be subrogated to all your rights against the non-complying plan. Such advance by the complying plan shall also be without prejudice it may have against the non-complying plan in the absence of such subrogation.

C. Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under this Plan and the other Health Care Arrangement and when benefits of this Plan are determined as a Secondary Plan.

1. Benefits of this Plan will be reduced when the sum of

a. the benefits that would be payable for the Allowable Expenses under this Plan, in the absence of this COB section; and

b. the benefits that would be payable for the Allowable Expenses under the other Health Care Arrangement or Arrangements, in the absence of provisions with a purpose similar to that of this COB section, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Health Care Arrangement or Arrangements do not total more than Allowable Expenses.

2. When the benefits of this Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of this Plan.
3. The Plan Administrator will not, however, consider the benefits of the other Health Care Arrangement or Arrangements in determining benefits under this Plan when
    a. the other Health Care Arrangement has a rule coordinating its benefits with those of this Plan and such rule states that benefits of the other Health Care Arrangement will be determined after those of this Plan; and
    b. the order of benefit determination rules requires this Plan to determine benefits before those of the other Health Care Arrangement.

D. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Plan Administrator has the right to decide which facts it needs. The Plan Administrator may get needed facts from or give them to any other organization or person. The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give The Plan Administrator (or its applicable Claims Administrator) any facts it needs to pay the claim.

E. Facility of Payment

A payment under another Health Care Arrangement may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term “Payment Made” includes providing benefits in the form of services; in which case, “Payment Made” means reasonable cash value of the benefits provided in the form of services.

F. Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of

1. the persons it has paid or for whom it has paid,
2. insurance companies, or
3. other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

G. Are You Also Covered by Medicare?

If you are also Covered by Medicare, the Plan Administrator follows the Medicare Secondary Payor (MSP) rules to determine your benefits. If you are eligible for Medicare but not enrolled, and the Plan would be secondary to Medicare if you were enrolled in Medicare, the Plan will pay as though you were enrolled in Medicare.

Subrogation and Right of Reimbursement

A. Subrogation Rights

The Plan assumes and is subrogated to your legal rights to recover any payments the Plan makes for Covered Services, when your illness or injury resulted from the action or fault of a third party. The Plan's subrogation rights include the right to recover the reasonable value of prepaid services rendered by Network Providers.

The Plan has the right to recover any and all amounts equal to the Plan's payments from

1. the insurance of the injured party;
2. the person, business entity (or combination thereof) that caused the illness or injury, or their insurance company; or
3. any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

B. Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage; or
3. business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from a Covered Person.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Covered Person is a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

C. Notice and Cooperation

Covered Persons are required to notify the Plan Administrator or the applicable Claims Administrator promptly if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the Plan Administrator to protect the Plan's rights under this section. Covered Persons are also required to cooperate with the Plan Administrator and BCBST to execute any documents deemed necessary to protect the Plan's rights under this section.

The Covered Person shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall

entitle the Plan to withhold any and all benefits due the Covered Person under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's subrogation rights and/or priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees and expenses, the Plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

D. Legal Action and Costs

If you settle any claim or action against any third party, you shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by you in such circumstances.

Additionally, the Plan has the right to sue on your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

E. Settlement or Other Compromise

You must notify the Plan Administrator or the applicable Claims Administrator prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that they may be present and protect its subrogation rights and/or priority right of reimbursement.

The Plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against you.

The right of subrogation and the right of reimbursement are based on the Plan's language in effect at the time of judgment, payment or settlement.

The Plan, or its representative, may enforce the subrogation and priority right of reimbursement.

F. Further Right of Subrogation as to Benefits Paid because of Error of Fact or Law

In the event that a benefit is paid from the Plan in part or in whole on the basis of a material error in fact or in law, regardless of the cause or the source of that error, and that benefit is paid to or on behalf of a Plan Covered Person, then, in consideration of the benefit obligations undertaken by the Plan, an amount equal to that payment is subject to the right of reimbursement back to the Plan from that Covered Person. The Plan shall also be entitled to recover reasonable attorneys' fees and court costs incurred in collecting such erroneous benefit payment if the Plan Covered Person does not voluntarily assist the Plan in obtaining such reimbursement and court action is necessary. The Covered Person is required to notify the Plan Administrator promptly of knowledge of such erroneous benefit payment.

Decisions About Benefit Eligibility and Amounts

The Plan Administrator has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Health Benefit Plan and any other Health Benefit Plan documents, instruments or communications and to decide all matters arising in connection with the operation or administration of the Health Benefit Plan. Without limiting the generality of the foregoing, the Plan Administrator has the sole and absolute discretionary authority

1. to take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Health Benefit Plan;
2. to formulate, interpret, and apply rules, regulations, and policies necessary to administer the Health Benefit Plan;
3. to decide questions, including legal or factual questions, relating to the eligibility for, and the calculation and payment of, benefits under the Health Benefit Plan; and
4. to resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Health Benefit Plan, or other Health Benefit Plan documents, instruments or communications;
5. except as specifically provided to the contrary elsewhere in the Health Benefit Plan, to process, and approve or deny, benefit claims and rule on any benefit exclusions, and determine the manner of benefit payments.

All determinations made by the Plan Administrator with respect to any matter arising under the Plan shall be final and binding on all parties. Benefits under this Health Benefit Plan will be paid only if the Plan Administrator decides in its sole and exclusive discretion that the applicant is entitled to them.

ERISA Benefit Claim Grievance Procedures

If you have a claim for benefits from the Health Benefit Plan, the provisions of these ERISA Benefit Claim Grievance Procedures will apply. (The term "ERISA" is short for the Employee Retirement Income Security Act of 1974.) These ERISA Benefit Claim Grievance Procedures apply only to the Health Benefit Plan. These procedures govern the filing of benefit claims for payment, notification of benefit determinations on such claims and the appeal of adverse benefit determinations under the Health Benefit Plan.

The term "claim" described herein means a request or claim for payment of services or items as a benefit provided by that Plan. A Claim for benefit that is denied may be appealed under the Claim Grievance Procedures of this Plan which follow.

These ERISA Benefit Claim Grievance Procedures apply only to claims you make to the Plan either requesting the Health Benefit Plan to pay for services or items in advance of that service or item being provided or requesting the Health Benefit Plan to pay for services or items already provided to you. However, these claim procedures do not affect your access to such services or items. In other words, described here are the procedures that apply to a determination of whether the Health Benefit Plan under its terms is responsible for payment of all or a portion of service or item you request or have received: your decision to have or not to have the service or item is not in any way governed or limited by either the Health Benefit Plan or these procedures.

When the term "you" is used in these ERISA Benefit Claim Grievance Procedures it refers both to a Covered Partner and to a Covered Dependent that is covered under the Health Benefit Plan.

Also, when the term "you" is used it means you or your authorized representative. The Claims Administrator will require proof, satisfactory to the Plan Administrator in its sole discretion, that an individual is your authorized representative. You may also be required to use a form approved by the Claims Administrator or the Plan Administrator to designate an authorized representative.

Finally the terms "adverse benefit claim determination" does not mean a medical management dispute with a Network Provider until (i) the Provider has exhausted the applicable Provider claim procedures set forth in the contract between the Claims Administrator and the Provider and (ii) it has determined that you are financially responsible for all or some portion of a disputed claim that is denied. You cannot use these procedures to resolve a claim you have for a Provider's negligence. These procedures are only to resolve a benefit claim that is subject to the Plan Administrator's control.

You must file claim with the Claims Administrator in accordance with this SPD. As noted earlier, if your service or item was provided by a Network Provider, the Network Provider will file the claim on your behalf. You are responsible for filing all other claims. If you properly and timely file a claim with the Plan, you will be notified in writing or electronically by the Claims Administrator of this initial adverse benefit claim determination. (This is called an "initial" adverse benefit claim determination because you have the right to appeal an initial adverse benefit claim determination for further review.) That notification should provide you the following:

1. The specific reason or reasons for the initial adverse benefit claim determination.
2. Reference to the specific Health Benefit Plan provision or provisions on which the initial adverse benefit claim determination was based.
3. A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.
4. A description of the Health Benefit Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a). The period of time for filing lawsuits is identified in Legal Information Section of this SPD.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making an initial adverse benefit claim determination, then the specific rule, guideline, protocol or other similar criterion (or, alternatively, a statement that such a rule, guideline, protocol or other similar criterion

was relied upon in making the initial adverse benefit claim determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon your request).

6. If an initial adverse benefit claim determination is based on a lack of Medical Necessity and Medical Appropriateness for the service, is based on the service requested being experimental and/or Investigational, is based on a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination which will describe the Health Benefit Plan's provision or provisions that apply to your medical circumstances (or, alternatively, a statement that such an explanation will be provided to you free of charge upon your request).

7. In the case of an Urgent Care claim, a description of the expedited review process which is available with respect to an Urgent Care claim (which are discussed later under the caption "Urgent Care Requests" in these ERISA Benefit Claim Grievance Procedures for the Health Benefit Plan).

You will have the opportunity to appeal any initial adverse benefit claim determination to the Plan Administrator. **However, in order to do so you must appeal the Claims Administrator's initial adverse benefit claim determination within 180 days following receipt of the notification of the adverse benefit claim determination. If you do not appeal the Claims Administrator's initial adverse benefit determination within this 180 day period, then you will be time-barred from appealing that adverse benefit claim determination under the terms of the Health Benefit Plan.** You must appeal an initial adverse benefit claim decision in order to exhaust the administrative remedies under these ERISA Benefit Claim Grievance Procedures for the Health Benefit Plan. You must exhaust the administrative remedies under these ERISA Benefit Claim Grievance Procedures in order to bring a civil action in State or Federal Court for Health Benefit Plan benefits under Section 502(a) of ERISA.

If you wish to appeal an initial adverse benefit claim determination, then you will be provided the following:

1. The opportunity to submit written comments, documents, records and other information relating to your claim for benefits;

2. Upon your request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

3. A review on appeal that considers all comments, documents, records and other information you submit, without regard to whether or not such information was submitted or considered in the initial adverse benefit claim determination;

4. A review on appeal that does not afford deference to the initial adverse benefit claim determination and that is conducted by a reviewer who is neither the individual who made the initial adverse benefit claim determination that is the subject of the appeal nor the subordinate of such individual;

5. If the initial adverse benefit claim determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular Treatment, drug or other item is experimental and/or Investigational, or not Medically Necessary and/or Medically Appropriate), then a review in which the reviewer consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither a person who was consulted in connection with the initial adverse benefit claim determination that is the subject of the appeal nor the subordinate of any such individual;

6. A review on appeal which provides the identity of medical or vocational experts whose advice was obtained by the Plan Administrator in connection with your initial adverse benefit claim determination, without regard to whether the advice was relied upon in making the initial adverse benefit claim determination.

If you appeal an initial adverse benefit claim determination and you are turned down on appeal, you will be notified in writing or electronically of the adverse benefit claim determination on review of your appeal. That notification will provide you the following:

1. The specific reason or reasons for the adverse benefit claim determination on review of your appeal.
2. Reference to the specific Health Benefit Plan provision or provisions on which the adverse benefit claim determination on review of your appeal was based.
3. A statement that, upon your request and free of charge, you are entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to your claim.
4. If an internal rule, guideline, protocol or other similar procedure was relied upon in making an adverse benefit claim determination on review of your appeal, then the specific rule, guideline, protocol or other similar criterion (or, alternatively, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit claim determination on review of your appeal, and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon your request).
5. If the adverse benefit claim determination on review of your appeal is based on a lack of Medical Necessity and/or Medical Appropriateness for a Treatment, is based on the Treatment being experimental and/or Investigational, or is based on a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination which will describe the Health Benefit Plan's provision or provisions that apply to your medical circumstances (or, alternatively, a statement that such an explanation will be provided to you free of charge upon your request).

If you make a benefit claim and your claim is turned down on the basis of (1) Medical Necessity, (2) Medical Appropriateness, (3) health care setting, (4) level of care or (5) effectiveness of a Covered benefit, and you disagree with this adverse determination on such basis, then you have a right to a further review of your claim by an independent, external review organization. This is a review of your benefit claim outside the internal review procedure of the Plan just described. Such an external review is available only in the case of a claim denial based of one or more of these five reasons, and for no other reason.

You may omit this exhaustion of the Plan's final, internal appeal requirement if the Plan fails to comply with the above requirements of the internal appeals procedures, except if that failure is based on a minor violation that does not cause, and is not likely to cause, you harm or materially interferes with your right to file such a claim for external review.

You must file a request for independent, external review no later than four months after the date you receive notice of the final internal adverse benefit determination, or if applicable because of the Plan's compliance failure as just described, the initial internal adverse benefit determination. If you do not file a request for external review within this four-month period, you lose your right to external review, and you will not thereafter have any right to external review.

The cost of this independent, external review will be paid by the Plan, though there may be a nominal charge to you, (as permitted under applicable law).

The decision of the independent review organization is binding on the Plan, as well as on you. However, you have the right to bring a civil action under ERISA 502(a) in State or Federal Court as described below.

The independent review organization must provide written notice to both you and the Plan of its decision to uphold or reverse the adverse benefit determination no later than 45 days after its receipt of the request for external review.

If your benefit claim is turned down in the final review for which you are eligible, you have a right to bring a civil action under ERISA Section 502(a) in Federal Court. If the Plan Administrator fails to follow these ERISA Benefit Claim Grievance Procedures with respect to your benefit claim on review of your appeal, your benefit claim on review of your appeal will be deemed to be denied, and an adverse benefit claim determination made on review of your appeal as of the last day the Plan Administrator could have complied with these procedures.

The preceding description of ERISA Benefit Claim Grievance Procedures apply generally to all benefit claims under the Health Benefit Plan, except as specifically otherwise indicated. There are special timing rules,

though, that apply to the Plan Administrator and to you with respect to such benefit claims. These special timing rules depend on the type of benefit claim you make.

There are three types of benefit claims: Urgent Care requests, Prior Authorization requests and post service claims.

An Urgent Care request is any claim in advance for benefit coverage from the Health Benefit Plan for services or items with respect to which the application of the time period for making a non-urgent Prior Authorization request (described in the following paragraph) could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or Treatment that is the subject of the claim.

A Prior Authorization request is any claim for benefit coverage from the Health Benefit Plan, which is conditioned, in whole or in part, on approval of benefit coverage from the Health Benefit Plan in advance of obtaining the medical care or Treatment. That is, a Prior Authorization request is a request for benefit coverage from the Health Benefit Plan which must be Pre-authorized.

A post-service claim is a claim for benefit coverage from the Health Benefit Plan you make after medical care or Treatment has already been provided.

Regardless of the type of benefit claim you make, benefit coverage from the Health Benefit Plan is the payment for medical care or Treatment.

A. Urgent Care Requests

The following special timing rules apply only to an Urgent Care request. You should be notified of the Plan Administrator's initial benefit determination (whether adverse or not) on your Urgent Care request as soon as possible, but not later than 72 hours after the receipt of your Urgent Care request, unless you are unable or fail to provide sufficient information for the Plan Administrator to determine whether, or to what extent, benefits are payable under the Health Benefit Plan. In that event you should be notified of the specific information necessary to complete the determination on your Urgent Care request as soon as possible, but not later than 24 hours after the receipt of your Urgent Care request. Generally, you will have 48 hours to provide the specified information, unless you are given an extension of time by the Plan Administrator to provide the specified information because of special circumstances. You should ask for this extension, preferably in writing, in order for you to have an extension of time beyond the 48 hours to provide the specified information, or otherwise the Plan Administrator may make its initial benefit determination based on the information the Plan Administrator has within the original 72 hour time period. The Plan Administrator will determine whether special circumstances exist to give the extension of time. If you are granted an extension of time to provide the specified information necessary to make a determination of your Urgent Care request, you should be notified about the determination as soon as possible when made, but not later than 48 hours after either the longer period given to you to provide that information because of special circumstances or, if earlier, the Plan Administrator's receipt of the specified information necessary to complete the determination on your Urgent Care request.

If a request for an ongoing course of Treatment to be provided to you over a period of time or for a specific number of Treatments has been previously approved, then that course of Treatment typically will not be reduced or terminated before the end of the period of time or number of Treatments (except where such reduction or termination is because the Health Benefit Plan itself is amended or terminated). If something comes up, however, and that course of Treatment is to be reduced or terminated, you will be notified sufficiently in advance of the reduction or termination of the previously approved Treatment for you to appeal that adverse determination. A determination by the Plan Administrator to reduce or terminate your previously approved Treatment is the same as an initial adverse benefit claim determination of an Urgent Care request under these ERISA Benefit Claim Grievance Procedures.

Likewise, provided your request is made at least 24 hours before the end of the previously approved Treatment, if you request an extension on a course of Treatment, the Plan Administrator should notify you of its decision (whether adverse or not) as soon as possible, but not later than 24 hours after the receipt of your request. A determination by the Plan Administrator not to extend the course of Treatment

will also be the same as an initial adverse benefit claim determination of an Urgent Care request under these ERISA Benefit Claim Grievance Procedures.

If your Urgent Care request is turned down, and you wish to appeal that initial adverse benefit claim determination, on your request orally or in writing your appeal will receive expedited review and all information necessary for the reviewer to perform the review may be transmitted between you and the reviewer by telephone, facsimile or other available similarly expeditious method to help speed your appeal. On your appeal of an initial adverse benefit claim determination of your Urgent Care request, the Plan Administrator should notify you of the Plan Administrator's benefit determination on review of your appeal as soon as possible, but not later than 72 hours after receipt of your appeal.

An adverse benefit claim determination of your Urgent Care request may be provided to you orally, as well as in writing or electronically within the time periods described earlier for a response to an Urgent Care request. However, if your Urgent Care request is turned down orally, then you should be provided with the information required to be included in an adverse benefit claim determination of an Urgent Care request not later than three days after the oral notification.

B. Pre-Service Requests

The following special timing rules apply only to a pre-service request (that is, a request requiring Prior Authorization). You should be notified of the Plan Administrator's initial benefit claim determination (whether adverse or not) on your pre-service request within a reasonable period of time appropriate to your medical circumstances, but not later than 15 days after the receipt of your initial pre-service request. If the Plan Administrator determines that an extension of this original 15-day period is necessary due to matters beyond the Plan Administrator's control, the Plan Administrator may extend this original 15-day period once for up to an additional 15 days. In that case the Plan Administrator, prior to the expiration of the original 15-day period, will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to make the benefit claim determination on your pre-service request. If the extension of time is necessary due to your inability or failure to submit information to the Plan Administrator necessary for the Plan Administrator to make a determination on your claim, the Plan Administrator's notice of extension will specifically describe the information required to make the benefit claim determination. You will have 45 days to provide this required information.

If you appeal an initial adverse benefit claim determination of your pre-service request, then the Plan Administrator should notify you of its benefit determination on review of your appeal within a reasonable period of time appropriate to your medical circumstances, but not later than 30 days after receipt of your appeal.

C. Post-Service Claims

The following special timing rules apply only to a post-service claim. If the Plan Administrator makes an initial adverse benefit claim determination of your post-service claim, then you should be notified of that determination within a reasonable period of time, but not later than 30 days after receipt of your initial claim. If the Plan Administrator determines that an extension of this original 30-day period is necessary due to matters beyond the Plan Administrator's control, the Plan Administrator may extend this original 30-day period once for up to 15 days. In that case the Plan Administrator, prior to the expiration of the original 30-day period, will notify you of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to make the benefit determination on your post-service claim. If an extension of time is necessary due to your inability or failure to submit information to the Plan Administrator necessary for the Plan Administrator to make a determination on your post-service claim, then the Plan Administrator's notice of extension will specifically describe the information required to make the benefit claim determination. You will have 45 days to provide this required information.

If you appeal an initial adverse benefit claim determination of your post-service claim, then the Plan Administrator should notify you of its benefit claim determination on review of your appeal within a reasonable period of time, but not later than 60 days after receipt of your appeal.

Limitations on Covered Services

The Plan will pay the Allowed Amount for Medically Necessary and Medically Appropriate services and supplies described and provided in accordance with the reimbursement schedules set forth in the Schedule of Benefits of this Plan, which is incorporated herein by reference. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with Claims Administrator's medical policies and procedures. (See the Prior Authorization, Care Management, Medical Policy and Patient Safety section of this Plan.)

Other Exclusions

Your benefits are greater when you use Network Providers. Each Claims Administrator contracts with Network Providers. Network Providers have agreed to accept the Allowed Amount as basis for payment to the Provider for Covered Services. (See the Definitions section for an explanation of Allowed Amount and Covered Services.) Network Providers have also agreed not to balance bill you for amounts above the Allowed Amount.

Out-of-Network Providers do not have a contract with the Claims Administrator. This means they may be able to charge you more than the Allowed Amount (that is, to balance bill you). When you use an Out-of-Network Provider for Covered Services, you will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. This means that you may owe the Out-of-Network Provider a large amount of money under Balance Billing.

Obtaining services not listed as a Covered Service in this Plan or not in accordance with the Plan's health care management policies and procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the Plan must be satisfied before benefits for Covered Services will be provided. The Claims Administrator's Medical Policies can help your Provider determine if a proposed service will be Covered.

Covered Services

A. Practitioner/Preventive Office Services

Medically Necessary and Appropriate Covered Services in a Practitioner's office.

1. Covered Services

   a. Diagnosis and treatment of illness or injury.

   b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See *Provider-Administered Specialty Drugs* section for information on Coverage).

   c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the Surgery.

   d. Well Child Care for children through age 5, including appropriate immunizations, screenings and diagnostics. Once child reaches age 6, well care services are provided as described below.

   e. Well Care Services are preventive health services for Covered Persons ages 6 and older, as recommended by the U.S. Preventive Services Task Force (USPSTF) with an A or B rating. Well care services include:

      (i) Annual preventive health exam including blood pressure screening, cholesterol screening, vision screening and hearing screening performed by the physician during the preventive health exam.

      (ii) Colorectal cancer screenings for members age 50-75.

      (iii) Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

      (iv) Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA).

      (v) Prescribed x-ray and laboratory screenings associated with preventive care.

      (vi) Influenza immunizations, including nasal spray flu vaccines payable up to the Allowed Amount for an influenza immunization injection.

      (vii) Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other USPSTF screenings with an A or B rating.

      (viii) Prostate cancer screening for men age 50 and older.

      (ix) Screening and counseling in the primary care setting for alcohol misuse and tobacco use.

      (x) Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.

      (xi) FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. Note that prescription contraceptive products are covered under the Prescription Drug Program.

      (xii) HPV testing once every 3 years for women age 30 and older.

      (xiii) Lactation counseling by a trained provider during pregnancy or in the post-partum period, and manual breast pump.

      Some of these services are not needed every year or may be appropriate only for people of particular age groups, gender, or those who meet other specific health criteria.

   f. Rehabilitation therapies.

   g. Allergy care including basic testing, evaluations, serum and injections.

h. Casts and dressings.

i. Foot care necessary to prevent the complications of an existing disease state.

j. Routine foot care for the treatment of (1) flat feet, (2) corns, (3) bunions, (4) calluses, (5) in-grown toenails and fungal infections, (6) fallen arches, (7) weak feet or chronic foot strain.

k. Foot orthotics, shoe inserts and custom made shoes.

l. Pre- and post-natal maternity care.

m. Services and Supplies for the diagnosis and treatment of illness or injury, including those relating to hearing, speech, voice or language.

n. Emergency conditions presented to the Practitioner's Office.

2. Exclusions from Coverage

a. Office visits and physical exams for (1) school, (2) camp, (3) employment, (4) travel, (5) insurance, (6) marriage or legal proceedings, (7) pastoral or financial counseling and (8) related immunizations and tests.

b. Rehabilitation therapies are subject to the limitations of the Therapeutic/Rehabilitation benefit.

B. Office Surgery

Medically Necessary and Appropriate surgeries/procedures performed in a Practitioner's office. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

1. Covered Services

a. Excisions (including mole removal), incisions

b. Surgical repairs, including suturing lacerations

c. Biopsies

d. Endoscopies

e. Casting and splinting

f. Joint injection and drainage

g. Cryosurgery

h. Vasectomy

2. Exclusions from Coverage

a. Dental procedures, except as otherwise indicated in this Plan

Some Covered procedures may require pre-certification (or Prior Authorization) and/or special consent, in accordance with the administrator's Medical Policy and procedures. Call the customer service department to find out which surgeries require Prior Authorization.

C. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies in a Hospital that (1) is a licensed Acute care institution, (2) provides inpatient services, (3) has surgical and medical facilities primarily for the diagnosis and treatment of disease and injury, and (4) has a staff of Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric Specialist Hospitals are not required to have a surgical facility.

1. Covered Services

    a. Room and board in a semi-private room; general nursing care; medications, injections, diagnostics and special care units.

    b. Prescription Drugs that are prescribed, dispensed or intended for use while the Covered Person is confined in a Hospital, skilled nursing facility or other similar facility.

    c. Attending Practitioner's services for professional care.

    d. Maternity and delivery services, including Complications of Pregnancy.

    e. Observation stays.

    f. Blood/plasma is a Covered Service unless free.

2. Assistant Surgeon

    Benefits will be provided for surgery performed by a physician who actively assists the operating surgeon in the performance of a Covered surgical procedure, provided (1) no intern, resident, or other staff physician is available; and (2) the Plan's Medical Policies and procedures recognize such procedure as requiring an assistant surgeon.

3. Exclusions from Coverage

    a. Inpatient stays primarily for therapy (such as physical or occupational therapy).

    b. Private duty nursing.

    c. Services that could be provided in a less intensive setting.

    d. Weekend Hospital admission only when surgical procedures are scheduled on the date of admission or in cases of documented emergency.

    e. Prior Authorization for Covered Services must be obtained from BCBST or benefits will be denied or reduced.

D. Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital that are required to determine, evaluate and/or treat an Emergency Medical Condition until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol.

1. Covered Services

    a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of the Covered Person's Emergency condition.

    b. Practitioner services.

2. Exclusions from Coverage

    a. Emergency Care does not include treatment of a chronic, non-Emergency Medical Condition where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.

    b. Once the Covered Person's medical condition has stabilized, Prior Authorization must be obtained from BCBST for inpatient care or transfer to another facility. Benefits will be denied or reduced if such Authorization is not obtained within 24 hours or the next working day.

E. Ambulance Services/Emergency Medical Transportation

Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the patient.

1. Covered Services

   Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate facility.

2. Exclusions from Coverage

   a. Transportation for the convenience of the Covered Person.

   b. Transportation that is not essential to reduce the probability of harm to the patient.

F. Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and surgery occurring in an outpatient facility which includes outpatient surgery centers, the outpatient center of a Hospital and outpatient diagnostic centers.

1. Covered Services

   a. Practitioner services.

   b. Outpatient diagnostics (such as x-rays and laboratory services).

   c. Outpatient Treatments (such as medications and injections.)

   d. Outpatient surgery and supplies.

   e. Observation stays.

2. Exclusions from Coverage

   a. Therapeutic Services are subject to the terms of the Therapeutic/Rehabilitation Services benefit.

   b. Services that could be provided in a less intensive setting.

Prior Authorization of certain outpatient surgeries must be obtained from BCBST or benefits will be denied or reduced. Call the customer service department to find out which surgeries require Prior Authorization.

G. Family Planning and Reproductive Services

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility.

1. Covered Services

   a. Benefits for family planning, history, physical examination and diagnostic testing.

   b. Sterilization procedures.

   c. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion.

2. Exclusions from Coverage

   a. Benefits for any services or supplies that are designed to medically enhance a Covered Person's level of fertility in the absence of a disease state.

   b. Assisted Reproductive Technology (ART), such as GIFT, ZIFT, in vitro fertilization and fertility drugs.

   c. Sperm preservation.

   d. Services or supplies for the reversals of sterilizations.

   e. Elective abortions.

   f. Induced abortion unless (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, (2) the fetus is not viable, (3) the pregnancy is a result of

rape or incest, or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

H. Reconstructive Surgery

Medically Necessary and Appropriate surgical procedures intended to restore normal form or function.

1. Covered Services
    a. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state.
    b. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy). Surgery on the non-diseased breast needed to establish symmetry between the two breasts.
2. Exclusions from Coverage
    a. Services, supplies or prosthetics primarily to improve appearance.
    b. Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance.

I. Skilled Nursing/Rehabilitation Facility Services

Medically Necessary and Appropriate Inpatient care provided to patients requiring medical, rehabilitation or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a Hospital setting, or custodial or functional care rendered in a nursing home.

1. Covered Services
    a. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units.
    b. The attending Practitioner's services for professional care.
    c. Coverage is limited as indicated in the Schedule of Benefits.
2. Exclusions from Coverage
    a. Custodial, domiciliary or private duty nursing services.
    b. Skilled nursing services not received in a Medicare certified skilled nursing facility.

Prior Authorization for Covered Services must be obtained from BCBST or benefits will be denied or reduced.

J. Therapeutic/Rehabilitation Services

Medically Necessary and Medically Appropriate Therapeutic and Rehabilitation Services intended to restore or improve bodily function lost as the result of illness or injury.

1. Covered Services
    a. Outpatient, home health or office Therapeutic and Rehabilitation Services that are expected to result in significant and measurable improvement in the Covered Person's condition resulting from a disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.
    b. Therapies include: (1) physical therapy, (2) speech therapy, (3) occupational therapy, (4) manipulative therapy, and (5) cardiac and pulmonary Rehabilitation Services.
        (i) Speech therapy (ST) is the treatment of communication impairment and swallowing disorders. Speech theraphy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis and Rehabilitation.
        (ii) Therapy services for Autism, Autism Spectrum disorder and Pervasive Development disorders in dependent children.

c. Coverage is limited as indicated in the Schedule of Benefits.

d. Services received during an inpatient Hospital, skilled nursing or rehabilitation facility stay are Covered as shown in the Inpatient Hospital Services or Skilled Nursing/Rehabilitation Facility Services section.

e. The services must be performed in a doctor's office, outpatient facility or Home Health setting.

2. Exclusions to Coverage

a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.

b. Enhancement therapy that is designed to improve the physical status beyond their pre-injury or pre-illness state.

c. Complementary and alternative therapeutic services, the value of which has not yet been determined to be Medically Necessary. These include but are not limited to (1) massage therapy; (2) acupuncture; (3) aquatic therapy; (4) craniosacral therapy; (4) neuromuscular reeducation; (5) vision exercise therapy; and (6) cognitive therapy.

d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that can be performed by the Covered Person without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to a caregiver or the Covered Person.

e. Behavioral therapy, play therapy, and therapy for self-correcting language dysfunctions.

f. Duplicate therapy - When you receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

K. Organ Transplants

As soon as your Provider tells you that you might need a transplant, you or your Provider must contact the BCBST's Transplant Case Management department.

Medically Necessary and Appropriate services and supplies provided to you, when you are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in the Plan Administrator's sole discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate.

You have access to three levels of benefits: In-Transplant Network, In-Network, and Out-of-Network. If you go to an In-Transplant Network Provider, you will have the highest level of benefits. (See section (3.f) for kidney transplant benefit information.)

Transplant Services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment authorization that must be obtained from BCBST before any pre-transplant evaluation or any Covered Service is performed. (See Prior Authorization Procedures below.)

1. Prior Authorization Procedures

To obtain Prior Authorization, you or your Practitioner must contact the BCBST's Transplant Case Management department before pre-transplant evaluation or Transplant Services are received. Authorization should be obtained as soon as possible after you have been identified as a possible candidate for Transplant Services.

Transplant Case Management is a mandatory program for those Covered Persons seeking Transplant Services. BCBST must be notified of the need for a transplant in order for the pre-transplant evaluation and the transplant to be Covered Services.

2. Covered Services

   The following Medically Necessary and Appropriate Transplant Services and supplies that have received Prior Authorization and are provided in connection with a Covered Service:

   a. Medically Necessary and Appropriate services and supplies, otherwise Covered under the Plan.

   b. Medically Necessary and Appropriate services and supplies for each listed organ Transplant Service are Covered only when Transplant Case Management approves a transplant. Not all In-Network Providers are in the Transplant Network. Please check with a Transplant case manager to see which Hospitals are in the Transplant Network.

   c. Travel expenses for your evaluation prior to a Covered Service, and to and from the site of a Covered Service by (1) private car, (2) ground or air ambulance, or (3) public transportation. This includes travel expenses for you and a companion. The companion must be your spouse, family member, your guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants.

      (i) Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the Transplant Network.

      (ii) Meals and lodging expenses, limited to $150 daily.

      (iii) The aggregate limit for travel expenses is $10,000 per Covered Service.

      (iv) Travel Expenses are Covered only if you go to an In-Transplant Network facility.

   d. Donor Organ Procurement. If the donor is not a Covered Person, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; (5) donor follow-up care; (6) travel expenses, to the extent approved by the claims administrator in advance and otherwise covered by the Plan as described above, that are incurred by the donor for travel to and from the transplant facility for the donation and post donation follow up; and (7) meals and lodging, limited to $150 daily. The aggregate limit for travel, meals and lodging expenses are limited to $10,000 per Covered Service. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of your organ Transplant Service.

3. Conditions/Limitations

   The following limitations and/or conditions apply to services, supplies or charges:

   a. You or your Physician must notify Transplant Case Management prior to your receiving any Transplant Service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all.

   b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with BCBST in coordination of these services.

   c. Failure to notify BCBST of proposed Transplant Services, or to coordinate all transplant related services with BCBST, will result in the reduction or exclusion of payment for those services.

   d. You must go through Transplant Case Management and receive Prior Authorization for your transplant to be Covered.

   e. Once you have notified Transplant Case Management and received Prior Authorization, you may decide to have the transplant performed outside the Transplant Network. However, your

benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the service provided will be Covered.

(i) In-Transplant Network transplants: If you have the transplant performed at an In-Transplant Network Provider, you receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in the Schedule of Benefits, at the Transplant Maximum Allowable Amount. The In-Transplant Network Provider cannot bill you for any amount over the Transplant Maximum Allowable Amount for the transplant, which limits your liability.

(ii) In-Network transplants: If you have the transplant performed outside the Transplant Network, but still at a facility that is an In-Network Provider, the Plan will reimburse the In-Network Provider at the benefit levels listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Amount. There is no maximum to your liability. The Preferred Provider also has the right to Balance Bill you for any amount not Covered by the Plan. This amount may be substantial.

(iii) Out-of-Network transplants: If you have the transplant performed by an Out-of-Network Provider, the Plan will reimburse the Out-of-Network Provider only at the benefit level listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Amount. There is no maximum to your liability. The Out-of-Network Provider also has the right to Balance Bill you for any amount not Covered by the Plan. This amount may be substantial.

You can find out what the Transplant Maximum Allowable Amount is for your transplant by contacting Transplant Case Management. Remember, the Transplant Maximum Allowable Amount can and does change from time to time.

f. Kidney transplants. There are two levels of benefits for kidney transplants: In-Network and Out-of-Network.

(i) In-Network kidney transplants: If you have a kidney transplant performed at a facility that is an In-Network Provider, you receive the highest level of reimbursement for Covered Services. The In-Network Provider cannot Balance Bill you for any amount over the Transplant Maximum Allowable Amount, which limits your liability.

(ii) Out-of-Network kidney transplants: If you have a kidney transplant performed by an Out-of-Network Provider, the Plan will reimburse the Out-of-Network Provider only at the benefit level listed in the Schedule of Benefits, at the Allowed Amount. There is no maximum to your liability. The Out-of-Network Provider also has the right to Balance Bill you for any amount not Covered by this Plan. This amount may be substantial.

g. If you go through Transplant Case Management for your transplant, follow its procedures, cooperate fully with them, and have your transplant performed at an In-Transplant Network facility, the transplant expenses specified in the Schedule of Benefits are Covered.

4. Exclusions from Coverage

The following services, supplies and charges are not Covered under this section:

a. Transplants and related services that did not receive Prior Authorization.

b. Any service specifically listed under Exclusions from Coverage, except as otherwise provided in this section.

c. Services or supplies not specified as Covered Services under this section.

d. Any attempted Covered Service that was not performed, except where such failure is beyond your control.

e. Non-Covered Services.

f. Services that are covered under any private or public research fund, regardless of whether you applied for or received amounts from such fund.

g. Any non-human, artificial or mechanical organ.

h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ.

i. Donor services including screening and assessment procedures that have not received Prior Authorization.

j. Removal of an organ from a Covered Person for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above.

k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate timeframe for the patient's covered stem cell transplant diagnosis.

l. Other non-organ transplants (such as the cornea) are not Covered under this Section but may be Covered as an inpatient Hospital Service or outpatient facility service, if Medically Necessary and Appropriate.

NOTE: If you receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network, you will have to pay the Provider any additional charges not Covered by the Plan.

L. Dental Services, TMJ, and Oral Surgical Treatment

Medically Necessary and Appropriate services performed by a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD) or any Practitioner licensed to perform dental related oral surgery except as indicated below.

1. Covered Services

   a. Dental services and oral surgical care to treat intraoral cancer or to treat accidental injury to the jaw, natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be completed within 12 months of the accident.

   b. Oral surgical care resulting from disease of the jaw, natural teeth, mouth or face, including cancer, tumors or bone cysts that require pathological examination of the maxilla or mandible.

   c. Surgery and services to correct congenital malformations that are outside of normal individual variation and have resulted in significant functional impairment.

   d. Inpatient or outpatient expenses, including anesthesia, for which Prior Authorization has been obtained, in connection with a dental procedure that includes

      (i) complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;

      (ii) concomitant systemic disease for which the patient is under current medical management and which significantly increases the probability of complications;

      (iii) mental illness or behavioral condition that precludes dental surgery in the office;

      (iv) use of general anesthesia and the Covered Person's medical condition requires that such procedure be performed in a Hospital; or

      (v) dental treatment or surgery performed on an Insured 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting.

   e. Removal of impacted teeth, including wisdom teeth.

   f. Oral appliances to treat obstructive sleep apnea, if Medically Necessary and Appropriate.

2. Benefits are available for the diagnosis and Treatment of temporomandibular joint syndrome or dysfunction (TMJ or TMD) and associated pain of the joint between the temporal bones and the mandible.

    a. Non-surgical TMJ includes: (1) history exam, (2) office visit, (3) x-rays, (4) diagnostic study casts, (5) medications, and (6) appliances to stabilize jaw joint and medications.

    b. Dental Covered Services should be filed with the dental carrier first if dental insurance is in effect.

3. Exclusions from Coverage

    a. Services as a result of an injury to the jaw, natural teeth, mouth, or face started after one year from the date of the injury.

    b. The facility charges for surgery will be Covered under the conditions of the inpatient or outpatient facility benefit.

    c. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of non-impacted wisdom teeth; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

    d. Treatment for correction of underbite, overbite, and misalignment of the teeth, including but not limited to, braces for dental indications, orthognathic surgery, occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.

    e. Professional charges except as indicated above.

M. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

1. Covered Services

    a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging.

    b. Diagnostic laboratory services ordered by a Practitioner.

2. Exclusions from Coverage

    a. Diagnostic services that are not Medically Necessary and Appropriate.

    c. Diagnostic services not ordered by a Practitioner.

N. Durable Medical Equipment

Medically Necessary and Appropriate medical equipment or items that, in the absence of illness or injury (1) are of no medical or other value to you; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not for your convenience.

1. Covered Services

    a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase.

    b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

    c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

d. The replacement of items needed as the result of normal wear and tear, defects or aging.

2. Exclusions from Coverage

a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.

b. Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical Equipment.

c. Supplies and accessories that are not necessary for the effective functioning of the Covered Durable Medical Equipment.

d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.

f. Motorized scooters, exercise equipment, hot tubs, pools, saunas "deluxe" or "enhanced" equipment. In all instances, the most basic equipment needed to provide the needed medical care will determine the benefit.

g. Portable ramp for wheelchair.

O. Prosthetics/Orthotics

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to (1) birth defect, (2) accident, (3) illness, or (4) surgery.

1. Covered Services

a. The purchase of surgically implanted prosthetic or orthotic devices, foot orthotics, shoe inserts or custom made shoes.

b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.

c. Splints and braces that are custom made or molded and are incident to a Practitioner's services or on a Practitioner's order.

d. Future replacement of Covered items that need replacement due to the Covered Person's growth, normal wear and tear, defects or aging.

e. The purchase of artificial limbs, eyes, or contacts after cataract surgery.

2. Exclusions from Coverage

a. Hearing aids.

b. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.

c. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

d. The replacement of contacts after the initial pair has been provided following cataract surgery.

P. Supplies

Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury.

1. Covered Services

a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility, or inpatient facility.

b. Supplies for treatment of disease or injury that cannot be obtained without a Practitioner's Prescription.

2. Exclusions from Coverage

a. Supplies that can be obtained without a Prescription, except for diabetic supplies. Examples include but are not limited to (1) plastic bandages, (2) dressing material for home use, (3) antiseptics, (4) medicated creams and ointments, (5) cotton swabs, and (6) eyewash.

b. Supplies must have a Practitioner's Prescription if used in the home setting or otherwise for self-use, unless prescribed by a Practitioner and both Medically Necessary and Appropriate.

Q. Home Health Care Services

Medically Necessary and Appropriate services and supplies authorized by the Plan and provided in a Covered Person's home by an agency who is primarily engaged in providing home health care services.

1. Covered Services

a. Part-Time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.

b. Home infusion therapy.

c. Rehabilitation therapies such as physical therapy, occupational therapy, speech therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitation benefit).

d. Medical social services.

e. Dietary guidance.

f. Coverage is limited as indicated in the Schedule of Benefits.

2. Exclusions from Coverage

a. Items such as non-treatment services or (1) routine transportation, (2) homemaker or housekeeping services, (3) behavioral counseling, (4) supportive environmental equipment, (5) maintenance or Custodial Care, (6) social casework, (7) meal delivery, (8) personal hygiene, and (9) convenience items.

b. BCBST's Medical Policy may limit the number of visits per hour per day.

c. Prior authorization must be obtained from BCBST for such services.

R. Hospice

Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less.

1. Covered Services

a. Benefits will be provided for (1) part-time intermittent nursing care, (2) medical social services, (3) bereavement counseling, (4) medications for the control or palliation of the illness, (5) home health aide services, and (6) physical or respiratory therapy for symptom control.

2. Exclusions from Coverage

a. Prior Authorization must be obtained from BCBST for services.

b. Inpatient hospice services, unless approved by Care Management.

c. Services such as (1) homemaker or housekeeping services, (2) meals, (3) convenience or comfort items not related to the illness, (4) supportive environmental equipment, (5) private duty nursing, (6) routine transportation, and (7) funeral or financial counseling.

d. Coverage is limited as indicated in the Schedule of Benefits.

S. Behavioral Health Services

1. Prior Authorization Requirements

   Prior Authorization is required for

   a. All inpatient levels of care. Inpatient levels of care include Acute care, residential care, partial Hospital care, and intensive outpatient programs.

   b. Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.

   c. ABA therapy.

   Call the toll-free number indicated on the back of your Covered Person ID Card if you have questions about Prior Authorization requirements for Behavioral Health Services.

2. Covered Services

   Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

   a. Inpatient and outpatient services for care and Treatment of mental health disorders and substance abuse disorders.

   b. You may substitute other levels of care for inpatient days as follows:

      (i) Two residential treatment days for 1 inpatient day.

      (ii) Two partial Hospital days for 1 inpatient day.

      (iii) Three intensive outpatient program days for 1 inpatient day.

   c. Other case management benefits may be available.

3. Exclusions from Coverage

   a. Pastoral counseling.

   b. Marriage and family counseling without a behavioral health diagnosis.

   c. Vocational and educational training and/or services.

   d. Custodial or domiciliary care.

   e. Conditions without recognizable ICD code classification, such as adult child of alcoholics (ACOA), co-dependency and self-help programs.

   f. Sleep disorders.

   g. Pain management.

   h. Hypnosis or regressive hypnotic techniques.

   Call the toll-free number indicated on the back of the membership ID Card if you have questions about your Behavioral Health Services benefit.

IMPORTANT NOTE: All inpatient Treatment (including Acute, residential, partial Hospitalization and intensive outpatient treatment) requires Prior Authorization. If you receive inpatient Treatment, including treatment for substance abuse, that did not receive Prior Authorization, and you sign a Provider's waiver stating that you will be responsible for the cost of the Treatment, you will not receive Plan benefits for the Treatment. You will be financially responsible for the full amount of charges you incur, according to the terms of the waiver.

T. Vision

Medically Necessary and Appropriate diagnosis and Treatment of diseases and injuries that impair vision.

1. Covered Services

    a. Services and supplies for the diagnosis and Treatment of diseases and injuries to the eye.

    b. First set of eyeglasses or contact lens following cataract surgery.

2. Exclusions from Coverage

    Benefits will not be provided for the following services, supplies or charges:

    a. Services, surgeries and supplies to detect or correct refractive errors of the eyes.

    b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.

    c. Eye exercises and/or therapy.

    d. Visual training.

U. Diabetes Treatment

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary and Appropriate. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. If Prescription Drugs are Covered under a prescription drug card benefit, items (a) through (j) below will be Covered under the terms of that section.

1. Covered Services

    a. Blood glucose monitors, including monitors designed for the legally blind.

    b. Test strips for blood glucose monitors.

    c. Visual reading and urine test strips.

    d. Insulin.

    e. Injection aids.

    f. Syringes.

    g. Lancets.

    h. Oral hypoglycemic agents.

    i. Glucagon emergency kits.

    j. Injectable incretin mimetics (such as Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes.

    k. Insulin pumps, infusion devices, and appurtenances, not subject to the benefit limit for Durable Medical Equipment indicated in the Schedule of Benefits. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.

    l. Podiatric appliances for prevention of complications associated with diabetes.

2. Exclusions from Coverage

    a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

    b. Supplies not required by State statute.

V. Prescription Drug Program

Medically Necessary and Appropriate pharmaceuticals for the treatment of disease or injury.

1. Benefits for Prescription Drugs

a. Value Option

Prescriptions obtained from retail pharmacies have a limited calendar day supply. This limit is shown in the Schedule of Benefits.

At the Network Pharmacy, you will pay the lesser of your In-Network Copayment or the Pharmacy's charge.

Your Copayments vary based on the days supply dispensed as shown in the Schedule of Benefits.

Some products may be subject to additional Quantity Limitations as adopted by EmpiRx.

If you or the prescribing Physician choose a Brand Name Drug when a Generic Drug equivalent is available, you will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.

If you have a Prescription filled at an Out-of-Network Provider Pharmacy, you must pay all expenses and file a claim for reimbursement with EmpiRx. You will be reimbursed based on the Allowed Amount, less any applicable Deductible, Coinsurance, and/or Drug Copayment amount.

b. HSA Value Option

Prescriptions obtained from retail pharmacies have a limited calendar day supply. This limit is shown in the Schedule of Benefits.

You pay the full discounted retail price at the time of purchase until deductible has been met. Applicable co-insurance will apply.

Your payment may vary based on the days supply dispensed as shown in the Schedule of Benefits.

Some products may be subject to additional Quantity Limitations as adopted by EmpiRx.

When you purchase Preventive Drugs at a network pharmacy you will pay the lesser of your In-Network Copayment or the Pharmacy's charge. Preventive drugs are defined in the *Definitions* section.

If you have a Prescription filled at an Out-of-Network Provider Pharmacy, you must pay all expenses and file a claim for reimbursement with EmpiRx. You will be reimbursed based on the Allowed amount, less any applicable Deductible, Coinsurance, and/or Drug Copayment amount.

c. Premier Option

Prescriptions obtained from retail pharmacies have a limited calendar day supply. This limit is shown in the Schedule of Benefits.

At the Network Pharmacy, you will pay the lesser of your In-Network Copayment or the Pharmacy's charge.

Your Copayments vary based on the days supply dispensed as shown in the Schedule of Benefits.

Some products may be subject to additional Quantity Limitations as adopted by EmpiRx.

If you or the prescribing Physician choose a Brand Name Drug when a Generic Drug equivalent is available, you will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.

If you have a Prescription filled at an Out-of-Network Provider Pharmacy, you must pay all expenses and file a claim for reimbursement with EmpiRx. You will be reimbursed based on the Allowed Amount, less any applicable Deductible, Coinsurance, and/or Drug Copayment amount.

2. Benefits for Self-administered Specialty Drugs

   You have a distinct Network for Specialty Drugs called the Specialty Pharmacy Network. Benefits are only available when you use a Specialty Pharmacy Network provider for your Self-administered Specialty Drugs. Please refer to *Provider-administered Specialty Drugs* in Definitions for information on benefits for Provider-administered Specialty Drugs.

   Specialty Drugs have a limited day supply per Prescription. (See the Schedule of Benefits).

3. Covered Services

   a. This Plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act:

      (i) Generic contraceptives,

      (ii) Vaginal ring,

      (iii) Hormonal patch, and

      (iv) Emergency contraception available with a prescription.

      Brand name Prescription Contraceptive Drugs are Covered as indicated in the Schedule of Benefits.

   b. Prescription Drugs prescribed when you are not confined in a Hospital or other facility. Prescription Drugs must be:

      (i) prescribed on or after the date your Coverage begins,

      (ii) approved for use by the Food and Drug Administration (FDA),

      (iii) dispensed by a licensed pharmacist or dispensing physician,

      (iv) listed on the Preferred Drug Formulary, and

      (v) not available for purchase without a Prescription.

   c. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.

   d. Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

   e. Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.

   f. Immunizations administered at a Network Pharmacy.

4. Limitations

   a. Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.

   b. The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will Cover the refill.

   c. Certain drugs are not Covered except when prescribed under specific circumstances as determined by the P & T Committee.

   d. Prescription and non-Prescription medical supplies, devices and appliances are not covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma.

e. Immunological agents, including but not limited to (1) biological sera; (2) blood; (3) blood plasma; or (4) other blood products are not Covered, except for blood products required by hemophiliacs.

f. Injectable drugs, except when (1) intended for self-administration, or (2) defined by EmpiRx.

g. Compound Drugs are Covered only when filled at an In-Network Pharmacy. The In-Network Pharmacy must submit the claim through the Plan's Pharmacy Benefit Manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug. The Compound Drug claim will apply the Non-Preferred Brand Drug Co-payment/Coinsurance. Prior Authorization may be required for certain Compound Drugs. Compound Drugs made from bulk powders and select bulk chemicals will be excluded.

h. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA-approved dosage for four calendar weeks.

i. The Plan does not Cover Prescription Drugs prescribed for purposes other than for

(i) indications approved by the FDA, or

(ii) off-label indications recognized through peer-reviewed medical literature.

If you abuse or overuse pharmacy services outside of the administrative procedures, your Pharmacy access may be restricted. EmpiRx will work with you to select a Network Pharmacy, and you can request a change in your Network Pharmacy.

j. Step Therapy is a form of Prior Authorization. When Step Therapy is required, you must initially try a drug that has been proven effective for most people with your condition. However, if you have already tried an alternate, less expensive drug and it did not work, or if your doctor believes that you must take the more expensive drug because of your medical condition, your doctor can contact EmpiRx to request an exception. If the request is approved, the Plan will cover the requested drug.

5. Exclusions from Coverage

In addition to the limitations and exclusions specified in the Plan, benefits are not available for the following:

a. Drugs that are prescribed, dispensed or intended for use while you are confined in a Hospital, skilled nursing facility or similar facility, except as otherwise specifically Covered in the Plan.

b. Any drugs, medications, Prescription devices, dietary supplements, or vitamins available over-the-counter that do not require a Prescription by Federal or State law (even if otherwise prescribed by the provider); and/or Prescription Drugs dispensed in a doctor's office are excluded except as otherwise Covered in the Plan.

c. Any quantity of Prescription Drugs that exceeds that specified by the Plan's P & T Committee.

d. Any Prescription Drug purchased outside the United States, except those authorized by EmpiRx.

e. Any Prescription dispensed by or through a non-retail Internet Pharmacy.

f. Contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the Plan.

g. Medications intended to terminate a pregnancy.

h. Non-medical supplies or substances, including support garments, regardless of their intended use.

i. Artificial appliances.

j. Allergen extracts.

k. Any drugs or medicines dispensed more than one year following the date of the Prescription.

l. Prescription Drugs you are entitled to receive without charge in accordance with any worker's compensation laws or any Municipal, State, or Federal program.

m. Replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law).

n. Drugs dispensed by a Provider other than a Pharmacy or dispensing physician.

o. Prescription Drugs used for the Treatment of infertility.

p. Prescription Drugs not on the Preferred Drug Formulary.

q. Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression).

r. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches, except as required by the Affordable Care Act.

s. All newly FDA approved drugs prior to review by the Plan's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval.

t. Prescription Drugs used for cosmetic purposes including, but not limited to (1) drugs used to reduce wrinkles, (2) drugs to promote hair-growth, (3) drugs used to control perspiration, (4) drugs to remove hair, and (5) fade cream products.

u. FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

v. Prescription Drugs used during the maintenance phase of chemical dependence treatment, unless Authorized by EmpiRx.

w. Compound drugs filled or refilled at an Out-of-Network Pharmacy.

x. Drugs used to enhance athletic performance.

y. Specialty Drugs filled or refilled at an Out-of-Network Pharmacy.

z. Experimental and/or Investigational Drugs.

aa. Provider-administered Specialty Drugs, as indicated on the Specialty Drugs list.

bb. Prescription Drugs or refills dispensed

(i) in quantities in excess of amounts specified in the Benefit payment section;

(ii) without Prior Authorization when required; or

(iii) that exceed any applicable Allowed Amount, or any other maximum benefit amounts stated in the Plan.

cc. Amounts in excess of the Maximum Allowable Charge (MAC).

These exclusions only apply to Prescription Drug Benefits. Items that are excluded under Prescription Drug Benefits may be Covered as medical supplies under the Plan. Please review your Plan carefully.

6. DEFINITIONS

a. **Brand Name Drug** – A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.

b. **Compound Drug** – An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and that contains at least one ingredient classified as a Legend Prescription Drug.

c. **Drug Copayment** – The dollar amount specified in the Schedule of Benefits that you must pay directly to the Network Pharmacy when the covered Prescription Drug is dispensed. The Drug Copayment is determined by the type of drug purchased and must be paid for each Prescription Drug.

d. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: "Caution – limited by Federal law to Investigational use."

e. **Generic Drug** – means a Legend drug or OTC that is identified by its chemical, proprietary, or nonproprietary name that is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. Unless the language expressly states otherwise, a Generic Drug does not include a Specialty Pharmacy Drug. Generic Drugs include all Single-Source Generics and Multi-Source Generics, including authorized generics, generics under exclusivity, house generics, patent litigated generics, and limited supply generics, as set forth by a nationally recognized source selected and disclosed by BlueCross.

f. **HDHP Preventive Drug List** – The Preventive Drug List applies to HSA Value option only. You pay a copay for preventive care medications instead of having to meet your plan's deductible for certain prescription drugs. Prescription drugs on the Preventive Drug List will be covered as if you already met your deductible, so you are only responsible for paying the appropriate copay.

   The list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. The list does not guarantee coverage for preventive care drugs that are not listed. The list is subject to change throughout the year. Check empirxhealth.com for the current list. To ensure coverage, check your Schedule of Benefits or call the toll-free number shown on your prescription ID card.

g. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."

h. **Multi-Source Generics** – means a prescription medication that is approved by the FDA under a generic drug ANDA and licensed and then currently marketed by two or more generic drug manufacturers under separate ANDAs.

i. **Non-Preferred Brand Drug or Elective Drug** – A Brand Name Drug that is not considered a Preferred Drug by the Pharmacy Benefit Manager. Usually there are lower cost alternatives to some Brand Name Drugs.

j. **Out-of-Network Pharmacy** – A Pharmacy that has not entered into a service agreement with the Pharmacy Benefit Manager or its agent to provide benefits at specified rates to you.

k. **Pharmacy** – A State or Federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the State in which he or she practices.

l. **Pharmacy Benefit Manager (PBM)** – A company that administers, or handles, the drug benefit program for the health Plan.

m. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of participating pharmacists, Network Providers, the Medical Director and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the (1) Drug Formulary, (2) Preferred Brand Drug list, (3) Prior Authorization Drug list, and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

n. **Preferred Brand Drug** – Brand Name Drugs that have been reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.

o. **Preferred Drug Formulary** – A list of specific generic and brand name Prescription Drugs Covered by the Plan subject to Quantity Limitations, Prior Authorization and Step Therapy. The Drug Formulary is subject to periodic review and modification at least annually by the Pharmacy and Therapeutics Committee. The Drug Formulary is available for review at empirxhealth.com, or by calling the toll-free number shown on the back of your prescription ID card.

p. **Preferred Provider Pharmacy or In-Network Pharmacy** – A Pharmacy that has entered into a Network Pharmacy Agreement with the Pharmacy Benefit Manager or its agent to legally dispense Prescription Drugs to you.

q. **Prescription** – A written, or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure and authorized by law to a pharmacist or dispensing Physician for a drug, or drug product to be dispensed.

r. **Prescription Drug** – A medication containing at least one Legend Drug that may not be dispensed under applicable State or Federal law without a Prescription, and/or insulin.

s. **Preventive Drug** – Drugs that are prescribed (1) for a Covered Person who has developed risk factors for a disease that has not yet become a health issue; (2) to prevent the reoccurrence of a disease from which the Covered Person has recovered; or (3) as part of preventive care procedures. Preventive Drug applies to HSA Value Option only. See empirxhealth.com for complete list of Preventive Drugs. The Preventive Drug list is reviewed at least periodically by the P&T Committee.

t. **Prior Authorization Drugs** – Prescription Drugs that are only eligible for reimbursement after Prior Authorization as determined by the P&T Committee. These are subject to change at any time. The current list can be found at empirxhealth.com.

u. **Provider-Administered Specialty Drugs** – Medically Necessary and Appropriate Specialty Drugs for the treatment of disease, administered by a Practitioner or home health care agency. Certain Provider-Administered Specialty Drugs require Prior Authorization from BCBST, or benefits will be reduced or denied. Call customer service at the number listed on your Health Plan ID card to find out which Provider-Administered Specialty Drugs require Prior Authorization.

   (i) Covered Services –Call customer service at the number listed on your Health Plan ID card with questions about a specific drug's classification. Only those drugs classified as Provider-administered Specialty Drugs are Covered under this benefit.

   (ii) Exclusions –

      a. Self-administered Specialty Drugs as identified on the EmpiRx Specialty Drug list, may be Covered in the *Prescription Drug* section.

      b. FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

v. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee. These are subject to change at any time. The current list can be found at empirxhealth.com.

w. **Single-Source Generics** – means a Prescription Drug that is approved by the FDA under a generic drug ANDA and is licensed and then currently marketed by one generic drug manufacturer under separate ANDAs.

x. **Specialty Drugs** – means those injectable and non-injectable drugs on the EmpiRx Specialty Drug List. Specialty Pharmacy Drugs typically have one or more of several key characteristics, including

frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive product availability and distribution; specialized product handling and/or administration requirements.

y. **Specialty Pharmacy** – A pharmacy that is designated as a Specialty Pharmacy by the Plan for Specialty Drug Prescription Orders or Refills.

z. **Step Therapy** – A form of Prior Authorization that begins drug therapy for a medical condition with the most cost-effective and safest drug therapy and progresses to alternate drugs only if necessary. Prescription Drugs subject to Step Therapy guidelines are; (1) used only for patients with certain conditions; (2) Covered only for patients who have failed to respond to, or have demonstrated an intolerance to, alternate Prescription Drugs, as supported by appropriate medical documentation; and (3) when used in conjunction with selected Prescription Drugs for the Treatment of your condition.

Generic Drugs – Prescription Drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If you have any questions, please contact your customer service representative by calling the toll-free number shown on the Covered Person ID Card.

IMPORTANT NOTE: The Preferred, Prior Authorization, Specialty, Quantity Limitations, Generic, Limited Formulary, and HDHP Preventive Drug lists are subject to change. Current lists can be found at empirxhealth.com/.

Additional Exclusions from Coverage

This Plan does not provide benefits for the following services, supplies or charges:

1. Services or supplies not listed under Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by BCBST.
3. Services or supplies that are Investigational in nature including, but not limited to (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) Treatments.
4. When more than one Treatment alternative exists, all are Medically Appropriate and Medically Necessary, and either would meet your needs, the Plan Administrator reserves the right to provide payment for the least expensive Covered Service alternative.
5. Illness or injury resulting from war and covered by (1) veteran's benefit, or (2) other coverage for which you are legally entitled and that occurred before your Coverage began under this Plan.
6. Self-treatment or training.
7. Staff consultations required by Hospital or other facility rules.
8. Services that are free.
9. Services or supplies for the Treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses resulting from self-employment by a sole-proprietor.
10. Personal, physical fitness, recreational and convenience items and services such as (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
11. Services that are not ordered, provided, or authorized by your Physician.
12. Services or supplies received before your effective date for Coverage with this Plan.
13. Services or supplies related to a Hospital confinement, received before your effective date for Coverage with this Plan.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
15. Telephone or email consultations, or charges for failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records.
16. Services for providing requested medical information or completing forms. The Plan will not charge you or your legal representative for statutorily required copying charges.
17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Charges in excess of the Maximum Allowable Charge for Covered Services.
20. Any service stated as a non-Covered Service exclusion, condition or limitation.
21. Charges for services performed by you or your spouse, or you or your spouse's parent, sister, brother or child.
22. Any charges for handling fees.

23. Unless Covered under the Prescription Drug program, in this Plan, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.
24. Safety items or items to affect performance primarily in sports-related activities.
25. Services or supplies related to obesity, including gastric stapling, stomach by-pass surgery, lap ban, reversible surgical or other treatment of morbid obesity except when determined to be Medically Necessary and Appropriate. Consultation of dieting, exercise & drugs are excluded.
26. Cosmetic Services, except as appropriate per Medical Policy. This exclusion also applies to surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Cosmetic Services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins, and varicose veins, except as appropriate per Medical Policy; (12) piercing ears or other body parts; (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculetomy/abdominoplasty; (16) thighplasty; (17) brachioplasty.
27. Genetic testing.
28. Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under this Plan.
29. Sperm preservation.
30. Treatment of sexual dysfunction, including but not limited to erectile dysfunction (such as Viagra), delayed ejaculation, anorgasmia and decreased libido unless determined by medical records to be organic in nature.
31. Services or supplies related to Treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Covered Person's refusal to accept Treatment, medicines, or a course of Treatment that a Provider has recommended or has been determined to be Medically Necessary and Appropriate, including leaving an inpatient medical facility against the advice of the treating physician.
32. Services for planned maternity delivery in a home setting or location other than a licensed Hospital or birthing center.
33. Services or supplies related to complications of non-covered services.
34. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic Surgery is not Surgery to treat cleft palate.
35. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
36. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

Schedule of Benefits — Value Option

To receive the maximum benefit from the Plan, make sure to use a Provider that is a member of the BlueCross BlueShield P Provider Network.

SERVICES RECEIVED AT THE PRACTITIONER'S OFFICE			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers [1]**	**Received from Out-of-Network Providers [2]**
Office Exams and Consultations			
Diagnosis and treatment of injury or illness		80% after Deductible	60% after Deductible
Maternity office visits		80% after Deductible	60% after Deductible
Preventive – Children under age 6		100% No Copayment	60% after Deductible
Well Woman Exam & Wellcare Exam – Ages 6 and up [3]		100% No Copayment	60% after Deductible
Injections and Immunizations			
Allergy injections and allergy serum		80% after Deductible	60% after Deductible
Immunizations, under age 6		100% No Copayment	60% after Deductible
Immunizations, age 6 and above		100% No Copayment	60% after Deductible
All other injections		80% after Deductible	60% after Deductible
Diagnostic Services and Preventive Screenings ***(e.g. x-ray and labwork)***			
Allergy Testing		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services [4]		80% after Deductible	60% after Deductible
All Other Diagnostic Services for illness or injury		80% after Deductible	60% after Deductible
Maternity care diagnostic services		80% after Deductible	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer Screening, Prostate Screening and Colorectal Cancer Screening [5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other office procedures, services or supplies			
Office Surgery, including anesthesia [6, 7]		80% after Deductible	60% after Deductible
Therapy Services: Physical, speech, and occupational, therapy	100%	80% after Deductible	60% after Deductible
Chiropractic and manipulative therapy		80% after Deductible	60% after Deductible
Cardiac and pulmonary rehab		80% after Deductible	60% after Deductible
DME		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other Office services		80% after Deductible	60% after Deductible

SERVICES RECEIVED AT A FACILITY			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Inpatient Hospital Stays, including maternity stays [8]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Skilled Nursing or Rehab Facility stays (limited to 365 days per incident) [8]			
Facility charges	100%	80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Hospital Emergency Care Services			
Emergency Room Charges		80% after Deductible	80% after Deductible
Non-Acute/Non-Emergency Use of Emergency Room		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All Other Hospital Charges		80% after Deductible	60% after Deductible
Practitioner Charges (Emergency)		80% after Deductible	80% after Deductible
Practitioner Charges (Non-Acute/Non-Emergency)		80% after Deductible	60% after Deductible
Outpatient Facility Services / Outpatient Surgery[6,7]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Outpatient Diagnostic Services and Outpatient Preventive Screenings			
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All other Diagnostic Services for illness/injury		80% after Deductible	60% after Deductible
Maternity care diagnostic services		80% after Deductible	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer, Prostate Screening and Colorectal Cancer Screening[5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other Outpatient Procedures, Services or Supplies			
Therapy Services: Physical, speech, and occupational therapy	100%	80% after Deductible	60% after Deductible
Chiropractic and Manipulative Therapy		80% after Deductible	60% after Deductible
Cardiac and Pulmonary Rehab		80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis		80% after Deductible	60% after Deductible

OTHER SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Ambulance		80% after Deductible	80% after Deductible
Home Health Care Services[8]	100%	80% after Deductible	60% after Deductible
Home Infusion Therapy[8]	100%	80% after Deductible	60% after Deductible
Hospice Care[8]	100%	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $40 charge until you satisfy OOP maximum.	N/A

BEHAVIORAL HEALTH SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
		Received from Network Providers[1]	**Received from Out-of-Network Providers[2]**
Inpatient[8]		80% after Deductible	60% after Deductible
Outpatient		80% after Deductible	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $76 charge until you satisfy OOP maximum.	N/A

Schedule of Benefits — HSA Value Option

A High Deductible Health Plan (HDHP) has a higher calendar year deductible than a typical health plan. Most services are covered only after you meet your Deductible. Some preventive care benefits may be paid before the Deductible is satisfied. When you are covered under a HDHP, you may qualify for tax savings by contributing to a Health Savings Account (HSA). An HSA is a custodial account used to pay for qualified medical expenses. HSAs are regulated by the Internal Revenue Service. An HSA is not part of your employer-sponsored and maintained benefits program.

To receive the maximum benefit from the Plan, make sure to use a Provider that is a member of the BlueCross BlueShield P Provider Network.

SERVICES RECEIVED AT THE PRACTITIONER'S OFFICE			
	PLAN'S PAYMENT FOR COVERED SERVICES		
COVERED SERVICES	**Received from NHC or an NHC Affiliate**	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Office Exams and Consultations			
Diagnosis and treatment of injury or illness		80% after Deductible	60% after Deductible
Maternity office visits		80% after Deductible	60% after Deductible
Preventive – Children under age 6		100% No Copayment	60% after Deductible
Well Woman Exam & Wellcare Exam – Ages 6 and up[3]		100% No Copayment	60% after Deductible
Injections and Immunizations			
Allergy injections and allergy serum		80% after Deductible	60% after Deductible
Immunizations, under age 6		100% No Copayment	60% after Deductible
Immunizations, age 6 and above		100% No Copayment	60% after Deductible
All other injections		80% after Deductible	60% after Deductible
Diagnostic Services and Preventive Screenings ***(e.g. x-ray and labwork)***			
Allergy Testing		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All Other Diagnostic Services for illness or injury		80% after Deductible	60% after Deductible
Maternity care diagnostic services		80% after Deductible	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer Screening, Prostate Screening and Colorectal Cancer Screening[5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other office procedures, services or supplies			
Office Surgery, including anesthesia[6, 7]		80% after Deductible	60% after Deductible
Therapy Services: Physical, speech, and occupational, therapy	100% after Deductible	80% after Deductible	60% after Deductible
Chiropractic and manipulative therapy		80% after Deductible	60% after Deductible
Cardiac and pulmonary rehab		80% after Deductible	60% after Deductible
DME		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other Office services		80% after Deductible	60% after Deductible

SERVICES RECEIVED AT A FACILITY			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Inpatient Hospital Stays, including maternity stays[8]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Skilled Nursing or Rehab Facility stays (limited to 365 days per incident) [8]			
Facility charges	100% after Deductible	80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Hospital Emergency Care Services			
Emergency Room Charges		80% after Deductible	80% after Deductible
Non-Acute/Non-Emergency Use of Emergency Room		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All Other Hospital Charges		80% after Deductible	60% after Deductible
Practitioner Charges (Emergency)		80% after Deductible	80% after Deductible
Practitioner Charges (Non-Acute/Non-Emergency)		80% after Deductible	60% after Deductible
Outpatient Facility Services / Outpatient Surgery[6,7]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Outpatient Diagnostic Services and Outpatient Preventive Screenings			
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All other Diagnostic Services for illness/injury		80% after Deductible	60% after Deductible
Maternity care diagnostic services		80% after Deductible	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer, Prostate Screening and Colorectal Cancer Screening[5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other Outpatient Procedures, Services or Supplies			
Therapy Services: Physical, speech, and occupational therapy	100% after Deductible	80% after Deductible	60% after Deductible
Chiropractic and Manipulative Therapy		80% after Deductible	60% after Deductible
Cardiac and Pulmonary Rehab		80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis		80% after Deductible	60% after Deductible

OTHER SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Ambulance		80% after Deductible	80% after Deductible
Home Health Care Services[8]	100% after Deductible	80% after Deductible	60% after Deductible
Home Infusion Therapy[8]	100% after Deductible	80% after Deductible	60% after Deductible
Hospice Care[8]	100% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $40 charge until you satisfy OOP maximum.	N/A

BEHAVIORAL HEALTH SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
		Received from Network Providers[1]	**Received from Out-of-Network Providers[2]**
Inpatient[8]		80% after Deductible	60% after Deductible
Outpatient		80% after Deductible	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $76 charge until you satisfy OOP maximum.	N/A

Schedule of Benefits — Premier Option

To receive the maximum benefit from the Plan, make sure to use a Provider that is a member of the BlueCross BlueShield P Provider Network.

SERVICES RECEIVED AT THE PRACTITIONER'S OFFICE			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Office Exams and Consultations			
Diagnosis and treatment of injury or illness		100% after Copayment	60% after Deductible
Maternity office visits		100% after Copayment (copay applies to 1st visit only)	60% after Deductible
Preventive – Children under age 6		100% No Copayment	60% after Deductible
Well Woman Exam & Wellcare Exam – Ages 6 and up[3]		100% No Copayment	60% after Deductible
Injections and Immunizations			
Allergy injections and allergy serum		80% after Deductible	60% after Deductible
Immunizations, under age 6		100% No Copayment	60% after Deductible
Immunizations, age 6 and above		100% No Copayment	60% after Deductible
All other injections		80% after Deductible	60% after Deductible
Diagnostic Services and Preventive Screenings ***(e.g. x-ray and labwork)***			
Allergy Testing		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All Other Diagnostic Services for illness or injury		80% after Deductible	60% after Deductible
Maternity care diagnostic services		80% after Deductible	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer Screening, Prostate Screening and Colorectal Cancer Screening[5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other office procedures, services or supplies			
Office Surgery, including anesthesia[6, 7]		80% after Deductible	60% after Deductible
Therapy Services: Physical, speech, and occupational, therapy	100%	80% after Deductible	60% after Deductible
Chiropractic and manipulative therapy		80% after Deductible	60% after Deductible
Cardiac and pulmonary rehab		80% after Deductible	60% after Deductible
DME		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other Office services		80% after Deductible	60% after Deductible

SERVICES RECEIVED AT A FACILITY			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Inpatient Hospital Stays, including maternity stays[8]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Skilled Nursing or Rehab Facility stays (limited to 365 days per incident) [8]			
Facility charges	100%	80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Hospital Emergency Care Services			
Emergency Room Charges		80% after Deductible	80% after Deductible
Non-Acute/Non-Emergency Use of Emergency Room		80% after Deductible	60% after Deductible
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All Other Hospital Charges		80% after Deductible	60% after Deductible
Practitioner Charges (Emergency)		80% after Deductible	80% after Deductible
Practitioner Charges (Non-Acute/Non-Emergency)		80% after Deductible	60% after Deductible
Outpatient Facility Services / Outpatient Surgery[6,7]			
Facility charges		80% after Deductible	60% after Deductible
Practitioner charges		80% after Deductible	60% after Deductible
Outpatient Diagnostic Services and Outpatient Preventive Screenings			
Non-Routine Advanced Radiological Imaging Services[4]		80% after Deductible	60% after Deductible
All other Diagnostic Services for illness/injury		100% No Copayment	60% after Deductible
Maternity care diagnostic services		100% No Copayment	60% after Deductible
Preventive Screenings, under age 6		100% No Copayment	60% after Deductible
Preventive Mammogram, Bone Density, Cervical Cancer, Prostate Screening and Colorectal Cancer Screening[5]		100% No Copayment	60% after Deductible
Other Wellcare Screenings, age 6 and above		100% No Copayment	60% after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.		100% No Copayment	60% after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.		100% No Copayment	60% after Deductible
Manual Breast Pump, limited to one per pregnancy		100% No Copayment	60% after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.		100% No Copayment	60% after Deductible
Other Outpatient Procedures, Services or Supplies			
Therapy Services: Physical, speech, and occupational therapy	100%	80% after Deductible	60% after Deductible
Chiropractic and Manipulative Therapy with office visit		100% No Copayment	60% after Deductible
Cardiac and Pulmonary Rehab		80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis		80% after Deductible	60% after Deductible

OTHER SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	Received from NHC or an NHC Affiliate	**Received from Network Providers[1]**	**Received from Out-of-Network Providers[2]**
Ambulance		80% after Deductible	80% after Deductible
Home Health Care Services[8]	100%	80% after Deductible	60% after Deductible
Home Infusion Therapy[8]	100%	80% after Deductible	60% after Deductible
Hospice Care[8]	100%	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)		80% after Deductible	60% after Deductible
Orthotics and Prosthetics		80% after Deductible	60% after Deductible
Supplies		80% after Deductible	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $40 charge until you satisfy OOP maximum.	N/A

BEHAVIORAL HEALTH SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
		Received from Network Providers[1]	**Received from Out-of-Network Providers[2]**
Inpatient[8]		80% after Deductible	60% after Deductible
Outpatient		100% No Copayment	60% after Deductible
Telemedicine (PhysicianNow)		You pay a $76 charge until you satisfy OOP maximum.	N/A

Organ Transplant Services

Value, HSA Value & Premier Options

ORGAN TRANSPLANT SERVICES			
COVERED SERVICES	**PLAN'S PAYMENT FOR COVERED SERVICES**		
	In-Transplant Network Benefits	**Network Providers not in the Transplant Network** [9]	**Out-of-Network Providers**
All Transplants Except Kidney[9]	80% after Deductible, Out-of-Pocket Maximum applies	80% of Transplant Maximum Allowable Charge (TMAC) after Deductible, Out-of-Pocket Maximum applies; amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered	60% of Transplant Maximum Allowable Charge (TMAC), after Deductible, Out-of-Pocket Maximum does not apply, amounts over TMAC do not apply to the Out-of-Pocket and are not covered
Kidney Transplants[9]		80% after Deductible; Out-of-Pocket Maximum applies.	60% of Maximum Allowable Charge (MAC), after Deductible, Out-of-Pocket Maximum does not apply; amounts over MAC do not apply to the Out-of-Pocket and are not covered.

Miscellaneous Limits

Miscellaneous Limits	Value Option	HSA Value Option	Premier Option
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible			
Individual	$4,000	$4,000	$2,500
Family	$8,000	$8,000	$5,000
In-Network **Out-of-Pocket Maximum (includes prescription drugs)**			
Individual	$6,000	$6,000	$5,000
Family (individual family members are subject to the individual Out of Pocket maximum)	$12,000	$12,000	$10,000
Out-of-Network **Out-of-Pocket Maximum**			
Individual	unlimited	unlimited	unlimited
Family	unlimited	unlimited	unlimited
In-Network Primary Care Office Visit	80% after Deductible	80% after Deductible	$40 Copayment
Out-of-Network Primary Care Office Visit	60% after Deductible	60% after Deductible	60% after Deductible
In-Network Specialist Office Visit	80% after Deductible	80% after Deductible	$75 Copayment
Out-of-Network Specialist Office Visit	60% after Deductible	60% after Deductible	60% after Deductible

[1] *Benefit percentages apply to BCBST Allowed Charge. In-Network level applies to services received from In-Network Providers and Non-Contracted Providers. The Covered Person is responsible for any amount exceeding the Allowed Amount for services received from Non-Contracted Providers.*

[2] *Out-of-Network Provider benefit percentages apply to BCBST Allowed Amounts. The Covered Person is responsible for any amount exceeding the Allowed Amount for services received from Out-of-Network Providers.*

[3] *Limited to one physical exam /annually exam per Calendar Year.*

[4] *CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.*

[5] *Age appropriate.*

[6] *Some procedures may require Prior Authorization. Call the customer service number on your Health Plan ID Card to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced as described in #8.*

[7] *Surgeries include invasive diagnostic services.*

[8] *Prior Authorization required. Benefits will be reduced to 60% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 60% for In-Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. In-Network Providers in Tennessee are responsible for obtaining Prior Authorization; the Covered Person is not responsible for penalty when Tennessee In-Network Providers do not obtain Prior Authorization.*

[9] *All organ Transplant Services require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call BCBST customer service before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may Balance Bill the Covered Person for amounts over the Transplant Maximum Allowable Charge (TMAC) not Covered by the Plan.*

Prescription Drug Program – HSA Value Option

PHARMACY PRESCRIPTION DRUG BENEFITS		
	IN-NETWORK	**OUT-OF-NETWORK**
Pharmacy (30 Day Supply)	**All Drugs Except Preventive and Specialty Drugs** *You pay the full discounted retail price at the time of purchase until deductible has been met, then:* Plan pays 80% Coinsurance You pay 20% Coinsurance until out-of-pocket maximum is met	You pay all costs, then file claim for reimbursement; Plan pays 60% after Deductible
Home Delivery & Retail 90 Day Network[1] (90 Day Supply)		N/A
Preventive Drugs[2] (30 Day Supply)	Generic: $ 20.00 Co-Pay Formulary: $ 35.00 Co-Pay Brand: $ 55.00 Co-Pay	You pay all costs, then file claim for reimbursement; Plan pays 60% after Deductible
Preventive Drugs[2] **Home Delivery & Retail 90 Day Network**[1] (90 Day Supply)	Generic: $ 50.00 Co-Pay Formulary: $ 87.50 Co-Pay Brand: $137.50 Co-Pay	N/A

SPECIALTY PHARMACY PRESCRIPTION DRUG BENEFITS *Specialty Pharmacy Products are limited to a 30-day supply per Prescription*			
SPECIALTY PHARMACY	**SPECIALTY PHARMACY NETWORK**	**OTHER NETWORK PHARMACIES**	**OUT-OF-NETWORK**
Preventive Drugs Self-Administered[2] (30 Day Supply)	$90.00 Co-Pay	You pay 100% *(You pay all costs, no out-of-network benefits)*	
Self-Administered[3] (30 Day Supply)	You pay Deductible and Coinsurance		
Provider-Administered[4] (30 Day Supply)	You pay Deductible and Coinsurance		

Prescription Drug Program – Value & Premier Options

PHARMACY PRESCRIPTION DRUG BENEFITS		
	IN-NETWORK	**OUT-OF-NETWORK**
Pharmacy (30 Day Supply)	Generic: $ 20.00 Co-Pay Formulary: $ 35.00 Co-Pay Brand: $ 55.00 Co-Pay	You pay all costs, then file claim for reimbursement; Plan pays 60% after Deductible
Home Delivery & Retail 90 Day Network[1] (90 Day Supply)	Generic: $ 50.00 Co-Pay Formulary: $ 87.50 Co-Pay Brand: $137.50 Co-Pay	N/A

SPECIALTY PHARMACY PRESCRIPTION DRUG BENEFITS *Specialty Pharmacy Products are limited to a 30-day supply per Prescription*			
	SPECIALTY PHARMACY NETWORK	**OTHER NETWORK PHARMACIES**	**OUT-OF-NETWORK**
Self-Administered[3] (30 Day Supply)	$90.00 Co-Pay	You pay 100% *(You pay all costs, no out-of-network benefits)*	
Provider-Administered[4] (30 Day Supply)	You pay Deductible and Coinsurance		

[1] *Go to empirxhealth.com/for further information.*

[2] *As indicated on the EmpiRx Preventive Drug List.*

[3] *As indicated on the EmpiRx Self-Administered Specialty Pharmacy Products list.*

[4] *As indicated on the EmpiRx Provider-Administered Specialty Pharmacy Products list. These specialty medications are ordered by your doctor and administered in an office or outpatient setting.*

Definitions

Defined terms are capitalized. When defined words are used in this Plan, they have the meaning set forth in this section or as otherwise expressly defined elsewhere in this Booklet.

1. **Actively at Work** – The performance of all of an Eligible Partner's regular duties for the Employer on a regularly scheduled work day at the location where such duties are normally performed. Eligible Partners will be considered to be Actively at Work on a non-scheduled workday (which would include a scheduled vacation day) only if the Eligible Partner was Actively at Work on the last regularly scheduled work day.
2. **Acute** – An illness or injury that is both severe and of short duration.
3. **Administrative Services Agreement or ASA** – The arrangements between i) National Health Corporation and BCBST and ii) National Health Corporation and EmpiRx, including any amendments, and any attachments to the ASA.
4. **Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.
5. **Affiliated Employer** – Any entity who is considered with National Health Corporation to be a single employer in accordance with Code Section 414(b), (c), or (m) and whose employees National Health Corporation has allowed to participate in the Plan.
6. **Allowed Amount or Maximum Allowable Charge (MAC)** – The amount that BCBST or BCBS, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider for Covered Services rendered by that Provider or the amount payable based on the Plan's fee schedule for the Covered Services for Services rendered by Out-of-Network Providers. For Prescription Drugs, the allowable Amount or Maximum Allowable Charge means the then current maximum allowable cost of certain prescription products that are subject to MAC pricing formulas utilized by EmpiRx Health. Such criteria and pricing formulas are subject to change from time to time at EmpiRx Health's sole discretion.
7. **Annual Enrollment Date** – This term is defined in the section on *Enrollment*.
8. **Annual Enrollment Period** – This term is defined in the section on *Enrollment*.
9. **Annual Enrollment Period** –Annual opportunity for Eligible Partners or otherwise eligible person, as designated by the Plan Administrator, to enroll or change Plan options in the Health Benefit Plan during the month of October or November each year. The Coverage begins immediately on the following January 1.
10. **Balance Billing** – This means when a Provider bills the Covered Person for the difference between the Provider's charge and the Allowed Amount. For example, if a Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill the Covered Person (and not the Plan) for the remaining $30.
11. **Behavioral Health Services** – Any services or supplies that are Medically Necessary and Appropriate to treat a mental or nervous condition, alcoholism, chemical dependence, drug abuse or drug addiction.
12. **Beneficiary** – A Beneficiary is an individual who has Coverage under the Health Benefit Plan through a Covered Person.
13. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Allowed Amount for services.

14. **BlueCard PPO Participating Provider** – A physician, Hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Association (BlueCard PPO) Plans and/or Authorized by the Plan to provide Covered Services to Covered Persons.

15. **Calendar Year** – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st of that same year.

16. **Care Management** – A program that promotes quality and cost effective coordination of care for Covered Persons with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.

17. **Child** – An individual who is any of the following: (i) a natural or adopted child of an Eligible Partner (ii) a child for whom the Eligible Partner is the legal guardian (iii) a step child of an Eligible Partner. A step-child is a child of the Partner's current Spouse.

18. **CHIP** – The State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq).

19. **Claim Determination** – This term is defined in the *Coordination of Benefits* section of this Plan. It is that period of time in which a benefit claim must be submitted in order to be paid.

20. **Clinical Trials** – Studies performed with human subjects to test new drugs or combinations of drugs, new approaches to surgery or radiotherapy or procedures to improve the diagnosis of disease and the quality of life of the patient. A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious and effective. Routine patient care associated with an approved Clinical Trial will be Covered under the Plan's benefits in accordance with the Plan's medical policies and procedures.

21. **Coinsurance** – The amount, stated as a percentage of the Allowed Amount for a Covered Service that is the Covered Person's responsibility during the Calendar Year after any Deductible is satisfied by you. The Coinsurance percentage is calculated as 100%, minus the percentage payment of the Allowed Amount as specified in the Schedule of Benefits.

    In addition to the Coinsurance percentage, you are responsible for the difference between the Billed Charges and the Allowed Amount for Covered Services if the Billed Charges of an Out-of-Network Provider are more than the Allowed Amount for such Services. This difference is also called Balance Billing.

22. **Complications of Pregnancy** – Conditions due to pregnancy, labor or delivery requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

    Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; non-emergency caesarian sections; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

23. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.

24. **Coordination of Benefits or COB** – This term describes whether this Plan or another Health Care Arrangement is primarily or secondarily liable for the payment of Medically Necessary and Medically Appropriate Services of a Covered Person.

25. **Copayment** – The fixed dollar amount specified in the Schedule of Benefits, that you are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time you receive those Covered Services. Copayments paid during a Calendar Year **do not** accumulate toward meeting the annual Deductible. Copayments paid during a Calendar Year **do** accumulate toward meeting the annual Out-of-Pocket Maximum.
26. **Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. The Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.
27. **Coverage** – This term refers to the rights to benefits described herein of Eligible Partners and Eligible Dependents after proper enrollment and arrangement for payment of Premiums therefore as of the effective date of the commencement of those benefit rights and for the duration of such rights.
28. **Covered Dependent –** An Eligible Dependent enrolled in the Plan by a Covered Partner in accordance with the Plan's enrollment procedures.
29. **Covered Family Members** – A Partner and his or her Covered Dependents.
30. **Covered Health Services, Coverage or Covered** – Those Medically Necessary and Appropriate services and supplies that are set forth in this Plan. Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan.
31. **Covered Partner –** An Eligible Partner that has enrolled for coverage in the Plan in accordance with the Plan's enrollment procedures.
32. **Covered Person** – A Covered Person is a Full-Time Partner or IPAR Partner and their Eligible Dependents and Beneficiaries while Covered by the Health Benefit Plan. If you are a Covered Person, this Plan may also use the lowercase term "you" to refer to you as a Covered Person in this Plan and only Covered Persons are included in the terms "you" or "your."
33. **Covered Person Payment** – The dollar amounts for Covered Services that you are responsible for as set forth in the Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The Plan Administrator may require proof that you have made any required Premium.
34. **Custodial Care** – Any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.
35. **Deductible** – The dollar amount, specified in the Schedule of Benefits, that you must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for services. There is one Deductible amount for In-Network Providers and Out-of-Network Providers combined. The Deductible will apply to the Individual Out-of-Pocket and Family Out-of-Pocket Maximum(s). Copayments and any Balance Billing (that is, the difference between Billed Charges and the Allowed Amount) are not considered when determining if you have satisfied a Deductible.
36. **Durable Medical Equipment** – Equipment and supplies ordered by a Health Care Provider for everyday or extended use.
37. **Eligibility Period** – The initial period of time following the date of employment during which a Partner may apply for Coverage.
38. **Eligible Dependent** – This term is defined in the section on *Eligibility*.
39. **Eligible Ongoing Partner Stability Period** – The 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan's Standard Measurement Period.
40. **Eligible Partner** – This term is defined in the section on *Eligibility*.
41. **Emergency Medical Condition** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in

a. serious impairment of bodily functions,

b. serious dysfunction of any bodily organ or part, or

c. placing a prudent layperson's health in serious jeopardy.

Examples of Emergency conditions include: (1) severe chest pain, (2) uncontrollable bleeding, or (3) unconsciousness.

42. **Emergency Medical Transportation** – Ambulance services for an Emergency Medical Condition.
43. **Emergency Room Care** – Emergency Services received in an emergency room.
44. **Emergency Services** – Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency Medical Condition.
45. **Employee** – A common law employee working for National Health Corporation. The term "Employee" refers to a Partner of (1) National Health Corporation.
46. **Employer** – The term "Employer" refers to any of the following: (1) National Health Corporation, or (2) an Affiliated Employer.
47. **Enrollment Form** – A form or application that must be completed in full by the Eligible Partner before he or she will be considered for Coverage under the Plan. The form or application may be in paper form, or electronic, as determined by the Plan Administrator.
48. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
49. **Excluded Services** – Health care services that this Plan does not pay for or services which are not covered.
50. **Full-Time Partner** – An employment status which requires the Partner to be regularly scheduled for at least 37½ Hours of Service each week.
51. **Grievance** – This term refers to a complaint a Covered Person communicates to the Plan Administrator regarding a denied benefit claim.
52. **Health Benefit Plan** – This term refers to this Health Benefit Plan sponsored by National Health Corporation and any Affiliated Employer authorized or contracted with National Health Corporation to document its own health care plan under this instrument.
53. **Health Care Arrangement** – This term refers to health coverage under another health care arrangement as defined in the *Coordination of Benefits* section of this Plan.
54. **High Deductible Health Plan** – A qualified High Deductible Health Plan (HDHP) is a type of health insurance plan with lower premiums and higher deductibles than traditional health insurance plans. Most services are covered only after you meet your deductible. Some preventive care benefits may be paid before the deductible is satisfied.
55. **HIPAA** – This term is an abbreviation for the Health Insurance Portability and Accountability Act of 1996.
56. **Home Health Care** – Health Care Services a person receives at home.
57. **Hospice Services** – Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
58. **Hospital** – An institution that engages in providing impatient diagnosis and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons. The facility must meet ALL the following requirements:

    a. Be licensed as a hospital to provide the above-described in the State in which it is located,

    b. Charge for the services and supplies it provides,

c. Keep a medical record of each patient,

d. Provide an ongoing quality assurance program with reviews by medical physicians or orthopedic physicians licensed by the State in which the facility is located,

e. Be supervised 24 hours a day by a staff of either medical physicians or orthopedic physicians licensed by the State in which the facility is located, and

f. Provide 24 hour a day skilled nursing services by registered nurses licensed by the State in which the facility is located.

59. **Hospital Outpatient Care** – Hospital services that usually do not require an overnight stay.

60. **Hospital Services** – Covered Services that are Medically Necessary and Appropriate to be provided by an Acute care Hospital.

61. **Hospitalization** – When you are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

62. **Identification Card (ID Card, Health Plan ID Card or Covered Person ID Card)** – Card provided to Covered Persons that identifies them as Covered by this Health Benefit Plan and provides basic information about their Coverage. Although such cards do not guarantee eligibility for medical care benefits at any given time, they outline procedures for Providers to allow verifying that a patient has health Coverage under this Plan.

63. **Incapacitated Child** – This term refers to an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excludes mental illness) or physical handicap; and (2) chiefly dependent upon the Covered Partner or Covered Partner's spouse for economic support and maintenance.

    a. If the child reaches the age while Covered under this Plan on which date Coverage would otherwise cease, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.

    b. We may ask you to furnish proof of the incapacity and dependency upon enrollment. We may ask for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

64. **Initial Enrollment Date** – This term is defined in the section on *Enrollment*

65. **Initial Enrollment Period** – This term is defined in the section on *Enrollment*.

66. **In-Network Benefit** – The Plan's payment level that applies to Covered Services received from an In-Network Provider. See the Schedule of Benefits for payment levels.

67. **In-Network Coinsurance** – The percentage you pay of the Allowed Amount for Covered Services to In-Network Providers who contract with BCBS or BCBST. In-Network Coinsurance usually costs less than Out-of-Network Coinsurance.

68. **In-Network Copayment** – The fixed amount you pay for Covered Services to In-Network Providers who contract with BCBS or BCBST. In-Network Copayments usually are less than Out-of-Network Copayments.

69. **In-Network Provider/Preferred Provider** – A Provider who has contracted with BCBS or BCBST to provide access to benefits to Covered Persons at specified rates. Such In-Network Providers may be referred to as BlueCard PPO Participating Providers, Preferred Provider, Network Hospitals, and Preferred Transplant Network Providers, or similar Network Providers. A Provider's status as an In-Network Provider can and does change. BCBS or BCBST reserves the right to change a Provider's status. It also includes any pharmacy that has a contract with EmpiRx.

70. **In-Transplant Network Provider** – A facility or Hospital that has contracted with BCBS or BCBST to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered

under this Plan. For example, some Hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network Provider is a Preferred Provider when performing BCBS or BCBST contracted transplant procedures in accordance with the requirements of this Plan.

71. **Investigational Services** – The definition of "investigational" is based on the BlueCross and BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet **ALL** of the following four criteria is considered to be investigational.

    a. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:

        (i) This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.

        (ii) Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.

    b. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:

        (i) The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

        (ii) The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

    c. The technology must improve the net health outcome, as demonstrated by:

        (i) The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

    d. The improvement must be attainable outside the investigational settings, as demonstrated by:

        (i) In reviewing the criteria above, the Medical Policy Panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

    The Medical Director has the authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

    a. your medical records;

    b. the protocol(s) under which proposed service or supply is to be delivered;

    c. any consent document that you have executed or will be asked to execute, in order to receive the proposed service or supply;

    d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by you;

    e. regulations and other official publications issued by the FDA and HHS;

    f. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Covered Persons requiring non-Investigational Services; or

g. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

The Medical Director's decision is a decision on a benefit claim subject to the *ERISA Benefit Claim Grievance Procedures* section of this Plan, and a denial of a claim by the Medical Director may be appealed under that section.

72. **IPAR** – A Part-Time employment status with a work schedule which requires the Partner to be regularly scheduled 30 hours or more, but less than 37½ hours, of work each week. IPAR status allows participation in the Health Benefit Plan.

73. **Maintenance Care** – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services (1) fail to contribute toward cure, (2) fail to improve unassisted clinical function, (3) fail to significantly improve health, and (4) are indefinite or long-term in nature.

74. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq).

75. **Medical Director** – The Physician designated by BCBST, or that Physician's designee, who is responsible for the establishment and maintenance of the Plan's medical management programs, including its Prior Authorization programs.

76. **Medical Policy** – This term is defined in the Prior Authorization, Case Management, Medical Policy and Patient Safety section.

77. **Medically Appropriate** – Services that have been determined by the Medical Director to be of value in the care of a specific Covered Person. To be Medically Appropriate, a service must:

    a. be Medically Necessary;

    b. be used to diagnose or treat a Covered Person's condition caused by disease, injury or congenital malformation;

    c. be consistent with current standards of good medical practice for the Covered Person's medical condition;

    d. be provided in the most appropriate site and at the most appropriate level of service for the Covered Person's medical condition;

    e. on an ongoing basis, have a reasonable probability of

        (ii) correcting a significant congenital malformation or disfigurement caused by disease or injury;

        (iii) preventing significant malformation or disease;

        (iv) substantially improving a life sustaining bodily function impaired by disease or injury;

    f. not be provided solely to improve a Covered Person's condition beyond normal variations in individual development and aging including

        (i) comfort measures in the absence of disease or injury;

        (ii) Cosmetic Service; and

        (iii) not be for the sole convenience of the Provider, Covered Person or Covered Person's family.

78. **Medically Necessary and Appropriate** – Services that are both Medically Necessary and Medically Appropriate.

79. **Medically Necessary or Medical Necessity** – "Medically Necessary" means procedures, Treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising

prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are

a. in accordance with generally accepted standards of medical practice;

b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;

c. not primarily for the convenience of the patient, physician or other health care Provider; and

d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

80. **Medicare** – Insurance as is provided in Title XVIII of the Social Security Act, as amended.

81. **Network or In-Network** – This term describes the group of medical care practitioners and facilities which have contracts with BCBS or BCBST to provide health care services. It also includes any pharmacy that has a contract with EmpiRx.

82. **Non-Contracted Provider** – A Provider in a category or type that collectively does not hold a contract with BlueCross. In other words, the Provider provides a type of service that is not provided by any Network Providers. A Provider's status as a Non-Contracted Provider can and does change. BCBS or BCBST reserves the right to change a Provider's status. A Non-contracted Provider is an Out-of-Network Provider and is subject to all of the Plan's terms and conditions applicable to Out-of-Network Providers except as expressly indicated herein.

83. **Non-Preferred Provider/Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with BCBS or BCBST to provide Covered Services. It also includes any pharmacy that does not hold a contract with EmpiRx to provide Covered Services.

84. **Non-Routine Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

85. **Oral Appliance** – This term refers to a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.

86. **Out-of-Network Coinsurance** – The percentage you pay of the Allowed Amount for Covered Services to Out-of-Network Providers who do not contract with BCBS or BCBST or EmpiRx. Out-of-Network Provider Coinsurance usually costs more than In-Network Providers.

87. **Out-of-Network Copayments** – A fixed amount you pay for Covered Services to Out-of-Network Providers who do not contract with BCBS or BCBST or EmpiRx. Out-of-Network Provider Copayments usually cost more than In-Network Providers.

88. **Out-of-Network Provider/Non-Preferred Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with BCBS or BCBST to provide Covered Services. It also includes any pharmacy that does not hold a contract with EmpiRx to provide Covered Services.

89. **Out-of-Pocket Maximum** – The total dollar amount, as stated in the Schedule of Benefits, that a Covered Person must incur and pay for Covered Services during the Calendar Year, including Deductible and Coinsurance.

Penalties, Out-of-Network Provider Coinsurance and any balance of charges (the difference between Balanced Billing Charges and the Allowed Amount) are not considered when determining if the Out-of-Pocket Maximum has been satisfied.

When the Out-of-Pocket Maximum is satisfied, 100% of available benefits is payable for other Covered Services incurred by the Covered Person during the remainder of that Calendar Year, excluding Penalties, Out-of-Network Provider Coinsurance and any balance of charges (the difference between Balance Billing Charges and the Allowed Amount).

90. **Partner** – A Partner is an Employee.
91. **Part-Time** – An employment status indicating less than full time for an indefinite period of time and used in this Plan to describe regularly scheduled 29 hours or less of work each week.
92. **Payor(s**) – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides, reimburses or pays for Covered Person's Covered health care benefits.
93. **Penalty/Penalties** – Additional Covered Person Payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in the Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in payment for Covered Services.
94. **Periodic Health Screening** – An assessment of patient's health status at intervals established by the Medical Director for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
    a. a complete history or interval update of the patient's history and a review of the systems; and
    b. a physical examination of all major organ systems, and screening tests per the Medical Directory's established Policy.
95. **Physician** – A licensed physician (M.D. – Medical Doctor or O.D. – Doctor of Osteopathic Medicine) who provides or coordinates health care services.
96. **Physician Services** – Health care services provided by a physician.
97. **Plan** – This health care benefit arrangement entitled *National Health Corporation Health Benefit Plan*.
98. **Plan Administrator** – The Plan Administrator of this Health Benefit Plan is National Health Corporation.
99. **Practitioner** – A person licensed by the State to provide medical services.
100. **Pre-Authorization/Prior Authorization** – A review conducted by BCBST prior to the delivery of certain services, to determine if such services will be considered Covered Services. It also includes any review conducted by EmpiRx prior to the delivery of certain prescription drugs.
101. **Preferred Provider/In-Network Provider** – A Provider who has contracted with BCBS or BCBST to provide access to benefits to Covered Persons at specified rates. Such Preferred Providers may be referred to as BlueCard PPO Participating Providers, Network Hospitals, and Preferred Transplant Network Providers, or similar Network Providers. A Provider's status as a Preferred Provider can and does change. BCBS or BCBST reserves the right to change a Provider's status. It also includes any pharmacy that has a contract with EmpiRx.
102. **Prescription Drug** – defined the same as in the Prescription Drug section of this Booklet.
103. **Primary Care Provider** – A physician, nurse practitioner, clinical nurse specialist or physician assistant allowed under State law who provides, coordinates or helps a patient access a range of health care services for that patient.
104. **Primary Plan** – Either this Plan or another Health Care Arrangement which, under the Coordination of Benefits (COB) rules of this Plan, is first liable to pay for covered health services before the other is liable.

105. **Prior Authorization/Pre-Authorization** – A review conducted by BCBST prior to the delivery of certain services, to determine if such services will be considered Covered Services. It also includes any review conducted by EmpiRx prior to the delivery of certain prescription drugs.

106. **Provider** – A person or entity engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

107. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or State administrative agency that creates or recognizes the existence of a child's right to receive Coverage benefits for which a Covered Partner is eligible under the Plan. Such order shall identify the Covered Partner and each such child by name and last known mailing address, give a description of the type and duration of Coverage to be provided to each child, and specifically identify this Plan as to which such order applies.

108. **Qualifying Events** – This term is defined in the *Continuation of Coverage Rights Under COBRA* section of this Plan.

109. **Reasonable and Customary or Usual, Reasonable and Customary (UCR)** – The charge which is the usual charge made to persons in the same general locality for identical services or supplies. The UCR is sometimes used to determine the Allowed Amount.

110. **Reconstructive Surgery** – Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical condition.

111. **Rehabilitation Services** – Health care services that help a Covered Person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a Covered Person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric services in a variety of inpatient and/or outpatient settings.

112. **Secondary Plan** – Either this Plan or another Health Care Arrangement which is not the Primary Plan.

113. **Self-Insured** – A medical benefit plan established by an Employer that directly assumes the functions, responsibilities and liabilities of Plan Coverage.

114. **Skilled Nursing Care** – Covered services from licensed nurses in your own home or in a nursing home. Skilled Nursing Care services are from technicians and therapists in your own home or in a nursing home.

115. **Special Enrollment Period** – This term is defined, together with its causes, appears in the *Enrollment* section of this Plan.

116. **Specialist** – A Physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or test certain types of symptoms and conditions. A Non-Physician Specialist is a Provider who has more training in a specific area of health care.

117. **Specialty Drugs** – Defined the same as in the Prescription Drug section of this Booklet.

118. **Sponsor** – The Sponsor of the Plan is National Health Corporation.

119. **Spouse** – A individual to whom the Partner is legally married in accordance with the Internal Revenue Code. A Spouse does not include a common law spouse.

120. **Surgery or Surgical Procedure** – Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

121. **Termination for Cause** – This term is defined in the *Termination of Coverage* section of this Plan.

122. **Totally Disabled or Total Disability** – this term applies to any of the following:

    a. A Covered Partner who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably

become qualified to perform by reason of education, training, or experience because of injury or disease.

b. A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

c. A determination by the United States Social Security Administration that you are eligible for Social Security disability benefits.

123. **Transplant Case Management** – The Case Management department of BCBST that must Pre-Authorize your Organ Transplant Services.

124. **Transplant Maximum Allowable Charge (TMAC)** – The amount that BCBST or BCBS, in its sole discretion, has determined to be the maximum amount payable for Covered Services for Organ Transplants. Each type of organ Transplant has a separate TMAC.

125. **Transplant Network** – A network of Hospitals and facilities, each of which has agreed with BCBS or BCBST to perform specific organ Transplants. For example, some Hospitals might contract to perform heart Transplants, but not liver Transplants.

126. **Transplant Service or Services** – Medically Necessary and Appropriate services listed as Covered under the *Organ Transplant Services* section in this Plan.

127. **Treatment** – Any medically recognized service, procedure or medication used for the evaluation, the cure, the improvement or the maintenance of health care for an illness, disease, injury or pathological conditions.

128. **U.S. Preventive Services Task Force (USPSTF)** – The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine. The panel is composed of primary care providers such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists.

    The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of "Recommendation Statements."

129. **Urgent Care** – Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

130. **Waiting Period** – The Waiting Period is the period following a person's becoming an Eligible Partner before Coverage becomes effective.

131. **Week –** Any seven (7) consecutive calendar-day period.

132. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children to age 16.

133. **Well Woman Exam** – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

Statement of ERISA Rights

The Employer Retirement Income Security Act of 1974 (ERISA) entitles you, as a Covered Person of this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator and at other specified locations, such as worksites, all Plan documents and copies of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Benefit Administration.
2. Obtain copies of all Plan documents and other Plan information upon written request to Administrator. The Plan Administrator may make a reasonable charge for these copies.
3. Receive a summary of the Plan's annual financial report. The Plan is required by law to furnish each Covered Person with a copy of this summary annual report.
4. Continue your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You will have to pay for such Coverage. Review the COBRA Coverage section of this Plan for the rules governing your continuation Coverage rights.

In addition to creating rights for Eligible Partners and Eligible Dependents, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan are called "fiduciaries" of the Plan and have a duty to do so prudently and in the interest of Plan Covered Persons and Beneficiaries. No one, including the Employer, may fire Eligible Partners or otherwise discriminate against Eligible Partners in any way to prevent Eligible Partners from obtaining a benefit under this Plan or exercising rights under ERISA. If your claim or arrangement for benefits is denied, in whole or in part, you have a right to know why this was done and to obtain copies of documents relating to the decision without charge. You have the right to have the Plan Administrator review your claim and reconsider it.

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 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 Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a State or Federal court. Also, if you disagree with Plan Administrator's decision (or lack thereof) concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If the Plan fiduciaries misuses money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or 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, it may order you to pay these expenses if it finds your claim is frivolous.

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, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.

Newborns' and Mothers' Health Protection Act

Your Plan provides maternity and newborn infant Coverage. This Plan does not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours where applicable). In any case the Plan may not, under Federal law, require that a Provider obtain Prior Authorization to prescribe a length of stay not in excess of the above periods. Please refer to the *Covered Services* section of this Plan for further details.

Women's Health and Cancer Rights Act of 1998

Covered Persons who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to Coverage for

1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the *Covered Services* section of this Plan for details.

Mental Health Parity Act

Under the Plan, the financial requirements and Treatment limitations imposed on mental health and substance abuse disorder benefits are not more restrictive than the predominate financial requirements and Treatment limitations that apply to substantially all medical and surgical benefits. The Plan's criteria for Medical Necessity determination with respect to mental health or substance abuse disorder are available upon request free of charge.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you leave your job here to perform military service, you have the right to elect to continue your existing Coverage under this Plan for you and your Eligible dependents for up to 24 months while you are in the military.

Even if you do not elect to continue your Coverage during your military service, you have the right to be reinstated in this Plan when you are reemployed. Benefits are not payable for military service connected illness or injury.

Health Benefit Plan General Information

PLAN NAME & IDENTIFICATION NUMBER	Health Benefit Plan
EMPLOYER IDENTIFICATION NUMBER	62-1294263
PLAN NUMBER	503
PLAN SPONSOR	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 (and affiliates)
PLAN ADMINISTRATOR	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 615-890-2020
TYPE PLAN	Employee Welfare Benefit Plan
PLAN YEAR	January 1 through December 31
AGENT FOR SERVICE OF LEGAL PROCESS	c/o General Counsel 100 Vine Street Murfreesboro, TN 37130 615-890-2020 (and the Plan Administrator at this same address)

Legal Provisions

Statute of Limitations

Claims for Benefits and Appeals of Adverse Benefit Determinations: A claimant or any other person may not challenge a decision of the Plan Administrator or its designees in court or in any other administrative proceeding unless and until the claim and appeal procedures described above have been complied with and exhausted. In no event may a claimant challenge the Plan Administrator's decision (including a deemed decision) upon appeal in any court or governmental proceeding after 12 months from the date of the Plan Administrator's decision (included a deemed decision) of the appeal.

Any other grievance: In no event may a Partner or any person bring any other claim for relief against the Plan Administrator, the Plan and/or NHC with respect to the Plan in court or in any other administrative proceeding more than 12 months after the claim arose.

Forum for Disputes

An employee shall only bring an action in connection with the Plan in the United States District Court for the Middle District of Tennessee.

Amendment / Termination

The Plan may be amended in any respect or terminated at any time, retroactively or otherwise, by NHC. The Plan may be amended by written amendment executed by an authorized officer of NHC or by any other process that clearly indicates the authorized officer has approved the amendment.

No Assignment

Your benefits under this Plan are not subject to anticipation, alienation, pledge, sale, transfer, assignment, garnishment, attachment, execution, or encumbrance of any kind and any attempt to do so will be void, except as required by law.

No Representations Contrary to the Plan

No verbal or written representations contrary to the terms of the Plan and its written amendments are binding upon the Plan, the Plan Administrator, NHC or an Affiliate.

No Employment Rights

The Plan does not confer employment rights upon any person. No person will be entitled, by virtue of the Plan, to remain in the NHC's employment, and nothing in the Plan restricts NHC's right to terminate any person's employment at any time.

Plan Funding

Benefits are paid first with available plan assets, including but not limited to participant contributions then any deficiencies may be funded by NHC, in its sole discretion, from its general assets. The Plan is responsible for paying all plan administration expenses of the Plan.

Applicable Law

The laws of the State of Tennessee govern the Plan, except where ERISA preempts the application of such laws.

Qualifying Partner Eligibility Appendix

A Partner who is not designated a Full-time Partner or IPAR may still qualify for eligibility for the Health Benefits Plan if the Partner falls into one of the following categories:

A. Qualifying Part-Time Partner Defined:

A Partner becomes a Qualifying Part-Time Partner if the partner averages 30 Hours of Service per week during the partner's New Hire Initial Measurement Period. If properly and timely elected during the initial enrollment period described in the Summary Plan Description, coverage for a Qualifying Part-time Partner will become effective on the first day of the Qualifying Part-Time Partner Stability Period (if still employed on that date). A Qualifying Part-time Partner remains eligible for the duration of the Qualifying Part-Time Partner Stability Period so long as the Partner remains employed during the Qualifying Part-Time Partner Stability Period. A Qualifying Part-time Partner who is permitted to take a leave of absence during a Qualifying Part-Time Partner Stability Period will be treated as a newly hired Partner upon return from any such leave that qualifies as a Break in Service.

B. Eligible Ongoing Partner Defined:

A Partner becomes an Ongoing Eligible Partner if the Partner averages 30 hours of service per week during the Plan's Standard Measurement Period. If properly and timely elected during the annual enrollment period described in the Summary Plan Description, coverage for an Ongoing Eligible Partner will become effective on the first day of the Eligible Ongoing Partner Stability Period (if still employed on that date). An Ongoing Eligible Partner remains eligible for the duration of the Ongoing Eligible Partner Stability period so long as the Partner remains employed during the Ongoing Eligible Partner Stability Period. An Ongoing Eligible Partner who is permitted to take a leave of absence during an Ongoing Eligible Partner Stability Period will be treated as a newly hired Partner upon return from any such leave that qualifies as a Break in Service.

The Plan Administrator has adopted policies and procedures for determining whether a Partner averages 30 hours of service per week and whether the Partner has experienced a break in service.

C. Additional Terms of Eligibility

1. If a Partner experiences a Break in Service during a Measurement Period and then again resumes Hours of Service following a Break in Service, such Partner will be treated as a newly hired Partner upon the date that the Partner resumes Hours of Service for the Employer.
2. An Eligible Partner who resumes Hours of Service during a Stability Period following a period with no Hours of service that does not qualify as a Break in Service will have his or her previous election of coverage reinstated upon return to employment as of the first day of the month following resumption of Hours of Service.
3. Each Partner's Hours of Service will be determined in a manner consistent with Internal Revenue Code Section 4980H and the regulations issued thereunder.
4. If a Partner takes a Special Unpaid Leave of Absence during a Measurement Period, the Employer will disregard all consecutive Weeks of such unpaid leave when determining the average Hours of Service during the applicable Measurement Period.

D. Definitions:

1. **Break in Service** – A period of at least 13 full consecutive Weeks during which the Partner has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Partner has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).
2. **Initial Measurement Peri**od – The twelve (12) Calendar Month period beginning on the first day of the Calendar Month coinciding with or next following the Employee's Date of Hire. Notwithstanding

the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein

3. **Measurement Period** – The Initial Measurement Period or the Standard Measurement Period, as applicable.
4. **Special Unpaid Leave of Absence** – Any of the following types of unpaid leaves of absence that do not otherwise constitute a Break in Service:
    a. Leave protected by the Family and Medical Leave Act
    b. Leave protected by the Uniformed Services Employment and Reemployment Rights Act or
    c. Jury Duty (as reasonably defined by the Employer).
5. **Standard Measurement Period** – The 12 month period that begins each November 1 and ends October 31; however, the first Standard Measurement Period begins January 1, 2014 and ends October 31, 2014. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Partners on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein

3. **Measurement Period** – The Initial Measurement Period or the Standard Measurement Period, as applicable.
4. **Special Unpaid Leave of Absence** – Any of the following types of unpaid leaves of absence that do not otherwise constitute a Break in Service:
    a. Leave protected by the Family and Medical Leave Act
    b. Leave protected by the Uniformed Services Employment and Reemployment Rights Act or
    c. Jury Duty (as reasonably defined by the Employer).
5. **Standard Measurement Period** – The 12 month period that begins each November 1 and ends October 31; however, the first Standard Measurement Period begins January 1, 2014 and ends October 31, 2014. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Partners on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Dental Insurance Plan

If you are regularly scheduled 20 hours or more each week, you are eligible for the NHC Dental Insurance Plan.

You are eligible for Dental Insurance even if you are not enrolled in the company-sponsored health plan.

Dental coverage is available for your spouse and dependents; however, you must be enrolled for them to be eligible.

You are responsible for the total Dental Insurance premium. It is payroll deducted on the first pay period of every month. The premiums are automatically tax-sheltered unless the plan is instructed to do otherwise.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

Remember, that the only opportunity to make a change to the available coverage is on January 1 of each year, unless you experience a change in status as defined in this Handbook. Also, changes to your current dental plan option may only be made during annual enrollment (normally November with a January 1 effective date).

Your dental coverage will end on the last day of the month of your termination of employment, status change or ineligibility date. Your coverage may be continued at your personal expense through COBRA (continuation of coverage). Coverage may continue through COBRA for up to 18 months, 29 months or 36 months depending on the original reason for COBRA eligibility.

Dental Insurance

PLAN HIGHLIGHTS	HIGH PLAN	LOW PLAN
Eligibility	You must be regularly working 20 hours or more per week to participate.	
Plan Benefit: Type 1 Procedures Type 2 Procedures Type 3 Procedures	 100% 80% 50%	Plan features a schedule of maximum covered expenses for each procedure. The Maximum Covered Expense schedule lists exactly how much the plan will pay based on the specific procedure. See the Sample Schedule below for a listing of some common procedures.
Deductible	$50/Calendar Year Type 2 & 3, Waived Type 1, No Family Maximum	$50/Calendar Year Type 2 & 3, Waived Type 1, No Family Maximum
Maximum (per person)	$1,200 per calendar year	$1,200 per calendar year
Dental Rewards®	Included	Included
Allowance	75th Usual & Customary	Maximum Covered Expense
Waiting Period	None	None
Annual Open Enrollment	Included	Included
ORTHODONTIA Adult and Child Coverage		
Allowance	Usual & Customary	Usual & Customary
Plan Benefit	50%	50%
Lifetime Maximum (per person)	$1,000	$1,000
Waiting Period	None	None

LOW PLAN SAMPLE SCHEDULE		Insurance Pays
Type 1 Procedures	Periodic Oral Exam	$21
	Prophylaxis (cleanings) age 14 and over	$47
Type 2 Procedures	Amalgam – One Surface, permanent	$37
	Resin – One Surface, anterior	$40
	Single tooth extraction	$37
Type 3 Procedures	Crown – full cast, predominately base metal	$242
	Crown – Porcelain fused to precious metal	$332
	Root Canal, Molar	$408

To locate a provider in your area, go to www.ameritas.com or call 1-800-487-5553

Eligibility

If you are an Eligible Partner, you may request enrollment for yourself and your Eligible Dependents in the Plan.

NOTE: You will be required to pay a Premium for the coverage you elect.

A. Eligible Partner Defined

An Eligible Partner is any Employee who satisfies the following requirements:

1. You are an Employee who is eligible to work in the United States legally as confirmed by the USCIS (United States Citizenship Immigration Services) I-9;
2. You are designated by your Employer as a Full-Time, IPAR or Part-Time Partner regularly scheduled 20 hours or more each week.

B. Eligible Dependents Defined

An Eligible Dependent is any person who satisfies at least ONE of the following requirements:

1. The person is an Eligible Partner's current Spouse.
2. The person is an Eligible Partner's Child who is under age 26, regardless of marital status.
3. The person is a Child, regardless of age, who is incapacitated and satisfies the additional eligibility requirements for Incapacitated Children.

C. Incapacitated Children

If a Covered Dependent Child is incapacitated on the date the Child turns age 26, coverage for such Child will continue beyond the age of 26 so long as the following requirements are satisfied:

1. You provide written notice of the incapacity prior to the date the child turns age 26; and
2. You provide sufficient documentation supporting the Child's incapacity.
3. A child is considered "incapacitated" if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

D. Proof of Eligibility and Other Information

If you request enrollment for a dependent, you will be required to provide the Plan Administrator (or its designee) with information the Plan Administrator deems necessary to verify eligibility, including but not limited to a marriage certificate, tax return, birth certificate, legal adoption or legal custody/guardianship documents and/or a certified copy of any Qualified Medical Child Support Order. You are also required to provide the federally issued taxpayer identification number for each dependent for whom you request enrollment. Your dependent's enrollment in the Plan is conditioned on the timely provision of all such information.

E. Appeals

If you request to enroll in the Plan but the Plan Administrator determines that you are not eligible for the Plan, you will receive written notice from the Plan Administrator that you are not eligible. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

Enrollment

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent's enrollment in the Plan is conditional pending the Plan Administrator's timely receipt of the requested information regarding your dependents.

It is very important for you to timely enroll in the Plan during the applicable enrollment periods. There are two general enrollment periods—the Initial Enrollment Period and the Annual Enrollment Period.

A. Initial Enrollment Period

If you are a newly hired Eligible Partner or you have recently become an Eligible Partner and you wish to request enrollment, you must request enrollment for yourself and any Eligible Dependents within the Initial Enrollment Period identified by the Plan Administrator.

If you timely request enrollment, and Your enrollment is approved or conditionally approved, coverage will take effect for you and any Eligible Dependent that you enroll at that time on the later of the date you enroll or the first day of the month following 60 days of continuous employment.

B. Annual Enrollment Period

Each year, the Plan Administrator conducts an Annual Enrollment Period during which you may request enrollment for yourself or your Eligible Dependents or you may make changes to your current elections. You will be notified in advance of the Annual Enrollment Period each year. If you request enrollment or make changes during the Annual Enrollment Period, your coverage (or changes) will be effective the following January 1 if you are still an Eligible Partner at that time. If you fail to enroll or make any changes during the Annual Enrollment Period, your prior coverage elections (including your prior election to waive coverage) in effect on the last day of that Plan Year will continue during the next Plan Year.

C. Changes In Coverage

Generally, you cannot change your coverage elections under the Plan during the Plan Year except as follows.

First, your election will automatically terminate if you terminate employment or lose eligibility under the Plan, except as otherwise described in the "Coverage Termination" section.

NOTE: You are still required to provide timely notice of an event that result in loss of eligibility (e.g. divorce).

Next, you may voluntarily change your elections to participate (or not to participate) during the Plan Year if you satisfy the following conditions (prescribed by federal law):

1. You experience one of the following Status Changes and the change you wish to make satisfies the Consistency Rule, described below; or
2. You experience a significant Cost or Coverage Change; and
3. You complete your enrollment change within 31 days of the date you experience the event (or within any longer period specifically identified below). If you do not change your election prior to the enrollment deadline, you will not be permitted to make a change to your benefit elections until the next Annual Enrollment Period.

D. Status Changes

The following status changes will allow you to change your enrollment election during the plan year:

1. *Marital Status*. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. *Change in Number of Dependents*. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with you for adoption, or death of a Dependent. See also "Special Enrollment" below.

3. *Change in Dependent Eligibility*. Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.
4. *Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan*. You, or your Eligible Dependent experiences a change in employment status due to one of the following events:
    a. Termination or commencement of employment;
    b. A strike or lockout;
    c. Commencement or return from an unpaid leave of absence;
    d. A change in employment status, *e.g*., unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
    e. A change in worksite; and
    f. Any other change in employment status that affects benefits eligibility.
5. *Change in Residence that Affects Eligibility*. You or your eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for dental coverage or becomes eligible for dental coverage.

You can only change your elections on account of a Status Change if the requested change is on account of and corresponds with the Status Change event, as determined by the Plan Administrator. This is called the "Consistency Rule" and it is a rule required by the IRS. As a result of the IRS's Consistency Rule, you may experience a Status Change event that does not let you change Your benefit elections.

Under the Consistency Rule, the Status Change has to affect you or Your Eligible Dependent's eligibility for dental coverage under an employer's dental plan. For example, if Your Spouse gains employment but does not become eligible for dental plan coverage offered by his or her new employer, no election change under this Plan is permitted. A Status Change also affects eligibility for dental coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must satisfy the following specific requirements in order to change Your election based on a Status Change:

1. *Loss of Dependent Eligibility.* If the event is divorce, legal separation, annulment, death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements and you are enrolled in dental coverage, you may not cancel the coverage for any other covered Person.

    Example. Pat is unmarried and has one married child. Pat elects family dental coverage. Pat's Child turns 26 and therefore loses eligibility for coverage under the Plan. Pat's coverage will automatically change to single coverage. Pat cannot, however, cancel coverage for herself.

2. *Gaining Eligibility Under Another Employer Plan.* For a Status Change in which you or your Spouse or Dependent gains eligibility for coverage under another employer's dental plan as a result of a change in marital status or a change in Your spouse's or Dependent's employment status, an election to cancel coverage for that individual under this Plan would correspond with that Status Change only if dental coverage for that individual becomes effective or is increased under the other employer's plan.

E. Cost or Coverage Changes

You may also make changes due to cost or coverage changes. The applicable cost or coverage changes are:

1. *Change in Cost of Coverage*. If Your share of the premium for dental coverage you elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another plan option may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your premiums will automatically be adjusted to reflect the insignificant cost

change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. *Entitlement to or Loss of Entitlement to Medicare or Medicaid*. you or your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. *Governmental Plan Coverage Change*. You or your Eligible Dependent loses coverage under a group dental plan sponsored by a governmental or educational institution.

4. *New Benefit Option Added*. You are eligible for a new or improved dental coverage option.

5. *Court Ordered Coverage*. You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order ("QMCSO") that requires dental coverage for Your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child you have enrolled in the Plan and such coverage is actually provided by the other plan.

6. *Reductions in Coverage*. If coverage under an option is significantly curtailed, you may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. *Change under another Employer Plan*. You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:

   a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or

   b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Dental Plan.

F. HIPAA Special Enrollment

There are three categories of "special enrollment" events, under the Health Insurance Portability and Accountability Act ("HIPAA") that will allow a midyear enrollment election change.

1. New Dependent Special Enrollment

   If an Eligible Partner marries, has a Child, adopts a Child or a Child is placed with the Eligible Partner for adoption (Dependent Event), the Eligible Partner will be permitted to enroll (i) the Eligible Partner only, (ii) the Eligible Partner and the Eligible Partner's Spouse only, (ii) the Eligible Partner and the newly acquired eligible Dependent only, or (iv) the Eligible Partner, his or her Spouse, and newly acquired Eligible Dependent.

   If a Covered Partner experiences a Dependent Event, the Covered Partner may enroll (i) the Spouse only (ii) the newly acquired Eligible Dependent or (iii) the Spouse and any newly acquired Eligible Dependents.

   The Eligible or Covered Partner (as applicable) must request enrollment within 31 days of the Dependent Event in order to qualify for special enrollment. If properly enrolled, coverage will begin on the date of the Dependent Event in the case of a birth, adoption or placement for adoption and on the first day of the month following the date the enrollment is processed in the case of marriage.

2. Loss Of Other Coverage Special Enrollment

   If an Eligible Partner initially refused coverage on behalf of the Eligible Partner and/or his/her Eligible Dependents because of other group dental coverage or dental insurance and the Eligible Partner or Eligible Dependent experiences a "loss of eligibility" for that other group dental coverage, the Eligible Partner may enroll (i) the Eligible Partner only, (ii) the Eligible Partner and any Eligible Dependents who lost eligibility for coverage. If a Covered Partner initially refused coverage for an Eligible Dependent because of other group dental coverage and the Eligible Dependent experiences a "loss of eligibility" for that other group dental coverage, the Covered Partner may enroll any Eligible Dependents who lose eligibility for other coverage. The Eligible Partner or Covered Partner (as applicable) must request enrollment within 31 days of the date of the loss of eligibility for other group coverage in order to qualify for special enrollment.

A "loss of eligibility" results if any of the following occurs:

a. Loss of eligibility for reasons other than failure to pay premiums or fraud if you elect COBRA Continuation Coverage, you must exhaust the maximum continuation period in order to qualify for special enrollment.

b. Reaching a lifetime limit on all benefits.

c. Cessation of all employer contributions.

d. Moving out of an HMO service area if the other plan does not offer other coverage.

e. Ceasing to be a "Dependent," as defined in the other plan.

f. Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time Employees).

3. Loss Of Eligibility for CHIP or Medicaid

The eligible Employee and/or an eligible Dependent Child may be enrolled if either of the following conditions is satisfied:

a. You or your Eligible Dependent Child loses eligibility for Medicaid or a state Child health plan; or

b. You or your Eligible Dependent Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state Child health Plan.

NOTE: Unlike the other special enrollment events, you have 60 days to request enrollment for Loss of Eligibility for Medicaid or eligibility for premium assistance as described above.

G. Qualified Medical Child Support Order

An Eligible Dependent Child may be enrolled in the Plan pursuant to a Qualified Medical Child Support Order in accordance with ERISA Section 609. If the Plan Administrator receives a medical child support that requires coverage under the Plan for your Eligible Dependent Child, you are an Eligible Partner, and the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order, the Eligible Dependent Child will become covered as of the first day of the month following the date that the Plan Administrator approves the order. You may be automatically enrolled involuntarily in order for the Plan Administrator to comply with the Qualified Medical Child Support Order. In order for a medical child support requiring coverage to be a "Qualified Medical Child Support Order", the order must clearly identify all of the following:

1. The name and last known mailing address of the Covered Person;

2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

3. A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and

4. The period to which the order applies.

H. Effective Date of Enrollment Changes

Except as noted above, election changes are typically effective on the first day of the month following the date the Plan Administrator receives the request to change coverage (if the request is approved).

I. Denial of Requested Enrollment Changes

If the Plan Administrator rejects your request to make an election change during the year, you will receive written notice of that decision. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

Termination of Coverage

Coverage will terminate if the Covered Partner does not continue to meet the eligibility requirements described in this Plan. Coverage for a Covered Person who has lost his or her eligibility shall automatically terminate on the last day of the month following the date that eligibility is lost.

Coverage under the Plan will be terminated if any of the following events occur:

1. Coverage will terminate for all Covered Persons at the end of the month in which You terminate employment.
2. If You fail to timely pay the required premium, Coverage will terminate for all Covered Persons at the end of the last month for which a timely and complete premium payment is made. Premium payments made by a Covered Person other than by payroll deductions are considered made when received by the Plan Administrator.
3. Except as otherwise indicated in this section, Coverage will terminate for all Covered Persons at the end of the month in which you cease to be an Eligible Partner.
4. Coverage will terminate for any Covered Persons at the end of the month following the Plan Administrator's receipt of a request to cancel such Covered Persons's coverage pursuant to a Change in Status event as described herein.
5. Coverage for a Covered Dependent will end on the date the dependent ceases to be an Eligible Dependent except that coverage for a child who is ceasing to be an Eligible Dependent because he or she is turning 26 will end at the end of the month in which the child turns age 26.
6. Coverage for a Covered Persons(s) will terminate if the Plan Administrator determines that a Covered Persons has failed to reasonably cooperate with the Employer or Plan, or the Covered Persons has committed fraud or made a material misrepresentation with respect to eligibility or coverage under the Plan. Coverage may be terminated immediately or it may be retroactively terminated in the case of fraud or a material misrepresentation.
7. A Covered Dependent's coverage will end as of the date that the information requested by the Plan Administrator with respect to such dependent is not timely provided.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the termination of Coverage for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys' fees, expenses and court costs.

If you lose coverage due to a Qualifying Event, you may be eligible to continue coverage under the Plan in accordance with a federal law called "COBRA.

DENTAL INSURANCE PLAN GENERAL INFORMATION	
Plan Name & Identification Number	NHC Dental Insurance Plan
Employer Identification Number	62-1294263
Plan Number	506
Plan Sponsor	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 615-890-2020
Plan Administrator	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 615-890-2020
Type Plan	Dental Coverage
Plan Year	January 1 through December 31
Cost of Coverage	Partner Paid
Agent for Service of Legal Process	General Counsel 100 Vine Street Murfreesboro, TN 37130 (and the Plan Administrator at this same address)
Claims Administrator	Ameritas Life Insurance Corporation P.O. Box 81889 Lincoln, NE 68501

Vision Insurance Plan

If you are regularly scheduled 20 hours or more each week, you are eligible for the NHC Vision Plan.

You are eligible for Vision Insurance even if you are not enrolled in the company-sponsored health plan.

Vision coverage is available for your spouse and dependents; however, you must be enrolled for them to be eligible.

Vision Services Plan (VSP) network is used. However, limited benefits are available for services received outside of the network.

The Vision Plan covers eye exams, lens and frames. The frequency allowable for each service or product is defined in the following information.

You are responsible for the entire Vision Insurance premium. It is payroll deducted on the second pay period of every month. The premiums are automatically tax-sheltered unless the Plan is instructed to do otherwise.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

Remember, the only opportunity to make a change to the available coverage is during annual enrollment (normally November with a January 1 effective date), unless you experience a change in status as defined in this Handbook.

Your vision coverage will end on the last day of the month of your termination of employment, status change or ineligibility date. Your coverage may be continued at your personal expense through COBRA (continuation of coverage). Coverage may continue through COBRA for up to 18 months, 29 months or 36 months depending on the original reason for COBRA eligibility.

Vision Insurance

Partners, Spouses & Dependent Children

PLAN HIGHLIGHTS	VSP NETWORK	OUT OF NETWORK
Eligibility	You must be regularly working 20 or more hours per week to participate.	
Deductibles	$10 Exam $25 Eye Glass Lenses or Frames*	$10 Exam $25 Eye Glass Lenses or Frames*
Annual Eye Exam	Covered in full	Up to $52
Lenses (per pair)		
Single Vision	Covered in full	Up to $55
Bifocal	Covered in full	Up to $75
Trifocal	Covered in full	Up to $95
Lenticular	Covered in full	Up to $125
Progressive	See lens options	NA
Contacts	15% discount	
Fit & Follow Up Exams	*See Additional Focus Features.*	No benefit
Elective	Up to $120	Up to $120
Medically Necessary	Covered in full	Up to $210
Frames	$150	Up to $45
Frequencies (months) Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service
LENS OPTIONS (member cost)**	**VSP NETWORK**	**OUT OF NETWORK**
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children; $25 adults	No benefit
Solid Plastic Dye	$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	$15	No benefit
Photochromatic Lenses (Glass & Plastic)	$27-$76	No benefit
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***Lens Option member costs vary by prescription, option chosen and retail locations.*

To locate a provider in your area, go to www.VSP.com or call 1-800-877-7195

Eligibility

If you are an Eligible Partner, you may request enrollment for yourself and your Eligible Dependents in the Plan.

NOTE: You will be required to pay a Premium for the coverage You elect.

A. Eligible Partner Defined:

An Eligible Partner is any Employee who satisfies the following requirements:

1. You are an Employee who is eligible to work in the United States legally as confirmed by the USCIS (United States Citizenship Immigration Services) I-9;
2. You are designated by your Employer as a Full-Time, IPAR or Part-Time Partner regularly scheduled 20 hours or more each week.

B. Eligible Dependents Defined:

An Eligible Dependent is any person who satisfies at least ONE of the following requirements:

1. The person is an Eligible Partner's current Spouse.
2. The person is an Eligible Partner's Child who is under age 26, regardless of marital status.
3. The person is a Child, regardless of age, who is incapacitated and satisfies the additional eligibility requirements for Incapacitated Children.

C. Incapacitated Children

If a Covered Dependent Child is incapacitated on the date the Child turns age 26, coverage for such Child will continue beyond the age of 26 so long as the following requirements are satisfied:

1. You provide written notice of the incapacity prior to the date the child turns age 26; and
2. You provide sufficient documentation supporting the Child's incapacity.
3. A child is considered "incapacitated" if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

D. Proof of Eligibility and Other Information

If You request enrollment for a dependent, you will be required to provide the Plan Administrator (or its designee) with information the Plan Administrator deems necessary to verify eligibility, including but not limited to a marriage certificate, tax return, birth certificate, legal adoption or legal custody/guardianship documents and/or a certified copy of any Qualified Medical Child Support Order. You are also required to provide the federally issued taxpayer identification number for each dependent for whom You request enrollment. Your dependent's enrollment in the Plan is conditioned on the timely provision of all such information.

E. Appeals

If you request to enroll in the Plan but the Plan Administrator determines that you are not eligible for the Plan, you will receive written notice from the Plan Administrator that you are not eligible. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

Enrollment

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent's enrollment in the Plan is conditional pending the Plan Administrator's timely receipt of the requested information regarding your dependents.

It is very important for You to timely enroll in the Plan during the applicable enrollment periods. There are two general enrollment periods---the Initial Enrollment Period and the Annual Enrollment Period.

A. Initial Enrollment Period

If You are a newly hired Eligible Partner or you have recently become an Eligible Partner and you wish to request enrollment, you must request enrollment for yourself and any Eligible Dependents within the Initial Enrollment Period identified by the Plan Administrator.

If You timely request enrollment, and Your enrollment is approved or conditionally approved, coverage will take effect for You and any Eligible Dependent that You enroll at that time on the later of the date you enroll or the first day of the month following 60 days of continuous employment.

B. Annual Enrollment Period

Each year, the Plan Administrator conducts an Annual Enrollment Period during which you may request enrollment for yourself or your Eligible Dependents or you may make changes to your current elections. You will be notified in advance of the Annual Enrollment Period each year. If you request enrollment or make changes during the Annual Enrollment Period, your coverage (or changes) will be effective the following January 1 if you are still an Eligible Partner at that time. If You fail to enroll or make any changes during the Annual Enrollment Period, your prior coverage elections (including your prior election to waive coverage) in effect on the last day of that Plan Year will continue during the next Plan Year.

C. Changes In Coverage

Generally, you cannot change your coverage elections under the Plan during the Plan Year except as follows.

First, your election will automatically terminate if You terminate employment or lose eligibility under the Plan, except as otherwise described in the "Coverage Termination" section.

NOTE: You are still required to provide timely notice of an event that result in loss of eligibility (e.g. divorce).

Next, you may voluntarily change your elections to participate (or not to participate) during the Plan Year if You satisfy the following conditions (prescribed by federal law):

1. You experience one of the following Status Changes and the change You wish to make satisfies the Consistency Rule, described below; or
2. You experience a significant Cost or Coverage Change; and
3. You complete your enrollment change within 31 days of the date You experience the event (or within any longer period specifically identified below). If you do not change your election prior to the enrollment deadline, you will not be permitted to make a change to your benefit elections until the next Annual Enrollment Period.

D. Status Changes

The following status changes will allow You to change Your enrollment election during the plan year:

1. *Marital Status*. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. *Change in Number of Dependents*. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with You for adoption, or death of a Dependent. See also "Special Enrollment" below.

3. *Change in Dependent Eligibility*. Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.
4. *Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan*. You, or Your Eligible Dependent experiences a change in employment status due to one of the following events:
    a. Termination or commencement of employment;
    b. A strike or lockout;
    c. Commencement or return from an unpaid leave of absence;
    d. A change in employment status, *e.g*., unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
    e. A change in worksite; and
    f. Any other change in employment status that affects benefits eligibility.
5. *Change in Residence that Affects Eligibility*. You or your Eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for vision coverage or becomes eligible for vision coverage.

You can only change your elections on account of a Status Change if the requested change is on account of and corresponds with the Status Change event, as determined by the Plan Administrator. This is called the "Consistency Rule" and it is a rule required by the IRS. As a result of the IRS's Consistency Rule, you may experience a Status Change event that does not let You change Your benefit elections.

Under the Consistency Rule, the Status Change has to affect You or Your Eligible Dependent's eligibility for vision coverage under an employer's vision plan. For example, if Your Spouse gains employment but does not become eligible for vision plan coverage offered by his or her new employer, no election change under this Plan is permitted. A Status Change also affects eligibility for vision coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must satisfy the following specific requirements in order to change Your election based on a Status Change:

1. *Loss of Dependent Eligibility.* If the event is divorce, legal separation, annulment, death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements and You are enrolled in vision coverage, you may not cancel the coverage for any other covered Person.

    Example. Pat is unmarried and has one married child. Pat elects family vision coverage. Pat's Child turns 26 and therefore loses eligibility for coverage under the Plan. Pat's coverage will automatically change to single coverage. Pat cannot, however, cancel coverage for herself.

2. *Gaining Eligibility Under Another Employer Plan.* For a Status Change in which You or Your Spouse or Dependent gains eligibility for coverage under another employer's vision plan as a result of a change in marital status or a change in Your spouse's or Dependent's employment status, an election to cancel coverage for that individual under this Plan would correspond with that Status Change only if vision coverage for that individual becomes effective or is increased under the other employer's plan.

E. Cost or Coverage Changes

You may also make changes due to cost or coverage changes. The applicable cost or coverage changes are:

1. *Change in Cost of Coverage*. If Your share of the premium for vision coverage You elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another plan option may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your premiums will automatically be adjusted to reflect the insignificant cost

change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. *Entitlement to or Loss of Entitlement to Medicare or Medicaid*. You or your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. *Governmental Plan Coverage Change*. You or Your Eligible Dependent loses coverage under a group vision plan sponsored by a governmental or educational institution.

4. *New Benefit Option Added*. You are eligible for a new or improved vision coverage option.

5. *Court Ordered Coverage*. You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order ("QMCSO") that requires vision coverage for Your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child You have enrolled in the Plan and such coverage is actually provided by the other plan.

6. *Reductions in Coverage*. If coverage under an option is significantly curtailed, you may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. *Change under another Employer Plan*. You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:

   a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or

   b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Vision Plan.

F. HIPAA Special Enrollment

There are three categories of "special enrollment" events, under the Health Insurance Portability and Accountability Act ("HIPAA") that will allow a midyear enrollment election change.

1. New Dependent Special Enrollment

   If an Eligible Partner marries, has a Child, adopts a Child or a Child is placed with the Eligible Partner for adoption (Dependent Event), the Eligible Partner will be permitted to enroll (i) the Eligible Partner only, (ii) the Eligible Partner and the Eligible Partner's Spouse only, (ii) the Eligible Partner and the newly acquired eligible Dependent only, or (iv) the Eligible Partner, his or her Spouse, and newly acquired Eligible Dependent.

   If a Covered Partner experiences a Dependent Event, the Covered Partner may enroll (i) the Spouse only (ii) the newly acquired Eligible Dependent or (iii) the Spouse and any newly acquired Eligible Dependents.

   The Eligible or Covered Partner (as applicable) must request enrollment within 31 days of the Dependent Event in order to qualify for special enrollment. If properly enrolled, coverage will begin on the date of the Dependent Event in the case of a birth, adoption or placement for adoption and on the first day of the month following the date the enrollment is processed in the case of marriage.

2. Loss Of Other Coverage Special Enrollment

   If an Eligible Partner initially refused coverage on behalf of the Eligible Partner and/or his/her Eligible Dependents because of other group vision coverage or vision insurance and the Eligible Partner or Eligible Dependent experiences a "loss of eligibility" for that other group vision coverage, the Eligible Partner may enroll (i) the Eligible Partner only, (ii) the Eligible Partner and any Eligible Dependents who lost eligibility for coverage. If a Covered Partner initially refused coverage for an Eligible Dependent because of other group vision coverage and the Eligible Dependent experiences a "loss of eligibility" for that other group vision coverage, the Covered Partner may enroll any Eligible Dependents who lose eligibility for other coverage. The Eligible Partner or Covered Partner (as applicable) must request enrollment within 31 days of the date of the loss of eligibility for other group coverage in order to qualify for special enrollment.

A "loss of eligibility" results if any of the following occurs:

a. Loss of eligibility for reasons other than failure to pay premiums or fraud if You elect COBRA Continuation Coverage, you must exhaust the maximum continuation period in order to qualify for special enrollment.

b. Reaching a lifetime limit on all benefits.

c. Cessation of all employer contributions.

d. Moving out of an HMO service area if the other plan does not offer other coverage.

e. Ceasing to be a "Dependent," as defined in the other plan.

f. Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time Employees).

3. Loss Of Eligibility for CHIP or Medicaid

The eligible Employee and/or an eligible Dependent Child may be enrolled if either of the following conditions is satisfied:

a. You or Your Eligible Dependent Child loses eligibility for Medicaid or a state Child health plan; or

b. You or Your Eligible Dependent Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state Child health Plan.

NOTE: Unlike the other special enrollment events, you have 60 days to request enrollment for Loss of Eligibility for Medicaid or eligibility for premium assistance as described above.

G. Qualified Medical Child Support Order

An Eligible Dependent Child may be enrolled in the Plan pursuant to a Qualified Medical Child Support Order in accordance with ERISA Section 609. If the Plan Administrator receives a medical child support that requires coverage under the Plan for your Eligible Dependent Child, you are an Eligible Partner, and the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order, the Eligible Dependent Child will become covered as of the first day of the month following the date that the Plan Administrator approves the order. You may be automatically enrolled involuntarily in order for the Plan Administrator to comply with the Qualified Medical Child Support Order. In order for a medical child support requiring coverage to be a "Qualified Medical Child Support Order", the order must clearly identify all of the following:

1. The name and last known mailing address of the Covered Person;

2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

3. A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and

4. The period to which the order applies.

H. Effective Date of Enrollment Changes

Except as noted above, election changes are typically effective on the first day of the month following the date the Plan Administrator receives the request to change coverage (if the request is approved).

I. Denial of Requested Enrollment Changes

If the Plan Administrator rejects your request to make an election change during the year, you will receive written notice of that decision. You have the right to appeal the Plan Administrator's decision. You must appeal the decision in writing to the Plan Administrator within 60 days of receiving the Plan Administrator's written notice of ineligibility. Your appeal should include any information that you believe is relevant to your appeal. The Plan Administrator will make its decision as soon as reasonably possible but no later than 60 days after receiving your appeal.

Termination of Coverage

Coverage will terminate if the Covered Partner does not continue to meet the eligibility requirements described in this Plan. Coverage for a Covered Person who has lost his or her eligibility shall automatically terminate on the last day of the month following the date that eligibility is lost.

Coverage under the Plan will be terminated if any of the following events occur:

1. Coverage will terminate for all Covered Persons at the end of the month in which You terminate employment.
2. If You fail to timely pay the required premium, Coverage will terminate for all Covered Persons at the end of the last month for which a timely and complete premium payment is made. Premium payments made by a Covered Person other than by payroll deductions are considered made when received by the Plan Administrator.
3. Except as otherwise indicated in this section, Coverage will terminate for all Covered Persons at the end of the month in which you cease to be an Eligible Partner.
4. Coverage will terminate for any Covered Persons at the end of the month following the Plan Administrator's receipt of a request to cancel such Covered Person's coverage pursuant to a Change in Status event as described herein.
5. Coverage for a Covered Dependent will end on the date the dependent ceases to be an Eligible Dependent except that coverage for a child who is ceasing to be an Eligible Dependent because he or she is turning 26 will end at the end of the month in which the child turns age 26.
6. Coverage for a Covered Persons(s) will terminate if the Plan Administrator determines that a Covered Persons has failed to reasonably cooperate with the Employer or Plan, or the Covered Persons has committed fraud or made a material misrepresentation with respect to eligibility or coverage under the Plan. Coverage may be terminated immediately or it may be retroactively terminated in the case of fraud or a material misrepresentation.
7. A Covered Dependent's coverage will end as of the date that the information requested by the Plan Administrator with respect to such dependent is not timely provided.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the termination of Coverage for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys' fees, expenses and court costs.

If you lose coverage due to a Qualifying Event, you may be eligible to continue coverage under the Plan in accordance with a federal law called "COBRA.

VISION INSURANCE PLAN GENERAL INFORMATION	
Plan Name & Identification Number	NHC Vision Insurance Plan
Employer Identification Number	62-1294263
Plan Number	517
Plan Sponsor	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 (and affiliates)
Plan Administrator	National Health Corporation 100 Vine Street Murfreesboro, TN 37130 615-890-2020
Type Plan	Vision Coverage
Plan Year	January 1 through December 31
Cost of Coverage	Partner Paid
Agent for Service of Legal Process	General Counsel 100 Vine Street Murfreesboro, TN 37130 (and the Plan Administrator at this same address)
Claims Administrator	Vision Service Plans 3333 Quality Drive Rancho Cordova, CA 95670

Partner Basic Term Life Insurance Plan

The NHC Partner Basic Term Life Insurance Plan provides Term Life and Accidental Death and Dismemberment (AD&D) insurance to all partners who are regularly scheduled 30 or more hours each week.

The monthly premium for this Term Life Plan is fully paid by your employer.

You, as a covered partner, designate the beneficiary for this term life plan. A beneficiary is the person or persons who will actually receive the proceeds from the term life plan if you die while the policy is in effect. There are no requirements as to who you can name as beneficiary.

Remember to update the beneficiary as changes occur in your life, i.e. marriage, divorce, birth, adoption, etc. You may update your life insurance beneficiary at any time at https://nhcpartnerbenefits.com.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

PARTNER BASIC TERM LIFE INSURANCE BENEFICIARY DESIGNATION

Partner basic term life insurance is insurance on your life with the premium fully paid by your employer. The amount of coverage is based on consecutive years of Full-Time or IPAR service.

YEARS OF FULL TIME OR IPAR SERVICE	BASIC LIFE	ADDITIONAL AD&D INSURANCE
2 years or less	$10,000	Up to $10,000
2 years but less than 5 years	$15,000	Up to $15,000
5 years or more	$20,000	Up to $20,000

In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen.

Partner Information

INSURED'S PARTNER'S NAME	DATE	SOCIAL SECURITY NUMBER (LAST 4 DIGITS) XXX / XX /	EMPLOYER

Basic Term Life Insurance Beneficiary Designation

(If you name more than one beneficiary, give percentages.)

	FIRST NAME	M.I.	LAST NAME	RELATIONSHIP	PERCENTAGE
1)					
2)					
3)					
4)					

Contingent Life Insurance Beneficiary Designation

(Used only if beneficiary named above predeceases you.)

	FIRST NAME	M.I.	LAST NAME	RELATIONSHIP	PERCENTAGE
1)					
2)					
3)					
4)					

INSURED'S SIGNATURE	DATE

Partner Basic Term Life Insurance

If you are a Full-Time or IPAR (regularly scheduled 30.00 or more hours each week) partner, you are covered by a company paid term life insurance and accidental death and dismemberment (AD&D) policy on the first of the month coinciding with your health benefit plan eligibility date.

The policy provisions are summarized below in question and answer form.

What is Partner Basic Term Life Insurance?

Partner basic term life insurance is insurance on your life. In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen.

What is Accidental Death and Dismemberment Insurance?

In the event of your death *and* if the death is an accident, excluding certain types of accidents, the benefit of life insurance is doubled. Dismemberment benefits are paid when one of the following losses occur: loss of a hand, foot or sight.

Who is eligible for the Partner Basic Term Life and Accidental Death and Dismemberment Benefit?

All full-time and IPAR partners.

How do I enroll in the Partner Basic Term Life and Accidental Death and Dismemberment Benefit?

You are automatically provided with partner term life and AD&D insurance with the full cost being paid by your employer. You must designate your beneficiary on the applicable Beneficiary Form.

How much Partner Basic Term Life and Accidental Death and Dismemberment Insurance am I eligible for?

The amount of your coverage is based on consecutive years of full-time service. The chart below explains:

Years of Service	Basic Life	Additional AD&D Insurance
2 years or less	$10,000	Up to $10,000
2 years but less than 5 years	$15,000	Up to $15,000
5 years or more	$20,000	Up to $20,000

If you are still employed when you attain age 70, your coverage will be reduced by 50% of your Amount of Life Insurance or Maximum Benefit in force on the day before you turn age 70. Your coverage at age 75 will be reduced to 30% of your Amount of Life or Maximum Benefit in force on the day before you turn age 75. Your coverage at age 80 will be reduced to 20% of your Amount of Life Insurance or Maximum Benefit in force on the day before you turn age 80.

How do I designate a beneficiary?

You should designate a beneficiary online at https://nhcpartnerbenefits.com. The beneficiary designation should be kept updated and current to reflect any family status changes, i.e. birth, death, marriage, divorce, adoption.

Do I pay any portion of the premium?

No. Your employer pays the full cost.

If I leave my employer, or become ineligible for coverage, how do I convert my life insurance to an individual policy?

Instructions regarding how to convert your coverage will be mailed to your home address. In the event you desire to convert all or any part of your group life insurance coverage to an individual policy, you should follow the instructions timely. If you contact the life insurance company, the life insurance company will mail you the forms to allow you to convert all or any part of your group life insurance coverage to an individual policy. Once you have converted all or any part of your group life insurance coverage to an individual policy, you are responsible for the full premium and you will be billed directly by the life insurance company. The notice of conversion form must be received by the insurance company within 31 days of coverage termination.

Partner & Dependent Term Life Insurance Plan

Partners who are regularly scheduled 30 or more hours each week are eligible to enroll themselves and their dependents in the NHC Partner & Dependent Term Life Insurance Plan. The Plan provides Term Life Insurance, as well as an equal amount of Accidental Death and Dismemberment (AD&D).

You are eligible to enroll yourself and your dependents when you become eligible for other insurance benefits.

The monthly premium is fully partner paid for all coverages under this plan. You are responsible for the entire Partner & Dependent Term Life Insurance Premium. It is payroll deducted each pay period of every month.

You, as a covered partner, designate the beneficiary for this term life plan. A beneficiary is the person or persons that will actually receive the proceeds from the dependent life plan if you or your covered dependent(s) die while the policy is in effect.

There are no requirements as to who you can name as beneficiary. Remember to update the beneficiary as changes occur in your life, i.e. marriage, divorce, birth, adoption, etc. You may update your life insurance beneficiary at any time at https://nhcpartnerbenefits.com.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

PARTNER & DEPENDENT TERM LIFE INSURANCE BENEFICIARY DESIGNATION

In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen. If you have elected partner & dependent life coverage, the beneficiary for life insurance on the lives of your spouse or children will automatically be you, if surviving; otherwise your estate will be the beneficiary, subject to policy provisions.

Partner Information

INSURED'S PARTNER'S NAME	DATE	SOCIAL SECURITY NUMBER (LAST 4 DIGITS) XXX / XX /	EMPLOYER

Term Life Insurance Beneficiary Designation

(If you name more than one beneficiary, give percentages.)

	FIRST NAME	M.I.	LAST NAME	RELATIONSHIP	PERCENTAGE
1)					
2)					
3)					
4)					

Contingent Life Insurance Beneficiary Designation

(Used only if beneficiary named above predeceases you.)

	FIRST NAME	M.I.	LAST NAME	RELATIONSHIP	PERCENTAGE
1)					
2)					
3)					
4)					

INSURED'S SIGNATURE	DATE

Partner & Dependent Term Life Insurance

As an eligible Partner of NHC and its affiliated companies, you may purchase additional Partner, Spouse and Child(ren) Life Insurance benefits at a greatly reduced price. This Life Insurance is in addition to all other NHC Life Insurance benefits offered.

Eligibility

Active full-time or IPAR benefits eligible Partners of NHC and its affiliated companies.

Eligibility Waiting Period

The waiting period is the same as for your other insurance coverages.

Partner Benefit Amount

$10,000, $25,000, $50,000, $75,000, $100,000, $125,000 or $150,000

Guaranteed Issue Amount

The guaranteed issue amount is the amount of insurance that you may elect without providing evidence of good health. If you enroll during your initial enrollment period, the guaranteed issue amount is up to $150,000. If you decline coverage and later desire to enroll, you may enroll during the annual enrollment period in November of each year, and evidence of good health would be required. If approved, coverage would be effective the first of the month following approval.

Benefit Reductions

Reduces to 50% at age 70; further reduces to 30% at age 75; to 20% at age 80.

Dependent Coverage

You may also elect coverage on the lives of your spouse and/or dependent children. A dependent is defined as your:

- legally recognized spouse;
- unmarried child under age 26.

Your unmarried step-child, foster child or adopted child is included as a dependent if he/she depends on you for 50% or more of his/her support and is living with you in a regular parent-child relationship. A child is considered adopted if in your legal custody under an interim court order of adoption, whether or not a final adoption order is ever issued.

Dependent does not include:

- any person who is insured as a partner; or
- any person residing outside the United States, Canada or Mexico.

If an unmarried child is:

- incapable of self-sustaining employment because of mental retardation, developmental disability or physical handicap; and
- depends on you for 50% or more of his/her support;

that child will continue to be a dependent for as long as these two conditions exist.

No person may be considered to be a dependent of more than one partner.

If you do not currently have an eligible child, you will have 31 days to enroll following the addition of your first dependent child. All future children will be automatically enrolled at the same benefit level at no additional cost. A Personal Health Statement will not be required for your spouse or child if you enroll them during your initial eligibility period. (Dependent coverage is available only when you elect coverage for yourself.)

If your spouse or dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

Spouse Benefit Amount: $5,000, $12,500, $25,000, $37,500, $50,000, $62,500 or $75,000, depending on the option that you selected for yourself. You may not elect coverage for your spouse if your spouse is covered as a Partner under this policy. A spouse is defined as a partner's legally recognized wife or husband. *Spouse Guaranteed Issue Amount: up to $75,000.*

Child Benefit Amount: $2,500, $6,250, $12,500, $18,750, or $25,000 per child (children ages 14 days to 6 months are limited to a reduced benefit of $100). *Child Guaranteed Issue Amount: up to $25,000.*

If you decline dependent coverage for any of your current eligible dependents and later desire to enroll, you may enroll them during the annual enrollment period in November of each year and evidence of good health would be required. If approved, coverage would be effective the first of the month following approval.

Portability or Conversion Option

If you leave your employer, *Portability* is a continuation option that allows you to continue your coverage. This provision applies if your employment terminates prior to age 70 and you port a minimum of $5,000. The option allows you to continue all or a portion of your Partner Life Insurance under a separate Portability term policy. Portability is subject to a maximum of $100,000. Portability is also offered on spouse and child coverage. It is subject to a maximum of $50,000 spouse and $25,000 child, at economical group rates. To elect Portability, you must apply and pay the premium within 31 days of the termination of your Term Life Insurance. Proof of good health will not be required. Portability allows for continuation of coverage for a short period of time.

If your Term Life Insurance terminates, the plan's *Conversion Privilege* allows you to convert all or a portion of your group coverage to an individual policy. You must request conversion and pay all the required premium within 31 days of the date of your Term Life insurance ends. No evidence of good health will be required. Conversion allows for permanent coverage continuation. PORTABILITY OR CONVERSION MAY BE ELECTED UPON TERMINATION OF BENEFITS.

Living Benefits Option

Should you be diagnosed as terminally ill with a 12-month life expectancy, the Living Benefits Option allows you to receive an accelerated payment of a portion of your life insurance proceeds. The option is available to individuals with at least $10,000 group coverage subject to any maximum age limit described in your certificate. You may request a minimum accelerated payment of $5,000 up to a maximum of 75% of your coverage. Funds are paid directly to you, with no policy restrictions on how you use them. The remaining benefit is then payable to the beneficiary.

Waiver of Premium

This provision applies if you become totally disabled before age 60 and your disability meets the definition of disability under the plan. You must provide proof of your condition within one year of your last day of work. Once approved, your coverage will continue without payment of premium up to age 65, as long as you remain totally disabled. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates. Payment of premium is required until waiver is approved.

Accidental Death & Dismemberment

If accident or injury occurs, directly and independently of all other causes, and results in any of the following losses within 365 days of the accident, the plan will pay as follows: Accidental Death benefit matches life amount selected. AD&D benefits also available for loss of speech/hearing; loss of thumb/forefinger; seat belt/airbag; and paralysis. (See certificate for details.)

Short Term Disability Insurance Plan

If you are designated by your Employer as a Full-Time, IPAR or Part-Time partner regularly scheduled 20 hours or more each week, you are eligible for the NHC Short Term Disability Plan.

The Short Term Disability Plan is an income replacement plan that replaces up to 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions; if your earnings are based on commissions, commissions will be averaged over the 12-month period prior to the date disability begins) when you become disabled due to illness (to include pregnancy) or accident.

NOTE: If you choose an amount greater than 70% of your basic weekly income, the weekly benefit amount will be reduced at the time of claim. Premium adjustment in these situations will be limited to the 12 months immediately prior to the time of claim.

If you are eligible for state-mandated temporary disability benefits, or any employer-paid income replacement plan, the combination of your state-mandated benefit or other income and your Short Term Disability weekly benefit may not exceed 70% of your basic weekly earnings.

This plan has a 15 calendar day waiting period. Disability payments can continue up to 13 weeks, depending on the length of the disability.

The plan has a 12/12 pre-existing condition provision, meaning that if a condition was present anytime in the 12 months prior to coverage; a short term disability claim for that particular condition made any time in the 1st 12 months after coverage is effective would not be covered. However, coverage would still be available for any condition unrelated to the preexisting condition. The pre-existing limitation also applies to all weekly benefit increases.

You are responsible for the entire Short Term Disability Insurance premium. It is payroll deducted on the second pay period of every month.

Please refer to your Certificate for details.

Remember, that the opportunity to make a change to the available coverage is only during annual enrollment (normally November with a January 1 effective date).

NATIONAL HEALTH CORPORATION
FLEXIBLE SPENDING ACCOUNT PLAN
SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2019

This Summary Plan Description supersedes all other Summary Plan Descriptions for this Plan with an earlier effective date.

Table of Contents

Introduction to the Flexible Spending Account Plan

About this Plan

National Health Corporation (the "Employer") is pleased to offer you The Flexible Spending Account Plan (the "Plan"). There are two types of flexible spending accounts available through the Plan: a Health Care Reimbursement Account ("HCRA") and a Dependent Care Reimbursement Account ("DCRA"). These spending accounts are described in more detail later in this Summary Plan Description ("SPD").

The Plan is called a "flexible" spending account plan because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible dependents) are expected to incur during the Plan Year and you elect to have the Employer withhold that amount from your pay *on a pre-tax basis* to spend on such expenses. Any amounts that you elect to have withheld for eligible medical expenses will be credited to the HCRA and any amounts that you elect to have withheld for dependent day care expenses will be credited to the DCRA. You must elect wisely because any amounts credited to a flexible spending account that are not spent on expenses incurred during the Plan Year will generally be forfeited (with a limited exception for amounts credited to the HCRA). Also, you cannot use amounts credited to your HCRA for dependent day care expenses and you cannot use amounts credited to your DCRA for medical care expenses.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay to spend on eligible expenses are not subject to any federal income and employment taxes (e.g., FICA and FUTA), and in most cases, state taxes. Participation in this Plan will actually increase your take home pay over what your take home would be if you paid for eligible expenses with after-tax dollars.

This Plan is a component of the Employer's "Cafeteria Plan" established in accordance with Internal Revenue Code ("Code") Section 125. The HCRA is also subject to Code Section 105 and the DCRA is subject to Code Section 129. It is intended that this Plan comply with the applicable Code sections; however, if there is a conflict between the terms of this SPD and an applicable Code Section, the conflict will be resolved in favor of the applicable Code Section.

About this SPD

The SPD is divided into four parts: Part I-General Information about the Plan; Part II-HCRA Benefits; Part III-DCRA Benefits; and the Plan Information Appendix. The first three parts of the SPD are in Question and Answer ("Q&A") format. If you have questions about your rights and obligations under the Plan, please refer to the Table of Contents for the Q&A that most resembles your question. The last part of this SPD—the Plan Information Appendix—identifies specific information related to your plan including but not limited to the following: eligibility, maximum reimbursement amounts, contact information for the Third Party Administrator and the Plan Administrator. You will be referred to the Plan Information Appendix throughout the SPD. Terms that are capitalized throughout are terms that are specifically defined in the SPD.

This SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The Plan is also established pursuant to a Plan document into which this SPD has been incorporated. You can request a copy of the plan document by submitting a written request to the Plan Administrator identified in the Plan Information Appendix.

Flexible Spending Account Plan
Questions and Answers

Part I: General Information about the Plan

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to enable eligible partners to pay for eligible medical and/or dependent day care expenses with Pre-tax Salary Reductions.

Q-2. Who can participate in the Plan?

Only Eligible Partners who make a proper election can participate in the Plan. See the Plan Information Appendix for the Plan's eligibility requirements. The eligibility requirements may differ for the HCRA and the DCRA. Eligible Partners who make a proper election to participate are referred to as "Participants."

Q-3. When does my participation in the Plan end?

You continue to participate in the Plan until the earliest of the following to occur:

- The date you revoke your election to participate in the Plan;
- If you fail to make a required contribution, your Participation ends on the last day of the last month for which you made a timely and complete contribution;
- The date you cease to be an Eligible Partner except that you may continue to participate in the DCRA through the end of the Plan Year up to your DCRA balance on the date you cease to be an Eligible Partner; or
- The date the Plan is terminated.

If your participation ends because you cease to be eligible, but you become eligible again during the same plan year but more than 30 days later, you may make new elections under the Plan for the remainder of the Plan Year. If you cease to be eligible but become eligible again during the same Plan Year but less than 30 days later, your prior elections will be reinstated and will remain in effect for the remainder of the Plan Year. You cannot use contributions credited to your account for expenses incurred during the period that you were not an Eligible Partner.

If you take an approved paid leave of absence, your participation in the HCRA will continue uninterrupted; however, your participation in the DCRA will end. If you take an approved unpaid leave of absence, you may choose to continue participating in the HCRA or you may choose to stop participating. Your participation in the DCRA will end once the leave begins. If you choose to continue participating in the HCRA, the contributions that you would otherwise be required to make during the leave will be withheld from your paycheck when you return from the approved unpaid leave. If your coverage ends during the leave, You will also have special rights when you return from an unpaid leave. See the Mid-Year Election Changes section of the Plan Information Appendix for more details regarding your participation and election change rights with respect to the HCRA during an unpaid FMLA leave.

Q-4. How do I become a Participant?

You become a Participant in the Plan by (i) timely and properly making an election during one of the applicable enrollment periods and (ii) making the required contributions. You must make your election in accordance with the instructions provided by the Employer. You cannot become a Participant in this Plan prior to the date you complete the election process and that election is approved by the Employer.

Q-5. What are the election periods under the Plan?

The Plan has three election periods: the Initial Election Period, the Annual Election Period, and the Mid-Year Election Period. **NOTE: You must elect the specific spending account(s) in which you want to participate.**

The Initial Election Period

The Initial Election Period begins on the date you become eligible and ends 60 days later. If you make an election to participate during the Initial Election Period, your participation in the spending account(s) that you elect will begin on the first day of the month that begins 60 days after you became an Eligible Partner. If you do not make an affirmative election to participate in either of the spending accounts during the Initial Election Period, you are deemed to have elected not to participate in this Plan. Elections that you make (or are deemed to make) during the Initial Election Period are effective for the remainder of the Plan Year and cannot be changed unless you experience an event that begins a Mid-Year Election Period.

The Annual Election Period

The Plan also has an Annual Election Period during which you may elect to participate, change your prior participation election, or elect not to participate during the following Plan Year. You will be notified each year of the beginning and end dates of the Annual Election Period. If you want to participate during the following Plan Year, you must make an affirmative election to either continue your current election or change your current election. If you do not make affirmative election to participate, you are deemed to have elected not to participate during the following Plan Year. The election that you make during the Annual Election Period is effective the first day of the following Plan Year and cannot be changed unless you experience an event that begins a Mid-Year Election Period. If you are a current Participant in the Plan and you fail to complete and submit an election form during the Annual Enrollment Period, you will be deemed to have elected not to participate during the next Plan Year.

The Mid-Year Election Period

Generally, the election that you make (or are deemed to make) during an Initial or Annual Election period cannot be changed during the Plan Year. If, however, you experience one of the events identified in the Plan Information Appendix, a Mid-Year Election Period begins, and you may make certain changes to your election during that period. The Mid-Year Election period begins on the date of the event and lasts 30 days. See the Plan Information Appendix for more details regarding the events that start a Mid-Year Election Period and the election changes you may make.

The Plan Year is generally a 12-month period (except during the initial or last Plan Year of the Plan). The beginning and ending dates of the Plan Year are described in the Plan Information Appendix.

Q-6. How do I make the required contributions ?

When you make an election to participate, you will specify which account or accounts in which you want to participate. You will also identify the amount that you want credited to each account during the Plan Year. If you are receiving a paycheck from the Employer, a pro-rate share of that amount will be withheld from each paycheck on a pre-tax basis and credited to the spending account(s) according to your election. These are called "Pre-tax Salary Reductions". These Pre-tax Salary Reductions are not subject to any federal income and employment taxes (and state income taxes in most cases).

NOTE: Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Q-7. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Flexible Spending Account Plan
Part II. HCRA Benefits

The following Questions and Answers relate to the HCRA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Salary Reductions to the HCRA.

Q-8. What is the "Health Care Reimbursement Account"?

The Health Care Reimbursement Account ("HCRA") is the portion of the Plan that enables you to pay for Eligible Medical Expenses with Pre-tax Salary Reductions. If you are an Eligible Partner for purposes of the HCRA (as defined in the Plan Information Appendix), and you want to participate, you estimate the amount of Eligible Medical Expenses that you and your Eligible Dependents will incur during the Plan Year and you elect during the applicable enrollment period (see Part-I) to make Pre-tax Salary Reductions equal to that amount (not to exceed the Maximum Salary Reduction Election identified in the Plan Information Appendix). When you or your Eligible Dependents incur Eligible Medical Expenses, you may pay or seek reimbursement for those expenses as described below. NOTE: the HCRA is not an actual account established in your name similar to a checking account. It is a notional bookkeeping account that records your Pre-tax Salary Reductions and reimbursements for the year.

You will find more details later in this SPD on the following:

- How much of the amount I elected is available for reimbursement at any given time during the year?
- What are Eligible Medical Expenses?
- When is an expense "incurred"?
- How do I pay or seek reimbursement of those expenses?

Q-9. How much of the amount that I elected for the HCRA is available for payment or reimbursement of Eligible Medical Expenses at any given time during the Plan Year?

Unlike the DCRA, the full Pre-tax Salary Reduction amount that you elected for the HCRA for the Plan Year (reduced by reimbursements already made for expenses incurred during the Plan Year) is available for payment or reimbursement of Eligible Medical Expenses without regard to how much you have actually contributed at that point. For example, if you elect $1200 for the Plan Year, $1200 is credited to your account the moment you become a Participant for that Plan Year. Also, if you elected $1200 and have already been reimbursed $500, $700 is available even though you have only contributed $500. NOTE: You must make the required contributions in order to remain a Participant; however, the amount available from your HCRA for payment or reimbursement of Eligible Medical Expenses is not based on how much you have contributed.

Q-10. How do I pay for or receive reimbursement for Eligible Medical Expenses from the HCRA?

When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by submitting a Request for Reimbursement through the Third Party Administrator's member online portal. You may obtain assistance with requesting the reimbursement by contacting the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement a written statement from the service provider (e.g., a receipt, explanation of benefits or "EOB") associated with each expense that indicates the following:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. The Third Party Administrator will process the claim once it receives the Request for Reimbursement from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense" you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

NOTE: If your health plan administrator or insurance carrier automatically submits an EOB to the Third Party Administrator for processing, you may not have to provide any additional substantiation or certification.

Alternatively, you may use an electronic payment card ("Electronic Payment Card" or the "Card") provided to you when you become a Participant in the Plan. The Electronic Payment Card enables you to pay for Eligible Medical Expenses at the point of sale instead of paying for them out of pocket first and then requesting a reimbursement from your HCRA as described above. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as described in this SPD and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement"). The following is a summary of how the Electronic Payment Card Program works. **NOTE: The Electronic Payment Card Program is governed by the terms of this SPD, the cardholder agreement that you receive with your Card, and applicable IRS guidance related to HCRA Cards**.

(a) *You must make an election to use the Card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of your Plan and this SPD.

(b) *The Card will be turned off when employment or coverage terminates.* The Card will be turned off when your coverage terminates under the Plan.

(c) *You certify that you will only use the Card to pay for Eligible Medical Expenses.* You certify during the applicable election period described above that you and any other cardholders will only use the Card to pay for Eligible Medical Expenses, that you have not been reimbursed for, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of Card use privileges.

(d) *You can only use the Card at certain merchants.* Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Third Party Administrator as having a medical merchant category code, certain Pharmacies that meet IRS requirements for HCRA Card use, and merchants that are participating in the Inventory Information Approval System (as defined by the IRS). If you have questions whether the Card will work at a particular merchant, contact the Third Party Administrator.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum amount available through your HCRA. Every time you swipe the Card, you certify to the Plan that the expense that you are paying for with the Card is an Eligible Medical Expense, that you have not been reimbursed from any other source (e.g. other health insurance) and that you will not seek reimbursement from another source.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the Card.* You must obtain a third party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card:

- The nature of the expense (e.g., what type of service or treatment was provided);
- If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

This statement provides substantiation required by the IRS that the expense is for an Eligible Medical Expense. You should retain this statement for at least one year following the close of the Plan Year in which the expense is incurred. In accordance with IRS guidance, some of the expenses that you pay for with the Card will not require additional substantiation. Unfortunately, many expenses that you pay

for with the Card will require additional substantiation as required by the IRS. If substantiation is required, you will receive notice from the Third Party Administrator requesting the substantiation. The notice from the Third Party Administrator will provide instructions on when and where to provide that substantiation.

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Third Party Administrator, you must repay the Plan for the unsubstantiated expense. You can either repay the Plan with your own funds or, if Eligible Medical Expenses are submitted for reimbursement, those expenses will be offset by the amount of any unsubstantiated claims. The Third Party Administrator will notify you of the date by which you must repay the unsubstantiated transactions. If you do not repay the Plan within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future Eligible Medical Expenses. If no claims are submitted prior to the date you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement) or the remaining unpaid amount may be treated by the Employer as any other bad debt, which will result in additional gross income for you.

(h) *You can use either the Electronic Payment Card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the Electronic Payment Card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

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Q-11. What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been *incurred* by you or your Eligible Dependents that satisfies the following conditions:

- The expense is for "Medical Care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse (in accordance with federal law) and any other individual who is a "dependent" as defined in Code Section 105(b) (i.e., a dependent who is eligible to receive tax-free health coverage under the Code). Coverage for an individual covered as an Eligible Dependent under the HCRA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent (e.g., a Spouse ceases to be an Eligible Dependent on the date a divorce is final; a child ceases to be an Eligible Dependent on the last day of the calendar year that the child turned age 26).

The Code generally defines "Medical Care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over-the-counter drugs (and over-the-counter products and devices). Not every health-related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Administrator/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a

medical condition and/or the particular item is necessary to treat a medical condition. Also, "stockpiling" of over-the-counter drugs and/or items is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs or items could be used during the Plan Year (as determined by the Plan Administrator). Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any HCRA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long-term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix and/or enrollment material.

Q-12. Can I use my HCRA for Eligible Medical Expenses that are incurred at any time?

No. Generally, your annual Pre-tax Salary Reductions may only be used for Eligible Medical Expenses incurred during the Plan Year and while you are a Participant (or if the expense is incurred by a dependent, the expense must be incurred while an Eligible Dependent). An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services (with limited exceptions for orthodontic treatments that meet IRS guidelines).

You will have until March 31 of the following year to submit for reimbursement any expenses incurred during the Plan Year. This is called the “Run-Out Period”.

Q-13. What if the Eligible Medical Expenses I or my Eligible Dependents incur during the Plan Year are less than my Pre-tax Salary Reductions for the year?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Medical Expenses you have incurred and your annual HCRA election. You will generally forfeit any unused Pre-tax Salary Reductions for a Plan Year; however, you may carry over to the next Plan Year up to $500 of any unused Pre-tax Salary Reductions not used for expenses incurred during the Plan Year to the extent that you make an election to be a Participant in the HCRA during the next Plan Year. Eligible Medical Care Expenses incurred in the current Plan Year will be reimbursed first from a Participant’s unused amounts credited for that Plan Year and then from amounts carried over from the prior Plan Year. Carryovers (also referred to as rollovers) that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant’s preceding Plan Year expenses during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount.

Q-14. What happens if a claim for benefits under the HCRA is denied?

If you are denied a benefit under the HCRA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-15. What happens to unclaimed HCRA reimbursement checks?

Any reimbursement checks under the HCRA that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred will be forfeited.

Q-16. What is COBRA continuation coverage?

If you lose coverage under the HCRA due to certain events, a Federal law called "COBRA" entitles you to make an election to continue coverage under the HCRA for certain circumstances. Your COBRA rights and obligations with respect to the HCRA are described below.

When Coverage May Be Continued

If you are a Participant in the HCRA, then you generally have a right to choose continuation coverage under the HCRA if you lose your coverage because of:

- A reduction in your hours of employment; or
- A voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

If you are the Spouse of a Participant, then you generally have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- The divorce or legal separation from the Participant.

In the case of a dependent child of a Participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- The death of the Participant;
- A voluntary or involuntary termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment;
- His or her parents' divorce or legal separation; or
- He or she ceases to be a dependent child.

Those events that entitle you to elect coverage are called "Qualifying Events." Those covered individuals who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries." A child who is born to, or placed for adoption with, the Participant during a period of continuation coverage is also entitled to continuation coverage under COBRA as a Qualified Beneficiary.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available for the remainder of the Plan Year. You will be notified of your particular right to elect COBRA continuation coverage.

Type of Continuation Coverage

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the HCRA will end with the date you would otherwise lose coverage.

Notice Requirements

You or your covered dependents (including your spouse) must notify the COBRA Administrator identified in the Plan Information Appendix in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost under the Plan because of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage by sending you the appropriate election forms. Notice to an employee's spouse is treated as notice to any covered dependents who reside with the spouse.

An employee or covered dependent is responsible for notifying the COBRA Administrator if he or she becomes covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

Each Qualified Beneficiary is entitled to make a separate election for continuation coverage under the Plan if they are not otherwise covered as a result of another Qualified Beneficiary's election. In order to elect continuation coverage, you must complete the Election Form(s) within 60 days from the date you would lose coverage as a result of a Qualifying Event or the date you are sent notice of your right to elect continuation coverage, whichever is later and send it to the COBRA Administrator identified in the Plan Information Appendix of this SPD. Failure to return the election form within the 60-day period will be considered a waiver of your continuation coverage rights.

Cost

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the HCRA until the end of the Plan Year in which the Qualifying Event occurs. However, continuation coverage may end earlier for any of the following reasons on the dates indicated:

- The last day of the last month for which a timely and complete COBRA premium is made (Note if your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides group health coverage to any of its employees.

Q-17. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") group health plans such as the HCRA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate privacy notice that outlines the Employer's health privacy policies.

Q-18. How long will the HCRA remain in effect?

Although the Employer expects to maintain the HCRA indefinitely, it has the right to modify or terminate the program at any time and for any reason.

Other Important HCRA Information

ERISA Rights

The HCRA Plan is an ERISA welfare benefit plan. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage. You may continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your eligible dependents will have to pay for such coverage. You should review the COBRA section of this SPD for more information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon 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 the Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Plan Administrator. If you have a claim for benefits that 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 domestic relations order or 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 the 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Flexible Spending Account Plan
Part III. DCRA Benefits

The following Questions and Answers relate to the DCRA benefits. This section only applies to the extent that you have elected to allocate Pre-tax Salary Reductions to the DCRA.

Q-19. What is the "Dependent Care Reimbursement Account"?

The Dependent Care Reimbursement Account ("DCRA") is the portion of the Plan that enables you to pay for Eligible Day Care Expenses with Pre-tax Salary Reductions. If you are an Eligible Partner for purposes of the DCRA (as defined in the Plan Information Appendix), and you want to participate, you estimate the amount of Eligible Day Care Expenses that you will incur during the Plan Year and you elect during the applicable enrollment period (see Part-I) to make Pre-tax Salary Reductions equal to that amount (not to exceed the Maximum Salary Reduction Election identified in the Plan Information Appendix). When you incur Eligible Day Care Expenses, you may pay or seek reimbursement for those expenses as described below. NOTE: the DCRA is not an actual account established in your name similar to a checking account. It is a notional bookkeeping account that records your Pre-tax Salary Reductions and reimbursements for the year.

You will find more details later in this SPD on the following:

- How much of the amount I elected is available for reimbursement at any given time during the year?
- What are Eligible Day Care Expenses?
- When is an expense "incurred"?
- How do I pay or seek reimbursement of those expenses?

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Q-20. How much of the amount that I elected for the DCRA is available for payment or reimbursement of Eligible Day Care Expenses at any given time during the Plan Year?

Unlike the HCRA, only the Pre-tax Salary Reductions credited to your account (reduced by prior reimbursements) are available for payment or reimbursement of Eligible Day Care Expenses at any given time during the Plan Year.

Q-21. How do I receive reimbursement under the DCRA?

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Third Party Administrator by submitting a Request for Reimbursement. You may obtain assistance with a Request for Reimbursement from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The nature of the expense;
- The date or dates the services were provided; and
- The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Day Care Expense" you will receive notification of this determination. You must

submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Run-out Period. The Run-out Period is described in the Plan Information Appendix.

Q-22. What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

- An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in Code Section 152(a)(1)) and who is age 12 or under, or
- A spouse or other tax "Dependent" (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this DCRA only, a "Dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The day care is not provided by a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by the Participant's Spouse or the parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income, the amounts you receive as reimbursement for Eligible Day Care Expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Q-23. Can I use my DCRA for Eligible Day Care Expenses that are incurred at any time?

You may only use your DCRA for Eligible Day Care Expenses that are incurred ***during*** the Plan Year and while a Participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the DCRA becomes effective or before your DCRA election becomes effective. In addition, if you cease to be a Participant, you may continue to be reimbursed for expenses incurred after the date you cease to be a Participant in the DCRA and prior to the end of the Plan Year up to your DCRA balance (i.e. the Pre-tax Salary Reductions credited to your DCRA minus prior reimbursements) on the date you cease to be a Participant.

Q-24. What if the Eligible Day Care Expenses I incur during the Plan Year are less than my Pre-tax Salary Reductions for the DCRA for the year?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Day Care Expenses you have incurred and the annual reimbursement amount that you have elected. Any Pre-tax Salary Reductions credited to the DCRA during the year will be forfeited if not used for Eligible Day Care Expenses incurred during the Plan Year. You have until March 31 of the following year to submit expenses incurred during the Plan Year for reimbursement.

Q-25. What happens if a claim for benefits under the DCRA is denied?

If you are denied a benefit under the DCRA, you should proceed in accordance with the claims and appeal procedures set forth in the Plan Information Appendix.

Q-26. What happens to unclaimed DCRA reimbursements?

Any DCRA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

Q-27. Will I be taxed on the DCRA reimbursement I receive?

You will not normally be taxed on your DCRA reimbursement, provided that your family's aggregate dependent day care reimbursement (under this DCRA and/or another employer's DCRA) does not exceed the maximum DCRA amount identified in the Plan Information Appendix. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q-28. If I participate in the DCRA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this DCRA, although the balance of your Eligible Day Care Expenses not reimbursed under this DCRA may be eligible for the dependent care credit.

Q-29. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual Eligible Day Care Expenses as a credit against your federal income tax liability under the Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Day Care Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Day Care Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

Flexible Spending Account Plan
Plan Information Appendix

This Plan Information Appendix provides information specific to the [employer] Flexible Spending Account Plan.

I. EMPLOYER/PLAN SPONSOR INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:		National Health Corporation 100 Vine Street Murfreesboro, TN 37130
2. Employer's federal tax identification number:		62-1294263
3. Plan Year:		January 1 through December 31
4. Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and this SPD.		Same as Employer/Plan Sponsor
5. Plan Number:		**506**
6. Third-Party Administrator:		HealthEquity 15 West Scenic Pointe Drive Draper, UT 84020
7. COBRA Administrator:		UnifyHR 105 Decker Court Suite 150 Irving, TX 75062

II. ELIGIBILITY REQUIREMENTS

(a) The HCRA. Any Partner who is otherwise eligible to participate in the National Health Corporation Health Benefit Plan.

(b) The DCRA. Any Partner of National Health Corporation is eligible to participate in the DCRA.

The Partner's commencement of participation in the Plan is conditioned on the partner properly enrolling online as summarized in the SPD. A "Partner" is limited to individuals who are considered by National Health Corporation to be a common law employee to whom National Health Corporation provides a W-2. Partner will have the same definition as "Employee" in the plan document.

III. SPENDING ACCOUNT ELECTION LIMITS

(a) HCRA Maximum: The maximum amount of Pre-tax Salary Reductions that you may elect to contribute to your HCRA during the Plan Year is the maximum amount permitted by the IRS for that Plan Year.

(b) DCRA Maximum. The maximum amount of Pre-tax Salary Reductions that you may elect to contribute to your DCRA during the Plan Year is the statutory maximum applicable to you.

You should note that the statutory maximum annual amount is currently $5,000 per Plan Year if you (this only applies if "statutory maximum" is identified as the maximum manual reimbursement that may be elected under the DCRA):

- Are married and file a joint return;
- Are married but your spouse maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Qualifying Individuals for whom you are eligible to receive tax-free reimbursements under the DCRA; or
- Are single.

If you are married and reside together, but file a separate federal income tax return, the statutory maximum reimbursement amount under the DCRA that you may elect is $2,500.

In no event can you receive tax free reimbursements in excess of your You and Your spouse's earned income (as defined in Code Section 32). If your spouse is incapacitated (as defined by the IRS for DCRA purposes) or a full-time student, your spouse's monthly earned income is deemed to be $250 if you have only 1 Qualifying Child and $500 if you two or more Qualifying Children.

IV. CLAIMS AND APPEAL PROCEDURES

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision.
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their claim or appeal.

V. MID-YEAR ELECTION PERIOD EVENTS

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Salary Reduction that you have elected to allocate to the HCRA and/or the DCRA. That being said, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable Eligibility Requirements. Otherwise, you may change your Pre-tax Salary Reduction elections only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule that you cannot revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) for an election change with the Plan Administrator (or the Third Party Administrator identified in the Plan Information Appendix) within 30 days of experiencing one of the following events. Note that not all of the events apply to HCRA elections.

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

- A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- A change in the number of your tax dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student; and
- A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. With the exception of an election change to the HCRA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage under the Plan. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another

employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.

- *Dependent Care Reimbursement Plan Benefits.* With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights (NOTE: This applies only to HCRA elections and only to the extent that the HCRA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996).** If you, your spouse and/or a dependent are entitled to special enrollment rights under HCRA as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment for yourself or your eligible dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect HCRA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within the 30-day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's HCRA coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such,

you may, subject to the terms of the underlying plan, elect to begin or increase that person's HCRA coverage.

5. **Change in Cost (applies only to DCRA elections)**. If you are notified that the cost of your DCRA coverage under the Plan has *significantly* increased or decreased or will *significantly* increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. For *insignificant* increases or decreases in the cost of DCRA coverage, however, your Pre-tax Salary Reductions will change automatically to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

6. **Change in Coverage (applies only to DCRA elections)**. If your coverage under the DCRA is significantly curtailed, you may revoke your election and either choose another day care provider or drop coverage altogether. Further, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the plan year for this Plan is different from the plan year of the other employer plan.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law**.**

7. **Approved Leave of Absence.** If you take an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

- If you take a paid leave of absence, your participation in the HCRA will continue uninterrupted; however, your coverage in the DCRA will end.
- If you take an approved unpaid leave of absence, you may choose to continue participating in either the HCRA (as applicable) or you may choose to stop participating. If you choose to continue participating, we will withhold your required contributions from your paycheck when you return from the leave. Your coverage in the DCRA will end.
- If your coverage ends during a leave, you will be permitted upon your return in the same Plan Year to (i) reinstate coverage level in effect at the time your participation stopped, reduced by the required contributions that were not made during the leave or (ii) reinstate your prior coverage level without any reductions; however, if you choose this option, we will withhold the contributions that would have otherwise been required during the leave from your paycheck when you return. In both situations, no expenses incurred during the leave of absence are eligible for reimbursement.

Retirement Plans

NHC offers two Retirement Plans. By the federal government's standards and definitions, both are qualified defined contribution plans and are on file with the Department of Labor as such. **The Plans are:**

401(k) Plan

The 401(k) Plan was introduced in 1990 to all NHC and NHC affiliated companies. Partners make contributions to their own individual accounts and their employer adds contributions to their accounts referred to as company matching contributions. The partner contributions come from earnings that are not taxed with federal income taxes.

Each participant chooses how they want their contributions invested within the 6 investment options available. Participants may also choose a target date portfolio as a portion or all of the partner's investment allocation.

This is a RETIREMENT PLAN and the federal government has established 401(k) retirement plans to allow employees to save for their retirement with dollars that are not taxed and allow employers to contribute to their employees' individual retirement accounts.

The federal government's expectation is that funds from 401(k) Plans will be used to supplement Social Security payments when an employee RETIRES from the workforce.

ESOP

The National Health Corporation Leveraged Employee Stock Ownership Plan, more commonly referred to as the "ESOP", is a retirement plan sponsored by National Health Corporation. Various forms of the ESOP have been in place since 1977.

This Plan is specific to National Health Corporation as an employer and the Plan is funded totally by the employer with shares of company related stock.

Since the ESOP is totally funded by company stock of the employer, the only employers and partners that can participate in the ESOP are those for which NHC has ownership.

NHC manages many locations that are owned by an owner /company independent of NHC. Based on federal ESOP regulations the companies are not eligible for participation in the ESOP Retirement Plan.

The section of this Handbook tabbed ESOP will only be applicable to partners who are employed by an NHC owned company. Your Administrator or Supervisor can answer questions related to your ESOP eligibility.

As of December 14, 2009 the ESOP became frozen.

Employer contributions, participant forfeitures and annual additions of new Plan participants ceased for the indefinite duration of the Plan freeze.

All other Plan provisions remain the same.

Current participation in one or both plans can be a valuable addition to your retirement income. Obviously, the more years of participation, the greater the asset for you when you reach retirement.

401(k) Plan

The 401(k) Plan is a retirement savings plan that allows deferring taxes on income and earnings until after retirement. No Federal Income Taxes are withheld on each contribution. However, Social Security Taxes are withheld. Contributions must be made through payroll deduction.

The 401(k) Plan provisions include:

1) All partners (except temporary) who are at least 18 years old or older can contribute to the 401(k) Plan.

2) $10.00 per pay period is the minimum contribution required and a maximum contribution of the lesser of 100% of gross income or $19,500 (2020, adjusted annually for inflation). Contributions are made 26 times per calendar year (26 pay periods). Annual Catch-Up contributions of up to $6,500 are available for plan participants age 50 or over at the end of the calendar year. Maximum contributions are indexed annually.

3) Your employer currently matches every dollar contributed in the 401(k) Plan with an additional 50 cents until the partner contributions reach 2 1/2% of their quarterly wages. The match is invested in NHC stock. The match is made quarterly. The matching contribution will be 100% vested after 3 years of service (paid for 1,000 hours per year). Years of service prior to January 1,1990, which is the effective date of the 401(k) Plan, will not be counted for vesting purposes.

4) Six (6) investment options: (Partner Chooses)

   - NHC Common Stock (non-diversified employer securities)
   - Aggressive Allocation Portfolio
   - Target Allocation Portfolio
   - Diversified Stocks Portfolio
   - Diversified Bonds Portfolio
   - Stable Return Portfolio

5) Target Allocation Portfolios: Partners may also choose a target date portfolio for a portion or all of the partner's investment allocation. Each of the target allocation portfolios is invested in a different mix of the Plan's diversified investment options, and allocations are adjusted over time by the Plan's investment adviser, with longer target dates exhibiting higher risks and volatility. Portfolios are designed to meet broad investment goals, not unique needs and circumstances.

6) The 401(k) plan allows for two different investment selections using the investment options available, including the individual investment options and the Target Allocation Portfolios. The two options for participants' balances are defined below.

   - "**Future Contribution Investments**" applies to all contributions made into the 401(k) Plan, in the future, starting with the first deduction / contribution for new partners and partners without prior plan participation. For partners already participating, the investment change will be effective for all future contributions beginning with the next pay period after the change request is made.
   - "**Current Account Balance Investments**" applies to the account balance at the end of each calendar month. All account balances at the end of the current month will be moved to the new selection at the beginning of the next month after the change request is made.

7) Partners can start, stop, or change their contribution at any time. Investment options can also be changed at any time. Future investment changes will be effective the next payroll processing following receipt. Current account balance investment changes will be effective on the first of the month following receipt of the change.

8) If contributions are stopped, the money remains in the 401(k) Plan until the partner becomes eligible for a distribution.

9) Lump sum rollovers from another qualified pension plan are accepted into the NHC 401(k) Plan immediately after employment starts. However, the money must be eligible for distribution from the prior plan before the NHC 401(k) Plan can accept it. All rollover funds are always 100% vested. The Plan can also accept rollovers from 457 (governmental) Plans as well as IRAs. To "roll" funds into this 401(k) Plan, contact the 401(k) Customer Service Hotline at 1-800-538-3628.
10) Each participant receives a quarterly statement as long as they maintain an account balance.
11) Each account is charged an annual $21.00 administration fee by the 401(k) Plan Recordkeeper. The administration fee will show on the quarterly statement, pro-rated quarterly ($5.25 each quarter).
12) Withdrawals are available based on retirement, termination, age and service, death, and disability and are lump sum withdrawals.
13) Normal retirement age for this 401(k) Plan is 65 and early retirement is age 55 with 10 years of service.
14) When a partner terminates, the vested account balance will be available for distribution as soon as administratively possible after the end of the quarter in which the partner terminates (normally within 8 to 10 weeks after the end of the quarter.)
15) If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of not yet vested benefits.
16) IRS allows the 401(k) Plan to offer loans to plan participants. When offering a loan provision, the 401(k) Plan is legally obligated to follow the rules that IRS has provided. For loan eligibility determinations and applications, contact the NHC 401(k) Customer Service Hotline at 1-800-538-3628.
17) Under certain circumstances, hardship withdrawals are available.
18) The recordkeeping for the 401(k) Plan is administered by The Trust Company of Tennessee in Knoxville, Tennessee. All inquiries about the 401(k) Plan should be made to the NHC 401(k) Customer Service Hotline at 1-800-538-3628.

NHC BENEFITS HOTLINE
Retirement Inquiries
1-800-538-3628

National Health Corporation 401(k) Plan
DESIGNATION OF BENEFICIARY FORM

_____ _____
Partner Name Social Security Number

_____ _____
Address / City / State / Zip Center Name and Location

This designation of beneficiary may be changed at any time. The beneficiary assignment should be reviewed as life changes occur, i.e. marriage, divorce, death, birth or adoption. When making a Beneficiary change, you must change or confirm both your Primary and Contingent Beneficiary designations. Leaving a section blank constitutes an update and will delete any previous Primary or Contingent Beneficiaries you may have on file for this account.

Check One: ___ Single ___ Married (Even if legally separated)

Married Participants - under federal law, if you are currently legally married and you designate anyone other than your spouse as your primary beneficiary, your spouse must sign the spousal consent portion at the bottom of this form in the presence of a notary public. If your spouse does not waive the right to be your Primary Beneficiary, you must list the spouse's name as Primary Beneficiary with complete address information. This Retirement Plan does not recognize (1) common law marriage or (2) any domestic relationship other than marriage that is legally recognized as such by the State of residence.

Non-Married Participants – If you are not married, you should name a Beneficiary to receive your benefit in the event of your death and a Contingent Beneficiary in the event that the Beneficiary you name predeceases you.

If a primary or contingent beneficiary does not survive you, his or her interest and the interests of his or her heirs shall terminate completely, and the percentage share of the remaining beneficiary(s) shall be increased on a pro-rata basis. If no primary or contingent beneficiary survives you and you are not married then the benefits will go to your estate.

Primary Beneficiary(s)

1)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

2)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

Contingent Beneficiary(s)

1)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

2)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

SPOUSE CONSENT OF NON-SPOUSE BENEFICIARY DESIGNATION

I, _____, spouse of _____, approve the designation of _____ as Primary Beneficiary and _____ as Contingent Beneficiary. I understand that I am forfeiting my right to any benefit to which I would be entitled under the Plan pursuant to the Retirement Equality Act.

_____ _____ _____ _____
Spouse's Signature Date Notary Signature Commission Expires

Partner Signature: _____ **Date:** _____

Return completed form to The Trust Company, Attn. NHC, 4823 Old Kingston Pike, Suite 100, Knoxville, TN 37919

NATIONAL HEALTHCARE CORPORATION 401(k) PLAN

SUMMARY PLAN DESCRIPTION

(Reflecting the IRS Required Final EGTRRA Remedial Amendments)

THE NATIONAL HEALTHCARE CORPORATION
401(k) Plan
(The "401(k) Plan")

This section of this Handbook is the general explanation and description of benefits under the National HealthCare Corporation 401(k) Plan.

This is only a summary of the 401(k) Plan. Discrepancies between this section of the Handbook and the actual 401(k) Plan, as well as the resolution of any differences, are governed by the provisions of the actual 401(k) Plan document itself and its related legal instruments. These documents are available from the 401(k) Plan Administrator. National Health Corporation reserves the right to modify, revoke, suspend, terminate or change any or all of the provisions of the 401(k) Plan and the policies under which it is administered at any time. This right can be exercised retroactively in certain circumstances and can be generally implemented with or without advance notice, consultation or reaching agreement with anyone, at any time. However, under federal law, the 401(k) Plan provisions cannot be changed in a way that reduces your then current vested account balance in the 401(k) Plan.

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INTRODUCTION TO THE 401(k)

National HealthCare Corporation 401(k) Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This description of the Plan is a summary of valuable information in the Plan document itself regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this summary to get a better understanding of your rights and obligations under the Plan. You may consult the Plan document itself for more details of the Plan's provisions anytime during regular business hours, but especially you are encouraged to consult the Plan document when you make important decisions about participation and benefits.

We have attempted to answer typical questions you may have regarding your participation and benefits in the Plan. Also please feel free to contact the administrator of the Plan anytime if you have questions. The "administrator" of the Plan as set forth in the Plan document is National Health Corporation, which has appointed a Retirement Plan Committee to administer the day-to-day operations of the Plan in accordance with the Plan document. You may contact the Retirement Committee through the NHC Partner Benefits Department anytime during regular business hours.

This summary attempts to describe the Plan's benefits and obligations as contained in the legal Plan document, which governs the provisions and operation of the Plan—especially as to the beginning and termination of coverage by the 401(k) plan of employers affiliated with National Health Corporation using this Plan document to reflect their own individual plans. The Plan document is written in much more technical, complete and precise legal language. If the non-technical language under this summary SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator through the NHC Partner Benefits Department.

This summary describes the current provisions of the Plan, as designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as ERISA (that is, the "Employee Retirement Income Security Act"), the Internal Revenue Code and other federal and applicable state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service or Department of Labor. We may also amend or terminate this Plan at any time for any reason. If the provisions of the Plan that are described in this summary plan description change, we will notify you.

PARTICIPATION IN THE PLAN

Am I eligible to participate in the Plan?

Provided you are not an "excluded employee" as defined below, you are eligible to participate in the Plan once you satisfy the Plan's eligibility conditions described in the next question. The following employees are "excluded employees" and are not eligible to participate in the Plan:

- employees who are leased employees.
- employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in this Plan.
- employees of an affiliated employer unless such affiliated employer has specifically adopted this Plan document in writing in order to reflect its own 401(k) plan—but only while such adoption is effective (contact the NHC Benefits Department for a current list of such adopting employers that are covered by the Plan).
- employees who are independent contractors under IRS rules.

When am I eligible to participate in the Plan?

Provided you are not an excluded employee as described above, you will be eligible to participate in the Plan once you satisfy the age 18 eligibility requirement.

When is my entry date for participation if I am eligible?

Once again, provided that you are not an excluded employee described above, you may begin participating under the Plan once you have satisfied age 18 eligibility requirement, which is also your "entry date" into the Plan. You will also need to determine contribution and investment information in order to reflect your Plan participation. Your choices must be entered in the Retirement section of the NHC Partner Benefits website, https://nhcpartnerbenefits.com.

What happens if I'm a participant, terminate employment and then I'm rehired?
You will no longer be a participant if your employment terminates for any reason. If you are rehired, then you will begin to participate again in the Plan as of your date of rehire provided you complete the participation form.

CONTRIBUTIONS

What kind of Plan is this?

This plan is a type of retirement plan qualified by the IRS for favorable tax treatment so that taxes on that portion of compensation contributed to the Plan by you or your employer are deferred from immediate taxation. This type of Plan is commonly referred to as a 401(k) plan. In effect, you are deferring your actual receipt of part of your compensation to a later date where benefits are paid. This defers taxes. Such deferrals are called "salary deferrals". Salary deferrals ALWAYS 100 percent belong to you. You yourself choose how much you want to defer as described later.

In addition to salary deferrals, we may make additional contributions to the Plan on your behalf. This section describes the types of contributions that may be made to the Plan and how these monies will be allocated to accounts set up in your name to provide you benefits described herein.

Do I have to contribute money to the Plan in order to participate?

No, you are not required to contribute any money in order to participate in the Plan. However, you may receive additional amounts if you do decide to defer part of your compensation. The reason you will want to consider making as much salary deferral as you prudently can is because your salary deferrals may be matched as described later, and thus may give you an immediate increase on your money in your accounts.

How much may I contribute to the Plan?

As a participant, you may generally elect to defer up to the maximum limit permitted by law instead of receiving that amount in taxable cash. This maximum limit may change each year by law based on inflation rates. In 2020 this maximum limit is $19,500. However, if you are a highly compensated employee the Retirement Committee may at any time limit your deferrals to the Plan in order to ensure that all categories of participants contributing to the Plan are fairly represented. But if your deferrals are going to be limited, the Retirement Committee will contact you to explain how your deferrals as elected by you will be affected.

Since October 1, 2007, as of January 1st of that year and thereafter participants projected to attain age 50 before the end of a calendar year may elect to defer additional amounts of compensation to the Plan (called "catch-up contributions"). Each year such a participant can make these catch-up contributions. The additional catch-up contributions may be deferred regardless of any other limitations on the salary deferrals that you may make to the Plan. The maximum catch-up contribution that you can make in 2020 is $6,500. Each year this maximum catch-up contribution may increase by law for inflation.

The amount you elect to defer, and any earnings on that amount, will not be subject to income tax until it is actually distributed to you as benefits. However, by law all salary deferrals you defer (including catch-up contributions) are counted as compensation for employment taxes in the year in which deferred.

You should also be aware that if an annual dollar limit is exceeded (including because you made salary deferrals under another employer's plan, 403(b) tax sheltered annuity or deferral arrangement of your own), then the excess deferrals must be included in your income for the year. For this reason, it is desirable to request in writing that any such excess salary reduction amounts and catch-up contributions as applicable be returned to you when you are contacted with this opportunity. If you fail to request such a return, you may be taxed a second time when the excess deferral amount is ultimately distributed from the Plan or the other deferral arrangement you are in.

Consequently, you must decide which plan or arrangement you would like to have return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Retirement Committee no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the dollar limit is exceeded in this Plan or any other deferral arrangement you are in, then you will be deemed to have notified the Retirement Committee of the excess as being in this Plan. The excess deferral and any earnings in the Plan will then be returned to you by April 15th.

You will always be 100% vested in ownership rights to the amounts you defer. This means that you will always be entitled to all amounts that you defer. This money will be affected by any investment changes, be they gains or losses. If there is an investment gain, then the balance in your accounts will increase. If there is an investment loss, then the balance in your accounts will decrease.

You may elect to receive an early distribution of your vested accounts once you have attained age 59½. Any earlier in-service distributions from amounts attributable to your salary deferrals would generally not be permitted by law without the imposition of an additional 10% tax. Before attaining age 59½ distributions are permitted only in the following circumstances:

(a) for reasons of being called to active duty as a reservist, and

(b) for reason of proven financial hardship.

(See the questions found in the section of this summary entitled "In-Service Distributions" for an explanation of such distributions.)

The 10% additional tax will not apply on the amount of such distributions, but ordinary income taxes will be assessed on these amounts by the IRS.

In the event you receive a hardship distribution from your deferrals to this Plan pursuant to your certification and the Retirement Committee's agreement that one of the above conditions are satisfied, you will not be allowed to make additional salary deferrals for a period of six (6) months after you receive the hardship distribution because of IRS rules.

Any early distributions from your accounts for hardship or active reservist duty are distributions of retirement benefits, so such distributions will reduce the benefits you ultimately will receive from the Plan.

How often can I modify the amount I contribute?

The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Retirement Committee. The procedure will require that you enter into a written salary deferral agreement after you satisfy the Plan's age 18 eligibility requirement. You will be permitted to modify your election during the year. You are also permitted to revoke your election any time during the year. But by law no elections can be given retroactive effect.

Will contributions be made to the Plan by my employer?

In addition to your own salary deferrals to the Plan, each quarter your employer hopes to make matching contributions to the Plan equal to a uniform percentage of the amount of the salary deferrals you elected. The making of matching contributions and percentage of such matching contributions will be determined by the company on a year by year basis.

Your account will be credited with this matching contribution if you are actively employed anytime during the year.

Furthermore, on behalf of each participant who is NOT a non-highly compensated participant, the company may make under the law something called a "discretionary qualified non-elective contribution" equal to a uniform percentage of that participant's compensation, which percentage also will be determined on a year to year basis.

You will share in this company discretionary qualified non-elective contribution if you are actively employed anytime during the year.

Will I share in such company contributions during the year of my early, normal or late retirement or total and permanent disability or death?

You will be eligible to share in the company contributions for a year if the reason your employment terminated is due to your early, normal or late retirement, total and permanent disability, or in the case of your death during that year.

How will such company contributions be allocated to my account?

All contributions to the extent made will be allocated as of each quarter end to the accounts maintained in your name.

Company matching contributions act as an immediate return on your own salary deferral contributions to the Plan. In addition to company contributions made to your accounts, your accounts will be credited monthly with a share of the actual investment returns on your accounts. These company contribution accounts will vest (that is, your ownership rights will become complete) in accordance with the vesting schedule. (See the question "What is my vested interest in my accounts?" found in this summary entitled "Retirement Benefits" for an explanation of your ownership vesting rights.)

What compensation is used to determine my Plan benefits?

For the purposes of the Plan, compensation has a special meaning. Compensation is defined as your total compensation that is subject to income tax: that is, all of your compensation paid to you by the company during a calendar year, but

- excluding reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits.
- including your salary deferral contributions to any plan or arrangement maintained by your employer.

In the first year of participation in the Plan, your compensation will be recognized for benefit purposes from your entry date into the Plan.

Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize annual compensation each year in excess of a certain dollar limit. The limit for 2020 is $285,000. The dollar limit may increase for inflation adjustments by the IRS each year.

Is there a limit on how much can be contributed to my accounts each year?

Generally, the law imposes a maximum limit on the amount of contributions you may be credited with under the Plan each year. This limit applies to all company matching or qualified non-elective contributions made on your behalf, all salary deferral contributions you make to the Plan (excluding catch-up contributions—which have its own separate legal limit) and any other amounts allocated to any of your accounts during the year, excluding earnings and any transfers/rollovers. For 2020, this total cannot exceed $57,000 or, if less, 100% of your annual compensation. For this purpose, compensation includes your salary deferrals (but excluding any "catch-up contributions"). The IRS may increase the dollar limit for inflation on a year by year basis.

May I roll over payment from another retirement plan or IRA?

At the discretion of the Retirement Committee, a participant may deposit into the Plan distributions received from other retirement plans or IRAs, excluding a ROTH IRA, provided these have not already been included as taxable income to the participant by operation of law. (However, benefits attributable to after-tax employee contributions you make to another employer's retirement plan cannot be rolled over.) Such a deposit is called a "rollover" and may result in tax savings to you. So ask a tax professional about this. You may then ask your prior retirement plan administrator or trustee to directly transfer (called a "direct rollover") to this Plan all or a portion of any amount which you are entitled to receive as a distribution from that other retirement plan or IRA. However, if you actually receive a distribution from a prior retirement plan, you must elect to deposit any amount eligible for rollover within 60 days of your receipt of the distribution. Once again, you should consult a tax professional to determine if a rollover is in your best interest.

The Retirement Committee will confirm for you if the prior retirement plan or IRA may make such a rollover contribution.

Your rollover will be placed in a separate account in your name designated for such rollover. You will always be 100% vested in your ownership rights in "rollovers" and "direct rollovers." This means that you will always be entitled to all of your rollover contributions. Like all other accounts, rollover contributions will be credited or debited with any investment returns.

When you become eligible to receive Plan benefits, the value of your special rollover account will be used to provide additional benefits for you or your designated beneficiary or beneficiaries.

How is the money in the Plan invested?

You will be able to direct the investment of certain contributions to the Plan. The Retirement Committee will provide you from time to time with information on the investment choices available to you, on the frequency with which you can change your investment choices and other related investment information. Periodically, you will receive a benefit statement that provides information on the balance of your accounts and investment returns on those accounts. If you have any questions about the investment of your Plan accounts, please contact the NHC Partner Benefits Department. To the extent you do not direct the investment of your applicable Plan accounts, then your accounts will be invested on your behalf in accordance with the default investment alternatives as established under the Plan. If a default investment is made on your behalf with the default investment alternative, you will be assumed to have chosen this investment option yourself.

When you direct investments, your accounts are segregated for purposes of determining the gains or losses on these investments. You should be assured your accounts do not share in the investment performance for other Participants who have directed their own investments.

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Investment returns will be gains as well as losses, both of which can occur. There are no guarantees of investment performance, and neither your employer, the Retirement Committee, the Trustee, nor any of their representatives provide investment advice or insure or otherwise guarantee the value or performance of any investment you yourself choose or are deemed to have chosen.

RETIREMENT BENEFITS

What benefits will I receive at normal retirement?

Your normal retirement date under the Plan is when you reach your 65th birthday.

You will be entitled to all your accounts under the Plan when you reach your normal retirement age of 65. Actual payment of your benefits will, at your election, begin as soon as administratively feasible following your normal retirement date. If you continue working after your normal retirement date, your benefits will be deferred until you actually retire at a later date.

What benefits will I receive at early retirement?

Your early retirement date is any December 31st following the date you have both attained age 55 and, if later, have also completed 10 years of service with us. You will have completed a year of service if you are credited with at least 1000 hours of service during a calendar year. (See the section in this summary entitled "Hours of Service" for an explanation of what is counted as an hour of service.) You may elect to retire when you reach the early retirement date if you choose.

You will be entitled to all your accounts under the Plan when you reach your early retirement date. Payment of your early retirement benefits will, at your election, begin as soon as administratively feasible following your December 31st early retirement date if you choose to retire. However, if you retire early and the value of your vested benefit is less than $1,000, a distribution will automatically be made to you within a reasonable time after you terminate employment without your request.

What is my late retirement date?

You may remain employed past your normal retirement date and instead retire on a later date. Your late retirement date is then the date you choose to retire after reaching your normal retirement date. On your late retirement date, you will be entitled to all your accounts under the Plan. Actual payment of your benefits will, at your election, begin as soon as administratively feasible following your late retirement date.

What happens if I leave the workforce covered by the Plan before I retire?

The Plan is designed to encourage you to stay with us until retirement. Consequently, payment of your account balances under the Plan is generally available automatically upon your retirement, or if earlier, your disability or death. Your accounts become fully vested on your retirement, disability or death regardless of your credited vesting years of service with the company.

However, if your employment terminates for reasons other than your retirement, you will be entitled to receive only the vested percentage of the balance of your account (other than your own salary deferral account and any rollover account you may have which ARE ALWAYS FULLY VESTED). The term "vested" means full ownership or interest.

You may elect to have your vested interest in your accounts distributed to you as soon as administratively feasible following your termination of employment. Nevertheless, if the value of your vested benefit is less than $1,000, a distribution will be made to you automatically within a reasonable time after you terminate employment. (See the question "How will my benefits be paid?" found in this summary entitled "Form of Benefit Payment" for an explanation of the dollar "cash-out" threshold.)

What is my vested interest in my accounts?

You always will be 100% vested in your salary deferral accounts, your rollover account (if you have one) and all of your company contribution accounts upon your early, normal or late retirement. However, if your service terminates for any reason other than retirement, disability or death, the vested percentage in your company contribution accounts is determined under the following vesting schedule and is based on your vesting years of service.

Vesting Schedule

Vesting Years of Service	Fully Owned Percentage
Less than 3	0 %
3 or more	100 %

Also company matching contributions attributable to your salary deferrals (but not your salary deferrals themselves) in excess of the dollar limit (described in the question in this summary entitled "How much may I contribute to the Plan?" to determine the dollar limit), or matching contributions attributable to salary deferral amounts that are distributed in a corrective distribution to highly compensated employees, will be forfeited as well.

Once again, please remember that regardless of the vesting schedule above, you are always 100% vested in your salary deferrals and any of the company's qualified non-elective contributions contributed to the Plan, as well as your rollover account (if you have one).

Your vested benefit will be distributed to you or your beneficiary or beneficiaries upon your retirement, disability or death as described in this summary.

How do I determine my "years of service for vesting purposes"?

To earn a "year of service", you must be credited with at least 1000 hours of service during a calendar year in which your employer is covered by the Plan. (See the section in this summary entitled "Hours of Service" for an explanation of what is counted as an hour of service.) The plan contains specific rules for crediting hours of service for vesting purposes. The Retirement Committee will track your service and will credit you with a vesting year of service for each calendar year in which you are credited with the required hours of service in accordance with the terms of the Plan. If you have any questions regarding your vesting service, or whether your employer is covered by this Plan (and the period of such coverage) you should contact the NHC Partner Benefits Department.

Does all my service count for vesting purposes?

In calculating your vested percentage, all service you perform for your employer while your employer is covered by the Plan will generally be counted. However, there are some exceptions to this general rule.

Years of service prior to the effective date of coverage under the Plan with respect to your employer will not count for vesting purposes.

Also, there are important "break in service" rules you should note. If you terminate employment and are rehired, you may not be credited for prior service under the Plan's break in service rules as described below.

For vesting purposes, you will have a break in service if you complete less than 501 hours of service during the calendar year. However, if you are absent from work for certain leaves of absence such as maternity or paternity leave, you may be credited with 501 hours of service to prevent a break in service.

As a veteran of the uniformed services, will my military service count as service with my covered employer?

If you are a veteran and are reemployed, then under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with your covered employer. If you may be affected by this law, ask the NHC Partner Benefits Department for further details.

What happens to my non-vested account balance if I'm rehired?

If you have no vested percentage in your company account balance attributable to company contributions when you leave (that is, you were 0% vested), that account balance will be forfeited as of the end of the fifth year thereafter in which you are not eligible to receive an allocation of company contributions.

What happens to the non-vested portion of a terminated participant's account balance?

The non-vested portion of the account which is attributable to company contributions of a participant whose employment terminates remains in the Plan and is called a forfeiture. Forfeitures may be used by the Plan for several purposes such as the payment of the Plan expenses. Any forfeitures not used by the Plan may also be used as company contributions to the Plan.

DISABILITY BENEFITS

How is disability defined?

Under the Plan, disability is defined as a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you incapable of continuing any gainful occupation with your covered employer. This condition must qualify for Social Security disability benefits.

What happens if I become disabled?

If you become disabled while a participant, you will be entitled to 100% of the balance of your accounts. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your vested benefits is less than $1,000, a distribution will be made to you automatically within a reasonable time after you terminate employment.

FORM OF BENEFIT PAYMENT

How will my benefits be paid?

If your vested benefit under the Plan is not greater than $1,000, then your benefit will be automatically "cashed out" to you in a single lump-sum payment as soon as possible following the event that entitles you to a distribution. However, if your vested benefit under the Plan is $1,000 or more, then you must consent to receive the distribution before your 65th birthday, at which point the distribution will automatically be made to you. You may elect to receive a distribution under one of the following methods:

- a single lump-sum payment in cash.
- installments over a period of not more than your assumed life expectancy (or your and your beneficiary's assumed life expectancies).

If the administrative processing fee equals or exceeds a very small benefit amount, the benefit will be $0 to reflect its offset of that administrative fee. A lost participant will also be assessed the administrative fee incurred in finding that lost participant. So always keep the NHC Partner Benefits Department advised of your current address so you do not become a "lost participant".

DEATH BENEFITS

What happens if I die when working while covered by the Plan?

If you die when working while your employer is covered by the Plan, then the entire balance of your accounts will vest and be used to provide your beneficiary or beneficiaries with a death benefit.

Who is the beneficiary of my death benefit?

If you are married at the time of your death, by law your then current spouse at the time of your death automatically will be the beneficiary of the death benefit, unless you make an election to name another person other than your spouse as your beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR THEN CURRENT SPOUSE, YOUR SPOUSE MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE'S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NON-SPOUSE BNEEFICIARY OR BENEFICIARIES TO RECEIVE THE DEATH BENEFIT.

If you are married and you wish to change your beneficiary designation from the beneficiary or beneficiaries your spouse approved, then your spouse must again consent to the change. You may elect a beneficiary or beneficiaries other than your spouse without your spouse's consent only if your spouse cannot be located.

You may designate your beneficiary or beneficiaries on a beneficiary designation form you may get from the NHC Partner Benefits Department through the Retirement section of its website at https://nhcpartnerbenefits.com.

In the event no valid designation of beneficiary exists, or if the beneficiary is not alive at the time of your death, the death benefit will be paid to your estate.

How will the death benefit be paid to a beneficiary?

The death benefit will generally be paid, unless otherwise provided in the next question, to a beneficiary in one of the following methods as elected by the beneficiary (unless you had already elected one of the following forms of distribution for the death benefit prior to your death):

- a single lump-sum payment in cash.
- installments over a period of not more than your beneficiary's IRS expected life expectancy.

When must the last payment be made to a beneficiary?

Regardless of the method of distribution selected, if your designated beneficiary is a person (rather than your estate or certain types of trusts) then minimum annual distributions of your death benefit will begin by the end of the year following the year of your death ("1-year rule") and must be paid over a period not extending beyond your beneficiary's life expectancy. If your spouse is the beneficiary, then under the "1-year rule," the start of payments will be delayed until the year in which you would have attained age 72 had you lived, unless your spouse elects to begin distributions over his or her own IRS life expectancy before then. However, instead of the "1-year rule" your beneficiary may elect to have the entire death benefit paid by the end of the fifth year following the year of your death (the "5-year rule"). Generally, if your beneficiary is not a person, your entire death benefit must be paid under the "5-year rule."

Since your then current spouse has an exclusive right to your death benefit, you should immediately report any change in your marital status (for example, on marriage or divorce) to the NHC Partner Benefits Department.

What happens if I'm a participant, terminate employment and die before receiving all of my benefits?

If you terminate employment while covered by the Plan and subsequently die, your beneficiary or beneficiaries then will be entitled to the vested percentage as of your termination of employment of your remaining balance of your accounts.

IN-SERVICE DISTRIBUTIONS

Can I withdraw money from my accounts while working?

You will be entitled to receive a pre-retirement in-service distribution of the vested balances in your accounts if you have reached age 59½. However, any distribution will reduce the value of the benefits you will receive at any later date. This pre-retirement in-service distribution is made at your election.

Can I withdraw money from my accounts if I am a reservist called to active duty?

Starting January 1, 2010, if you are a reservist called to active duty for 179 days or more (or indefinitely) after the 9/11 terrorist attacks, you may elect to make an in-service withdrawal of your own salary deferrals from the Plan. Also starting January 1, 2010, if you are on duty for more than 30 days you may elect to make an in-service withdrawal, but in this case (unlike the 179 day or more in-service withdrawal just described) when you return to work by law you may not make salary deferrals to the Plan for six months once you begin again to participate in the Plan. (Company contributions are not available for withdrawal for either of these reservist withdrawal provisions.) Reservist distributions will reduce the value of benefits the reservist is eligible to receive at a later date. However, a reservist who receives such a distribution may repay all or a portion of the distributed salary deferrals or rollover any time throughout the 2-years following the end of the active duty period and thereby reestablish his or her salary deferral or rollover accounts.

Can I withdraw money from my account in the event of financial hardship?

Yes, if you satisfy certain conditions the Retirement Committee may direct the Trustee to distribute up to 80% of the balance in your accounts attributable to your salary deferrals or 100% of your rollover/transfer (if you have one) in the event of hardship. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at your termination of employment, early in-service post-age 59½ withdrawal, retirement, death or disability.

What constitutes a hardship?

A hardship is allowed only on account of an immediate and heavy financial need, which is caused by one of the following:

(a) expenses for medical care previously incurred by you, your spouse or your dependent or your designated beneficiary (or beneficiaries) under the Plan, or necessary for you or any of the above to obtain medical care;

(b) costs directly related to the purchase of your principal residence (excluding mortgage payments);

(c) tuition, related educational fees, and room and board expenses for the next twelve months of post-secondary education for yourself, your spouse or dependent, or your designated beneficiary (or beneficiaries) under the Plan;

(d) amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence;

(e) payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents; and

(f) expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code.

Are there any conditions to receiving a hardship distribution?

A distribution will be made from the above accounts, but only if you certify that **ALL** of the following conditions are satisfied:

(a) The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the hardship distribution.

(b) You have obtained all distributions, other than hardship distributions, and all nontaxable (at the time of the loan) loans currently available under any other plan maintained by your covered employer.

(c) That your elective salary deferral contributions, with respect to hardship distribution after December 31, 2001, will be suspended for at least six months after your receipt of the hardship distribution.

TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution (other than a loan) in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution.

Can I reduce or defer tax on my distribution?

You may reduce or defer the tax due on your distribution through use of one of the following methods:

(a) The rollover of all or a portion of the distribution to a regular traditional Individual Retirement Account (IRA) or to another qualified employer plan. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, the direct transfer option described in paragraph (b) below might be the better choice for you.

(b) For most distributions, you may request that a direct transfer of all or a portion of a distribution be made to either a regular IRA or another qualified employer plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the regular IRA or other qualified employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer, e.g., a distribution of less than $200 will not be eligible for a direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld by law for federal income tax purposes.

WHENEVER YOU RECEIVE A DISTRIBUTION, THE RETIREMENT COMMITTEE WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATEMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH A QUALIFIED TAX ADVISOR BEFORE MAKING A CHOICE.

HOURS OF SERVICE

What is an "hour of service"?

You will be credited with an hour of service for:

(a) each hour for which you are directly or indirectly compensated while covered by the Plan for the performance of duties during the calendar year;

(b) each hour for which you are directly or indirectly compensated while covered by the Plan for reasons other than performance of duties (such as vacation, holidays, sickness, disability, military duty, jury duty or leave of absence during the year); and

(c) each hour for back pay awarded or agreed to by the Plan.

You will not be credited for the same hours of service both under (a) or (b), as the case may be, and under (c).

How are hours of service credited?

You will be credited with your actual hours of service.

LOANS

May I borrow money from the Plan?

Yes. You may request a participant loan by calling the NHC Retirement Hotline at 1-800-538-3628. Your ability to obtain a participant loan depends on several factors. The Retirement Committee determines whether you satisfy these factors.

What are the loan rules and requirements?

There are various rules and requirements that apply for any loan which are outlined in this question. In addition, we have established a written loan program which explains these requirements in more detail. You can request a copy of the loan program by calling the NHC Retirement Hotline at 1-800-538-3628. The rules for loans include the following:

- Loans are available to participants on a reasonably equivalent basis. Loans will be made to participants who are creditworthy. The Retirement Committee may request that you provide additional information, such as financial statements, tax returns and credit reports to make this determination.
- All loans must be adequately secured. You must sign a promissory note along with a loan pledge. You must use the vested balance in your accounts as security for the loan, provided the outstanding balance of all your loans does not exceed 50% of your vested balance. In certain cases, the Retirement Committee may require you to provide additional collateral to receive a loan.

- You will be charged a reasonable rate of interest for any loan received from the Plan. The Retirement Committee will determine a reasonable interest rate by reviewing the interest rates charged for similar types of loans by other lenders.
- If approved, your loan will provide for level amortization with payments to be made not less frequently than quarterly. Generally, the term of the loan may not exceed five (5) years. However, if the loan is for the purchase of your principal residence, the Retirement Committee may permit a longer repayment period. Generally, the Retirement Committee will require that you repay your loan by agreeing to payroll deduction. If you have an unpaid leave of absence or go on military service leave while you have an outstanding loan, please contact the NHC Retirement Hotline at 1-800-538-3628 to find out your repayment options.
- All loans will be considered a directed investment from your account under the Plan. All payments of principal and interest by you on a loan will be credited to your accounts.
- The amount the Plan may loan to you is limited by rules under the Internal Revenue Code. All loans, when added to the outstanding balance of all other loans from the Plan, will be limited to the lesser of:

  (a) $50,000 reduced by the excess, if any, of your highest outstanding balance of loans from the Plan during the one-year period prior to the date of the loan over your current outstanding balance of loans; or

  (b) 1/2 of your vested balance in your accounts.

  Also, no loan in an amount less than $1,000 will be made nor will a loan be made if a prior loan is currently outstanding.
- If you fail to make payments when they are due under the terms of the loan, you will be considered to be "in default." The Trustee will consider your loan to be in default if any scheduled loan repayment is not made by the end of the calendar quarter following the calendar quarter in which the missed payment was due. The Plan would then have authority to take all reasonable actions to collect the balance owing on the loan. This could include filing a lawsuit or foreclosing on the security for the loan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan and could result in taxable income to you. In any event, your failure to repay a loan will reduce the benefit you would otherwise be entitled to from the Plan.
- The loan application fee is $75.00, and there is an annual maintenance fee of $25.00.

YOUR PLAN'S TOP HEAVY RULES

What is a top heavy plan?

A retirement plan that primarily benefits "key employees" is called a "top heavy plan." Key employees are certain owners or officers. A plan is generally a "top heavy plan" when more than 60% of the Plan assets are attributable to such key employees.

Each year, the Retirement Committee is responsible for determining whether the Plan is a "top heavy plan."

What happens if the Plan becomes top heavy?

If this Plan becomes top heavy in any Plan Year, then the company may be required to make a contribution on behalf of non-key employees in order to provide such employees with at least "top heavy minimum benefits" for the year.

PROTECTED BENEFITS AND CLAIMS PROCEDURES

Is my benefit protected?

As a general rule, your interest in your accounts, including your vested interest, may not be "alienated". This means that your interest may not be sold, used as collateral for a loan (other than a Plan loan), given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your accounts.

Are there any exceptions to the general rule?

There are two exceptions to the general rule. The Retirement Committee must honor a "qualified domestic relations order." A qualified domestic relations order is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, child or other dependent. If a qualified domestic relations order is received by the Retirement Committee, all or a portion of your benefits may be used to satisfy the obligation. The Retirement Committee will determine the validity of any domestic relations order received. You and your beneficiaries can obtain, without charge, a copy of the QUALIFIED DOMESTIC RELATIONS ORDER PROCEDURE from the NHC Retirement Hotline at 1-800-538-3628.

The second exception applies if you are involved with the Plan's administration. If you are found liable for any action that adversely affects the Plan, the Retirement Committee can offset your benefits by the amount you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

Can the Plan be amended?

Yes. National Health Corporation has the right to amend the Plan for any reason at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your accounts.

What happens if the Plan is discontinued or terminated?

Although National Health Corporation intends to maintain the Plan indefinitely, it reserves the right to terminate the Plan for any reason at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. Distribution of accounts will be made in the manner permitted by the Plan as soon as practicable. (See the question "How will my benefits be paid?" found in the section of this summary entitled "Form of Benefit Payment.") Furthermore, if your employer is an affiliated employer using this National Health Care Plan document to reflect its own 401(k) Plan (that is, your employer is a covered employer), then if your covered employer becomes no longer affiliated with National Health Care, your coverage under this Plan document will automatically immediately terminate, (as will your employment for purposes of the Plan) unless your employer uses another tax qualified 401(k) document to reflect its plan.

How do I submit a claim for Plan benefits?

Benefits will be paid to you and your beneficiaries without the necessity of formal claims. However, if you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Retirement Committee.

If the Retirement Committee determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Retirement Committee will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Retirement Committee, unless the Retirement Committee determines that special circumstances require an extension of time for processing your claim. If the Retirement Committee determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90 day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

The Retirement Committee's written or electronic notification of any adverse benefit determination must contain the following information:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination is based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure in the next question.

What is the claims review procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Retirement Committee.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN OR ELECTRONIC NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

(b) You may submit written comments, documents, records, and other information relating your claim for benefits.

(c) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Retirement Committee will provide you with written or electronic notification of the Plan's benefit determination on review. The Retirement Committee must provide you with notification of this denial within 60 days after the Retirement Committee's receipt of your written claim for review, unless the Retirement Committee determines that special circumstances require an extension of time for processing your claim. If the Retirement Committee determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60 day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. In the case of an adverse benefit determination, the notification will set forth:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination is based.

(c) 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 your claim for benefits.

If you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or Federal court.

What are my rights as a Plan participant?

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 all Plan participants are entitled to:

(a) Examine, without charge, at the NHC Partner Benefits Department during regular business hours and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Retirement Committee, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Retirement Committee may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Retirement Committee is required by law to furnish each participant with a copy of this summary annual report.

(d) Obtain a statement telling you whether you have a right to receive a retirement benefit at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a retirement benefit, the statement will tell you how many years you have to work to get a right to such a benefit. THIS STATEMENT MUST BE REQUESTED IN WRITING AND IS NOT REQUIRED TO BE GIVEN MORE THAN ONCE EVERY TWELVE (12) MONTHS. The Plan must provide this statement free of charge.

In addition to creating rights for Plan participants, the law called the Employee Retirement Income Security Act (or "ERISA") imposes duties upon the people who are responsible for the operation of the 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 pension benefit or exercising your rights under ERISA which governs the Plan.

If your claim for a pension 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 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 Retirement Committee to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Retirement Committee.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state of Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the qualified domestic relations order (or "QDRO") procedures from the NHC Partner Benefits Department.

If it should happen that the Plan's 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 if, for example, it finds your claim is frivolous.

What can I do if I have questions or my rights are violated?

If you have any questions about the Plan, you should contact the Retirement Committee. If you have any questions about this summary or about your rights under ERISA, or if you need assistance in obtaining documents from the NHC Partner Benefits Department, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries. 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 Employee Benefits Security Administration.

PLAN EXPENSES

The Plan permits the payment of Plan expenses to be made from the Plan assets. If we do not pay these expenses from the company's own assets, then the expenses paid using the Plan's assets will generally be allocated among the accounts of all participants in the Plan. These expenses will be allocated either proportionately based on the value of the account balances or as an equal dollar amount based on the number of participants in the Plan. The method of allocating the expenses depends on the nature of the expense itself. For example, certain administrative (or recordkeeping) expenses would typically be allocated proportionately to each participant. For example, if the Plan pays $1,000 in expenses and there are 100 participants, your account balance would be charged $10 ($1,000 divided by 100 equals $10) of the expense.

After you terminate employment with your covered employer, the right is reserved to charge your account for your pro rata share of the Plan's administration expenses, regardless of whether some of these expenses are paid on behalf of current employees.

There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because these expenses are directly attributable to you under the Plan. The Retirement Committee will inform you when there will be a charge (or charges) directly to your account.

The Plan may, from time to time, change the manner in which expenses are allocated.

GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this section.

General Plan Information

National HealthCare Corporation 401(k) Plan is the name of the Plan.

The Plan has been assigned Number 003.

The amended and restated provisions of the Plan became effective on January 1, 2013.

The Plan's records are maintained on a twelve-month period of time. This is known as the "Plan Year". The Plan Year is the calendar year beginning on January 1 and ending on December 31.

Certain valuations and distributions are made on the "Anniversary Date" of the Plan. This date is the last day of the Plan Year.

The contributions made to the Plan will be held and invested by the Trustee of the Plan.

The Plan and Trust will be governed by the laws of the State of Tennessee to the extent not preempted by ERISA.

Benefits provided by the Plan are provided from your accounts as described under the Plan document. This is not the type of plan which must be insured by the Pension Benefit Guaranty Corporation because the insurance provisions under the Employee Retirement Income Security Act are not applicable to the 401(k) plans like this Plan.

Employer Information

The Employer which has adopted the legal document reflecting the Plan is sponsored by:

National Health Corporation
100 Vine Street
Murfreesboro, Tennessee 37130
EIN: 62-1294263

National Health Corporation has adopted this Plan as an employer. The Plan document allows certain other employers on their own to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of such employers, if any, who have adopted the Plan at any time during regular business hours by making a written request to the Retirement Committee.

Administrator Information

The Retirement Committee is responsible for the day-to-day administration and operation of the Plan. For example, the Retirement Committee maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation and directs the payment of your account at the appropriate time. The Retirement Committee will also allow you to review the formal National Health Corporation Plan document and certain other materials related to the Plan. If you have any questions about the Plan and your participation, you should contact the Retirement Committee through the Benefits Department. The Administrator of the Plan, however, is National Health Corporation, it has just authorized the Retirement Committee to perform its day-to-day duties as the Administrator. If for any reason the Retirement Committee is vacant, then references in this summary will mean National Health Corporation itself.

The Administrator itself shall have the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply, and interpret the Plan document, its associated Trust and any other Plan documents, instruments or communications, and to decide all matters arising in connection with the operation or administration of the Plan document and its associated Trust, as well as the investment of the Plan assets. Without limiting the generality of the foregoing, the Administrator shall have the sole and absolute discretionary authority:

(1) to take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

(2) to formulate, interpret and apply rules, regulations and policies necessary to administer the Plan;

(3) to decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

(4) to resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan, its associated Trust or other Plan documents, instruments or communications; and

(5) except as specifically provided to the contrary in the Plan document itself, to process, and approve or deny, benefit claims and rule on any benefit exclusions, and determine the manner and timing of benefit payments.

All determinations made by the Administrator with respect to any matter arising under the Plan, its associated Trust, and any other Plan documents, instruments or communications shall be final and binding on all parties. Benefits under this Plan will be paid only if the Plan Administrator decides in its sole and exclusive discretion that the applicant is entitled to such benefits.

The name, address and business telephone number of both the Retirement Committee and the Administrator are:

National Health Corporation
100 Vine Street
Murfreesboro, Tennessee 37130
(615) 890-2020

You can also contact the Retirement Committee through the NHC Partner Benefits Department.

Trustee Information

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund. The trust fund established by the Trustee will be the funding medium used for the accumulation of assets from which benefits will be distributed.

The name of the Plan's Trustee is:

The Trust Company of Tennessee, Inc.

The principal place of business of the Plan's Trustee is:

4823 Old Kingston Pike, Suite 100
Knoxville, Tennessee 37919

Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

The Retirement Committee of the National HealthCare Corporation 401(k) Plan
100 Vine Street
Murfreesboro, Tennessee 37130

Service of legal process may also be made upon the Trustee.

Plan Notices

All notices made by the Plan may be delivered by electronic media.

AS OF DECEMBER 14, 2009, THE NATIONAL HEALTH CORPORATION LEVERAGED EMPLOYEE STOCK OWNERSHIP PLAN (ESOP) WAS FROZEN.

EMPLOYER CONTRIBUTIONS, PARTICIPANT FORFEITURES AND ANNUAL ADDITIONS OF NEW PLAN PARTICIPANTS CEASED FOR THE INDEFINITE DURATION OF THE PLAN FREEZE.

THE PLAN WAS AMENDED ON DECEMBER 14, 2009 TO REFLECT THE FROZEN PLAN STATUS.

ALL OTHER PLAN PROVISIONS REMAIN THE SAME AS SUMMARIZED IN THE SUMMARY PLAN DESCRIPTION.

ESOP (National Health Corporation Leveraged Employee Stock Ownership Plan)

The ESOP is a retirement plan that is fully funded by your employer. It is available ***only*** to eligible partners whose employers are owned companies of NHC.

- The employer is responsible for all annual Plan contributions. There are no partner contributions, meaning that money is never deducted from your paycheck for the ESOP. The ESOP was "frozen" as of December 14, 2009. In compliance with Federal Regulations there will be no contributions for the duration of the frozen plan status.
- A partner must be paid at least 1,000 hours of service, annually, to receive an annual contribution, when applicable.
- A year of service is defined as a payroll year (stops with the final payroll ending date of the calendar year, which may be prior to 12/31) with at least 1,000 hours of service.
- All partners with account balances became 100% vested on December 14, 2009. The prior vesting schedule is not applicable for the duration of the frozen plan status.
- Each participant receives an annual statement.
- The partner, if vested, will receive the full value of the account after retirement. Normal retirement age for the ESOP is 65 and early retirement is age 55 with at least 10 full years of participation in the ESOP Plan. Distributions are made once annually for previous year retirees and other eligible ESOP participants.
- Withdrawals can be one lump sum or paid out over a 5 year period. The entire vested account balance can remain in the ESOP plan indefinitely except for the required age related distributions starting at age 72. Vested account balances will continue to receive the annual plan revaluing. The account value can increase or decrease annually based on the value of all NHC related stock performances, as well as NHC's profitability for the year.
- Participants who leave their employment for reasons other than retirement, death, or disability must have a one year break in service before their vested account balance can be withdrawn. A break in service is a calendar year in which a participant is paid for or receives credit for less than 500 hours. Distributions for reasons other than retirement, death or disability will be made in the year following the break in service.
- Distributions of vested account balances for retirement and terminations are made midyear following the ESOP plan year in which the eligible event occurs.

  Example: Partner retires (age 65 or age 55 with at least 10 years of plan participation) on May 1. Funds will be available midyear, of the following calendar year. (No break in service required, regardless of paid hours in year of termination).

  Partner terminates employment on August 21 and has been paid for 1,201 hours. Funds will be available midyear, of the second calendar year following termination. Termination distributions require at least a 1 year break in service (calendar year of less than 500 hours).

- Death and disability distributions are made (with proper qualifying documents) as the event occurs.
- If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination and may result in the forfeiture of earned benefits.
- The ESOP Plan is valued annually. The account balance only changes annually. The value of each ESOP account can either increase or decrease annually based on stock market prices and other business evaluations. All distributions are made based on the account value as of the prior plan year end.

NHC BENEFITS HOTLINE — 1-800-538-3628

National Health Corporation ESOP Plan
DESIGNATION OF BENEFICIARY FORM

_____ _____
Partner Name Social Security Number

_____ _____
Address / City / State / Zip Center Name and Location

This designation of beneficiary may be changed at any time. The beneficiary assignment should be reviewed as life changes occur, i.e. marriage, divorce, death, birth or adoption. When making a Beneficiary change, you must change or confirm both your Primary and Contingent Beneficiary designations. Leaving a section blank constitutes an update and will delete any previous Primary or Contingent Beneficiaries you may have on file for this account.

Check One: ___ Single ___ Married (Even if legally separated)

Married Participants - under federal law, if you are currently legally married and you designate anyone other than your spouse as your primary beneficiary, your spouse must sign the spousal consent portion at the bottom of this form in the presence of a notary public. If your spouse does not waive the right to be your Primary Beneficiary, you must list the spouse's name as Primary Beneficiary with complete address information. This Retirement Plan does not recognize (1) common law marriage or (2) any domestic relationship other than marriage that is legally recognized as such by the State of residence.

Non-Married Participants – If you are not married, you should name a Beneficiary to receive your benefit in the event of your death and a Contingent Beneficiary in the event that the Beneficiary you name predeceases you.

If a primary or contingent beneficiary does not survive you, his or her interest and the interests of his or her heirs shall terminate completely, and the percentage share of the remaining beneficiary(s) shall be increased on a pro-rata basis. If no primary or contingent beneficiary survives you and you are not married then the benefits will go to your estate.

Primary Beneficiary(s)

1)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

2)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

Contingent Beneficiary(s)

1)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

2)

_____ _____%
Name Share

_____ _____
Relationship Social Security Number

_____
Address

_____
City / State / Zip

SPOUSE CONSENT OF NON-SPOUSE BENEFICIARY DESIGNATION

I, _____, spouse of _____, approve the designation of _____ as Primary Beneficiary and _____ as Contingent Beneficiary. I understand that I am forfeiting my right to any benefit to which I would be entitled under the Plan pursuant to the Retirement Equality Act.

_____ _____
Spouse's Signature Date Notary Signature Commission Expires

Partner Signature: _____ **Date:** _____

Return completed form to The Trust Company, Attn. NHC, 4823 Old Kingston Pike, Suite 100, Knoxville, TN 37919

THE NATIONAL HEALTH CORPORATION
LEVERAGED EMPLOYEE STOCK OWNERSHIP PLAN

This section of this Handbook is the general explanation and description of benefits under the National Health Corporation Leveraged Employee Stock Ownership Plan (the "ESOP").

This is only a summary of the ESOP. Discrepancies between this section of the Handbook and the actual ESOP, as well as the resolution of any differences, are governed by the provisions of the actual ESOP document itself and its related legal instruments. These documents are available from the ESOP Plan Administrator. National Health Corporation reserves the right to modify, revoke, suspend, terminate or change any or all of the provisions of the ESOP and the policies under which it is administered at any time. This right can be exercised retroactively in certain circumstances and can be generally implemented with or without advance notice, consultation or reaching agreement with anyone, at anytime. However, under federal law, the ESOP provisions cannot be changed in a way that reduces your then current vested account balance in the ESOP.

Revised July 1, 2010

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INTRODUCTION TO THE ESOP

This is a summary of the important provisions of the National Health Corporation Leveraged Employee Stock Ownership Plan, or ESOP. The ESOP was adopted on January 1, 1988 and that same year the National Health Corporation and Subsidiaries Employees Stock Purchase Plan was merged into the ESOP. The ESOP is intended to help you build benefits for your retirement.

The ESOP has fully repaid the loans that it used to purchase shares of National Health Corporation and was "frozen" as of December 14, 2009. No new Participants are eligible to enter the ESOP on or after this date. In addition, the ESOP account balances of all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of January 1, 2009. Benefits payable under the ESOP will continue to be paid at the time and in the manner described in this section of the handbook. The word "you" refers to all partners who became ESOP Participants prior to December 14, 2009.

WHO IS ELIGIBLE FOR THE ESOP?

The ESOP was "frozen" as of December 14, 2009. No new Participants are eligible to enter the ESOP on or after that date.

All partners of National Health Corporation and partners of business organizations affiliated with the Company which were authorized to adopt, and did adopt, the ESOP were eligible to participate in the ESOP. For ease of communication, National Health Corporation and these affiliated business organizations are called collectively "the Company" in this Section of the Handbook.

If you were a partner of the Company on January 1, 1988, you automatically were a Participant in the ESOP. Additionally, all participants in the National Health Corporation and Subsidiaries Employee Stock Ownership Plan automatically became Participants in the ESOP as a result of the merger of that plan into the ESOP. All other partners became Participants on the first day of the month coincident with or next following the performance of their first "Hour of Service" (as explained below) for the Company prior to December 14, 2009. Partners covered by collective bargaining agreements in which retirement benefits were the subject of good faith bargaining were not covered by the ESOP, unless the collective bargaining agreement specifically provided for coverage. Leased partners also were not eligible to participate in the ESOP.

HOW THE ESOP GENERALLY WORKS

The ESOP holds assets in a special related trust (the "Trust") which is tax-exempt. Individual Accounts are set up within the Trust in each Participant's name and these Accounts reflect each individual Participant's ESOP benefits.

The ESOP borrowed money to buy common stock of National Health Corporation ("Company Stock") which was deposited in the Trust. The Company Stock in the Trust which was bought with borrowed money was held in a suspense account in the ESOP while the loan was being repaid. While the loan was outstanding, as the Company contributed to the ESOP each year, the Company contributions paid off the loan and the Company Stock acquired with the borrowed money was released from the ESOP suspense account as the loan was paid off for allocation among Participants' Accounts. The ESOP fully repaid the loans that it used to purchase shares of Company Stock and was "frozen" as of December 14, 2009. You were not required or permitted to make any contributions to the ESOP.

Voting on the Company Stock in your Account is passed through to you in certain major corporate events.

The bookkeeping of the ESOP is kept on a yearly basis. This is called the "Plan Year". The Plan Year is a period consisting of 26 or 27, as the case may be, biweekly payroll periods of National Health Corporation with the last such payroll period ending nearest to (and prior to) December 31.

In order to have received an allocation of Company Stock or other Company contributions under the ESOP for a Plan Year, you must have been credited with 1,000 or more Hours of Service in that Plan Year. Hours of Service are strictly defined by the law. Of course, the hours you actually worked for the Company were counted as Hours of Service. You also got credit for certain times you were not at work for the Company, such as vacation, holidays, sickness, layoffs or disability leave. You also got credit because of a back pay award at the Company, but in no case did you get credit twice for the same time period with the Company. As required by law, you may also have gotten credit for certain periods in which you were absent from work with the Company and did not get paid, but these instances are limited to events like jury duty or military service. Because the law places many technicalities on the measurement of service, you should contact the Plan Administrator if you have any questions.

WHAT IS IN IT FOR YOU?

For purposes of the ESOP, the term "Compensation" means the total compensation you received from the Company for the applicable Plan Year that was subject to FICA tax. Your Compensation was determined as if there was no dollar limit on the amount of income on which FICA taxes were payable. Your Compensation included overtime pay, bonus payments and commissions. It also included your contributions to our 401(k) Plan and your contributions to our Internal Revenue Code Section 125 flexible benefit or cafeteria plan. Prior to January 1, 1996, nonqualified deferral compensation was also considered part of your Compensation, and prior to January 1, 1997, tax law required that the Compensation of your spouse, or son or daughter under age 19, who works here was included in your Compensation if you were a very highly compensated partner. Also as a matter of law, Compensation above certain limits was not counted for purposes of the ESOP. That limit was $245,000 in 2009 (the year in which the ESOP was frozen and all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of January 1, 2009) and is adjusted for inflation as time goes by. Also, only the Compensation you make while you are an ESOP Participant is counted for purposes of the ESOP.

Your ESOP Account's share of the Company Stock, Company contributions or other assets allocated each Plan Year were allocated to your ESOP Account based on the percentage that your Compensation for the Plan Year was to the total Compensation of all the ESOP's Participants to share in the allocation that Plan Year. In other words, your share is a fraction where the top number of the fraction was your Compensation and the bottom number of the fraction was the total of Compensation of all partners entitled to share in the allocation for that Plan Year. Dividends paid on Company Stock in the ESOP suspense account in a Plan Year were allocated the same way each Plan Year. In other words, your percentage of dividends paid on Company Stock in the ESOP suspense account was the same as your percentage of Company Stock, Company contributions and other assets allocated that Plan Year. Your share of any ESOP forfeitures were also calculated the same way. Dividends paid on Company Stock already allocated to your Account for the entire Plan Year were allocated to your Account.

For instance, let's say you became an ESOP Participant in a Plan Year prior to the freeze and made $10,000 working full time. Let's assume you were credited with at least 1,000 Hours of Service in that Plan Year and you were employed by the Company on the last day of the Plan Year. Also assume that the total Compensation of all Participants in that Plan Year amounted to $60,000,000. This means that your share or allocations for that Plan Year would be determined by dividing your Compensation of $10,000 by $60,000,000. Consequently, your share or allocation for that Plan Year would equal .0167%. Your ESOP Account would also be credited with .0167% of the dividends paid on Company Stock held in the ESOP suspense account. Your ESOP Account would be credited with .0167% of ESOP forfeitures for that Plan Year and all of the dividends paid on Company Stock held in your Account the entire Plan Year.

The ESOP Committee also reserved the right to distribute dividends to all Participants rather than credit those dividends to Participants' Accounts. Such a distribution would have been made within 90 days after the end of the Plan Year the dividends were paid.

With everyone's hard work, as the value of Company Stock increases, so will the value of your Company Stock Sub-Account. Any earnings or loses from other investments each Plan Year are allocated pro-rata among Participants' Other Investment Sub-Accounts based on each Participant's Other Investment Sub-Account balance.

THE COMPANY'S COMMITMENT

Through the Company's commitment to contribute an annual amount to the ESOP, the ESOP was able to repay the loan that it used to purchase Company Stock, as well as the interest payments due on the loan. Once the loan was repaid, neither the making of further contributions to the ESOP nor the payment of future dividends on the ESOP's shares of Company Stock was required and the Company decided against making and/or paying any *discretionary* contributions or dividends to the ESOP. The ESOP therefore was frozen as of December 14, 2009.

BENEFITING FROM THE ESOP

The ESOP account balances of all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of that date. Being fully vested means you are entitled to the full value of your ESOP Account which can be paid at the time and in the manner described in this section of the handbook.

HOW DO YOU KNOW WHAT YOUR ESOP ACCOUNT IS WORTH?

As of each December 31st, all Participant ESOP Accounts will be valued. This is called the ESOP's "Valuation Date".

Each Plan Year the ESOP retains an independent appraisal company which has knowledge and expertise in appraising the ESOP assets. The appraiser arrives at a "fair market value" of each share of Company Stock in your Account as of December 31st. There are many, many factors which are taken into account by the appraising company, some of which are the value of the National HealthCare Corporation stock shares owned by the Company, the real estate value of the healthcare properties owned by the Company, and the operational value of the healthcare centers, assisted living centers, retirement centers, homecare offices and other affiliated companies, which is, of course, very dependent upon creating and maintaining excellence in performance by all partners. The ESOP has securities which are valued at the trading price of National HealthCare Corporation stock shares, as well as securities that were acquired with borrowed money. As that borrowed money was repaid by Company contributions, the repayment had positive effects on the value of the securities. Your year-end "Statement of Account" takes all of these values into account and is the annual basis for any distributions to which you may become eligible. The value of your Account on each Plan Year's Valuation Date will be reported to you approximately five months after the end of the Plan Year. Any distribution under the ESOP may be delayed so that the value of your Account may be determined.

BENEFITS ON RETIREMENT

As a Participant in the ESOP, you are entitled to receive the full value of your ESOP Account coincident with or immediately following your "Normal Retirement Date". Your Normal Retirement Date is the date you attain age 65. You may also retire prior to your Normal Retirement Date and receive the full value of your ESOP Account as of the Valuation Date coincident with or immediately following your "Early Retirement Date". Your Early Retirement Date is the date you have both attained age 55 and been credited with at least 10 full Years of Vesting Service. You are fully vested at either retirement date regardless of your credited Years of Vesting Service.

You may work past your Normal Retirement Date. If you do, you will continue to participate in the ESOP and you may elect to receive an in-service distribution of all or a portion of your ESOP Account on each succeeding Valuation Date. Once you do retire, you will be entitled to receive the full value of your ESOP Account coincident with or immediately following your termination of employment (your "Delayed Retirement Date") less any in-service distributions you already received or are scheduled to receive. If you still have a balance in your ESOP Account past age 72, the law may require the ESOP to begin distribution of benefits to you.

PRE-RETIREMENT DISTRIBUTION RIGHT

If you have attained age 55 and have been credited with at least 10 full years of participation in this ESOP by the beginning of a Plan Year, then you have the right to elect a distribution of your ESOP Account balance in that Plan Year. This is referred to as a "Pre-Retirement Distribution Right". The election period is the first 90 days in that Plan Year. The Pre-Retirement Distribution Right begins with the first Plan Year after you reach age 55 and have been credited with 10 years of participation in the ESOP and ends with the fifth Plan Year thereafter. For example, if you first become eligible to elect a Pre-Retirement Distribution in the Plan Year beginning January 1, 2010, you will be entitled to elect a Pre-Retirement Distribution in the period January 1, 2010 through March 30, 2010. If you elect such distribution, the distribution will be made within 90 days after the end of the 90 day election period at the beginning of the Plan Year. The amount which may be elected for distribution during the first such election period is 25% of your Account balance. The amount which may be elected for distribution upon future elections, during successive election periods, is determined by multiplying your Account balance (including amounts which have been previously distributed to you in Pre-Retirement Distributions) by 25% or, with respect to your fifth and final election period, by 50%, reduced by the amount of any prior distributions. If the balance of your Account is less than five hundred dollars ($500.00) as of the Valuation Date immediately preceding the first day of an election period, then you will not be entitled to elect to receive a Pre-Retirement Distribution for that election period.

BENEFITS ON DEATH

If your employment with the Company is terminated by your death, the amount in your ESOP Account as determined on the Valuation Date coincident with or immediately following the date of death will be paid to your Beneficiary. Your Beneficiary by law will be your surviving spouse if you are married on that date. This will be the case whether or not you designated your spouse as your beneficiary on your Designation of Beneficiary form, or whether you even have not filed such a form. Your spouse, however, can waive this legal right to be your Beneficiary if you are married. This waiver must take the form of a consent to the non-spouse beneficiary on a properly completed Designation of Beneficiary form. If your surviving spouse cannot be located after your date of death, or you and your surviving spouse were legally separated as evidenced by a valid court order, then your Beneficiary will be as you designate in your Designation of Beneficiary form.

If you are not married on the date of your death, your beneficiary will be as designated in your Designation of Beneficiary form.

A Designation of Beneficiary form is included in this Handbook or you can also obtain the form from your employer or by contacting the Benefits Hotline at 1-800-536-3628. Subject to a surviving spouse's right to your death benefit required by law as just described, you may designate a person or persons (including a trust or estate) to receive your death benefit on the Designation of Beneficiary form.

BENEFITS ON DISABILITY

If your employment with the Company is terminated by reason of your total and permanent disability, the amount in your ESOP Account on the Valuation Date coincident with or immediately following the date of your total and permanent disability will be paid to you on your "Disability Benefit Date." Your Disability Benefit Date will be the date as of which the Social Security Administration determines that you are totally and permanently disabled.

If the date that your total and permanent disability actually occurs precedes the determination of your Disability Benefit Date, then the distribution of your total and permanent disability may be made before the time just described, provided you waive basing the value of your disability benefit on the value of your Account for the Plan Year in which your Disability Benefit Date occurred and instead you request that the value of your Account be paid without waiting by determining the value of your Account with reference to the Valuation Date of the Plan Year in which your total and permanent disability actually occurred.

BENEFITS ON OTHER TERMINATION OF SERVICE

If your employment with the Company terminates for any reason other than by normal retirement, early retirement, delayed retirement, disability or death, your ESOP benefit will be the amount in your ESOP Account on the Valuation Date coincident with or immediately preceding the date of the distribution. Your ESOP benefit will be distributed on your written request in a form acceptable to the ESOP. If the amount in your ESOP Account on the Valuation Date immediately preceding the Plan Year during which a distribution is scheduled to occur is $1,000 or less, your benefits under the ESOP will be immediately distributable to you without your consent.

HOW BENEFITS ARE PAID

Benefits are normally paid out in one lump sum payment (but allowing for separate distributions of cash and Company Stock within the same calendar year from your Account). However, Participants and Beneficiaries may elect to receive their benefits in equal annual payments over a five year period. This installment distribution for Participants and Beneficiaries who have more than $500,000 in their accounts will be extended for one additional year for each additional $100,000 (or fraction thereof) in their ESOP Accounts. Your benefit distribution can be made in cash, or if you prefer, to the extent your Account holds Company Stock, in whole shares of Company Stock. If you want Company Stock, you must give the ESOP at least 30 days advance notice, but you should note that once you give the ESOP this notice, your decision cannot be changed.

If you elect a distribution that includes Company Stock, you will have a right to have the Company buy back the Company Stock from you at the Company Stock's fair market value. This is called a "put option" right. The put option may be exercised at any time during the 60-day period following the date of the distribution of Company Stock to you. If the put option is not exercised during such 60-day period, you may exercise your put option during an additional period of 60 days following the end of the Plan Year in which the distribution was made at the then current fair market value. This put option will be available to you even if the ESOP is terminated. The Company may elect to pay for Company Stock in substantially equal periodic installments (not less frequently than annually) over a period beginning not later than 30 days after exercise of the put option and not exceeding five years. The Company in that case will provide security and pay reasonable interest.

The Company also has a right of first refusal of the Company Stock you elect to receive in a distribution at a price equal to the greater of the then fair market value of the Company Stock or at the same price and on the same terms as a bona fide offer from a third party. If this right of first refusal is not exercised by the Company within 14 days, this right of first refusal expires.

If, at the time of your distribution, the Company's charter or by-laws restricts Company Stock ownership to partners, or the Company is an S corporation, your distributions by law will be only in cash. In this case, no distribution will be made in Company Stock.

CONTACT US WITH YOUR QUESTIONS

If you have questions about how the ESOP works or you want a copy of the actual ESOP document, all you have to do is contact the Benefits Hotline at 1-800-538-3528.

ADDITIONAL INFORMATION

In accordance with Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the following additional information is furnished to Participants and Beneficiaries with respect to the ESOP:

1. The name of the ESOP is the National Health Corporation Leveraged Employee Stock Ownership Plan.

2. National Health Corporation, which is located at 100 Vine Street, Murfreesboro, Tennessee 37130, is the employer of the partners covered by the ESOP and the ESOP's Sponsor. Other affiliated employers may be authorized to be a Sponsor. You may receive from the Plan Administrator, upon written request, information as to whether an employer or other organization is a sponsor and the sponsor's address.

3. The Employee Identification Number assigned to National Health Corporation by the Internal Revenue Service is 62-1294263, and the ESOP's Plan Number for use by the United States Department of Labor as well as the Internal Revenue Service is 002.

4. The ESOP is an employee stock ownership plan. The ESOP invests primarily in common stock of National Health Corporation. The ESOP is intended to satisfy the requirements of an employee stock ownership plan within the meaning of Section 4975(e)(7) of the Internal Revenue Code.

5. The ESOP is administered by National Health Corporation.

6. The Plan Administrator is the ESOP Committee appointed by the Board of Directors of National Health Corporation, the address of which is 100 Vine Street, Murfreesboro, Tennessee 37130, and the phone number of which is (615) 890-2020. You should contact the Plan Administrator by calling the Benefits Hotline at 1-800-538-3836.

7. In the event of any lawsuit, the agent for service of legal process for the ESOP is General Counsel, whose address is 100 Vine Street, Murfreesboro, Tennessee 37130. Service of process can also be made upon the Plan Administrator or the Trustee.

8. The Trustees of the ESOP are Richard F. LaRoche, Jr. and Daniel K. McDaniel, 100 Vine Street, Murfreesboro, Tennessee 37130.

9. A copy of the ESOP's qualified domestic relations order ("QDRO") procedures can be found at the end of this section in this handbook. In the event of a QDRO, all or part of your benefit may become payable to an Alternate Payee. Generally, this means that your spouse or children may gain a right to all or some portion of your ESOP Account through divorce proceedings.

10. National Health Corporation reserves, in its sole discretion, the exclusive right to terminate the ESOP at any time, to amend the ESOP at any time and from time to time and to eliminate prospective contributions to the ESOP at any time. If the ESOP is terminated, all Account balances will then immediately become fully vested.

11. Because your benefits depend solely on the amount in your Account in the ESOP, the law provides that the ESOP is not insured as a pension plan under Title IV of ERISA.

12. The Internal Revenue Code states that the annual addition to your account may not exceed the lesser of (a) $51,000 for 2013 (which may be adjusted in the future for changes in the cost of living) or (b) 100% of your annual Compensation. This limitation applies to the combined Company contributions made under the ESOP as well as the 401(k) Plan.

13. In the unlikely event that the ESOP becomes "top-heavy", additional provisions will apply. The ESOP is top-heavy if sixty percent (60%) of the funds held in the ESOP are used to provide benefits for certain highly compensated key partners as defined in the ESOP. If the ESOP is top-heavy, a minimum contribution of 3% of your Compensation for the Plan Year will likely be made for all Participants who are not key partners. This minimum contribution will be made to the 401(k) Plan.

14. An ESOP Committee is appointed by the Board of Directors of National Health Corporation. The Committee has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the ESOP, its associated Trust and any other ESOP documents, instruments or communications and to decide all matters arising in connection with the operation or administration of the ESOP and its associated Trust. Without limiting the generality of the foregoing, the Committee has the sole and absolute discretionary authority:

- to take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the ESOP;
- to formulate, interpret, and apply rules, regulations, and policies necessary to administer the ESOP;
- to decide questions, including legal or factual questions, relating to the eligibility for, and the calculation and payment of, benefits under the ESOP;
- to resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the ESOP, its associated Trust or other ESOP documents, instruments or communications; and
- except as specifically provided to the contrary elsewhere in the ESOP, to process, and approve or pay, benefit claims and rule on any benefit exclusions, and determine the manner of benefit payments.

All determinations made by the Committee with respect to any matter arising under the ESOP, Trust Agreement and any other ESOP documents, instruments or communications shall be final and binding on all parties. Benefits under this ESOP will be paid only if the Committee decides in its sole and exclusive discretion that the applicant is entitled to them.

15. At such time as you are eligible to receive benefits, your claim for benefits should be made to the Plan Administrator in writing in a form acceptable to the Plan Administrator.

16. Upon application for benefits made by you or your Beneficiary, if the Plan Administrator should determine that the benefits applied for will be denied either in whole or in part, the following provisions will govern. The Plan Administrator will notify you of the Plan Administrator's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of your claim by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing your claim is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the benefit determination.

In the event that a period of time is extended as provided herein due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The Plan Administrator will provide you with written or electronic notification of any adverse benefit determination. The notification will set forth the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific ESOP provision or provisions on which the determination is based;

- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and

- in the case of an adverse disability benefit determination, if the adverse disability benefit determination relies upon an internal rule, guideline, protocol or other specific direction, then the specific rule, guideline, protocol or other similar criterion relied upon will be provided to you free of charge.

If the benefit determination is adverse to you, you will have 60 days following receipt of the notification of the adverse benefit determination within which to appeal the determination. You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits.

You must exhaust all of the remedies available to you under these claim procedures in order to bring a civil action in court under Section 502(a) of ERISA. Except where the Plan Administrator fails to follow these claim procedures, you must appeal an initial adverse benefit determination as described in these claims procedures in order to exhaust the remedies available to you. You will have 180 days, and only 180 days, following an initial adverse benefit determination to appeal an initial adverse determination of your benefit claim. If you do not file an appeal of the initial adverse benefit determination within such 180 days following your receipt of the notice of the initial adverse benefit determination, then you will be time-barred from appealing the initial adverse benefit determination.

The Plan Administrator will notify you of the Plan Administrator's benefit determination on review within a reasonable period of time, but not later than 50 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim, If the Plan Administrator determines that an extension of time for processing your claim is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review. The period of time within which any benefit determination on review is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as provided herein due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The Plan Administrator will provide you with written or electronic notification of the benefit determination on review. In the case of an adverse benefit determination, the notification will set forth the following:

- the specific reason or reasons for the adverse determination; and

- reference to the specific ESOP provision or provisions on which the benefit determination is based.

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 a denial on review of your claim for benefits. You have a right to bring an action in court under Section 502(a) of ERISA no later than 10 days after the denial of the claim on review; and if you do not bring an action in court under Section 502(a) of ERISA within 180 days of the denial of your claim on review, then you will be time-barred from bringing an action in court under Section 502(a) of ERISA.

In the case of the failure by the Plan Administrator to follow the claim procedures set forth herein, you will be deemed to have exhausted the administrative remedies available under the ESOP and you will be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the ESOP failed to provide reasonable claim procedures that would yield a decision on the merits of your claim.

These claim procedures may be utilized by any authorized representative acting on your behalf. The Plan Administrator, however, may establish procedures for determining whether an individual has been authorized to act on your behalf.

17. As a participant in the National Health Corporation Leveraged Employee Stock Ownership Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all ESOP participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the ESOP, and a copy of the latest annual report (Form 5500 Series) filed by the ESOP with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the ESOP, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the ESOP's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

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

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 the ESOP documents or the latest annual report from the ESOP 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 Plan 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 Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that ESOP fiduciaries misuse the ESOP's assets, 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.

If you have any questions about your ESOP, 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, 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.

18. Your ESOP participation does not give you the right to ongoing employment with National Health Corporation or any of its affiliates nor does it guarantee your right to benefits, except as outlined in the ESOP. No provision of the ESOP gives you rights to continued employment, prohibits changes in terms of employment or prohibits your termination of employment.

EMPLOYEE STOCK PURCHASE PLAN

Common Stock of: National HealthCare Corporation
Trading Symbol: NHC
Traded On: NYSE-American Stock Exchange

Partners may buy NHC stock through payroll deduction. Purchases are made with after tax dollars. No brokerage fees are charged.

Stock will be purchased after the end of the calendar year at the lower of the market (closing) price on the first trading day of the calendar year or the last trading day of the calendar year.

The stock is issued in book-entry form to each participating partner after the end of the calendar year. After the issue, the stock is treated as if it were purchased by the partner through the stock market.

Open Enrollment for purchasing stock is January 1 through March 31 each year.

Payroll deductions for current partners can be stopped at any time during the year. The partner has the choice to withdraw the funds or leave them in the Employee Stock Purchase Plan and purchase stock at the end of the year.

If the partner terminates employment (other than for retirement or death), the money already deducted will be refunded, without interest.

NATIONAL HEALTHCARE CORPORATION EMPLOYEE STOCK PURCHASE PLAN REQUEST FOR PARTICIPATION FORM

1. The undersigned employee at _____ (Employer), hereby requests participation in the National HealthCare Corporation ("NHC") Employee Stock Purchase Plan ("ESPP") and authorizes my employer to deduct from my paycheck, until further notice, the amount of $_____ each pay period. (This amount cannot be less than $10 per pay period or more than the total compensation to the employee for that pay period).

2. The undersigned employee directs that the Contribution Account balance funded with the above payroll deduction and the NHC Common Stock purchased therewith be owned and registered as follows:

(PLEASE PRINT CLEARLY)

Name: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Social Security Number _____

3. I acknowledge receipt of the Prospectus for the National HealthCare Corporation Employee Stock Purchase Plan.

_____ _____

Date Signature of Employee

_____ _____

Name of Center or Affiliate Approved By

Please also complete Form W-9, Request for Taxpayer Identification Number and Certification.
Please return this completed form and the completed W-9 to your employer or to:
NHC PAYROLL DEPARTMENT, **P.O. BOX 1398, MURFREESBORO, TENNESSEE 37133.**

NOTICE: ALL EMPLOYEES MUST HAVE THEIR FORM APPROVED BY THE ADMINISTRATOR OR THEIR IMMEDIATE SUPERVISOR. THE FOLLOWING GUIDELINES SHOULD BE USED TO HELP IN COMPLETING YOUR FORM ACCURATELY.

Please check your subscription form carefully, and, if you have questions, check with your Administrator or Supervisor. If the form is incorrectly completed or lacking an approval signature, it will be returned to you and the payroll deduction will not be processed until it is properly completed.

One Final Note: Be sure to carefully read the section in the Prospectus regarding the tax consequences.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

• Generally, individuals (including sole proprietors) are not exempt from backup withholding.

• Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.

• Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

• Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

NATIONAL HEALTHCARE CORPORATION
EMPLOYEE STOCK PURCHASE PLAN
REQUEST FOR TERMINATION OF PARTICIPATION

The undersigned, an employee of _____(Employer), hereby requests termination of contributions to the National HealthCare Corporation ("NHC") Employee Stock Purchase Plan ("ESPP"). I, the undersigned employee, request my Employer to terminate the deduction from my paycheck of $_____ each pay period.

In discontinuing participation in the Plan, the undersigned employee directs that the current funds in the contribution account be handled as follows (choose one):

___a. refund as soon as possible.

___b. leave in the account for purchase of shares at the end of the Plan Year.

___c. partial withdrawal of $_____, with remaining funds left in the account for purchase of shares at the end of the Plan Year.

The Contribution Account is registered as follows:

Name _____

Address _____

City_____ State_____ Zip_____

Social Security Number _____

PLEASE NOTE: The discontinuance will become effective as soon as practical but not more than 30 days following the receipt of this notice by National HealthCare Corporation. Once discontinued, Employee cannot enter the Plan again until the next Plan Year (January 1) following termination of participation.

Date: _____ _____
(Signature of Employee)

_____
Employer

By:_____

Please return this completed form to your employer or to:
NHC PAYROLL DEPARTMENT, **P.O. BOX 1398, MURFREESBORO, TN 37133.**

NATIONAL HEALTHCARE CORPORATION
EMPLOYEE STOCK PURCHASE PLAN
REQUEST FOR PARTIAL WITHDRAWAL OF FUNDS

The undersigned, an employee of _____(Employer), hereby requests a partial withdrawal of funds from the National HealthCare Corporation ("NHC") Employee Stock Purchase Plan ("ESPP") in the amount of $_____.

The Contribution Account is registered as follows:

Name _____

Address _____

City_____ State_____ Zip_____

Social Security Number _____

PLEASE NOTE: The partial withdrawal will become effective as soon as practical but not more than 30 days following the receipt of this notice by National HealthCare Corporation. Only one partial withdrawal is allowed per year. A second request for partial withdrawal will terminate your participation in the Plan. Once discontinued, Employee cannot enter the Plan again until the next Plan Year (January 1) following termination of participation.

Date: _____ _____
(Signature of Employee)

_____
Employer

By:_____

Please return this completed form to your employer or to:
NHC PAYROLL DEPARTMENT, **P.O. BOX 1398, MURFREESBORO, TN 37133.**

NATIONAL HEALTHCARE CORPORATION

Employee Stock Purchase Plan, a sub plan under the
National HealthCare Corporation 2020 Omnibus Equity Incentive Plan

Information Summary

This document contains current information about the National HealthCare Corporation Employee Stock Purchase Plan (the "ESPP"), which is a sub plan under the National HealthCare Corporation 2020 Omnibus Equity Incentive Plan (the "2020 Plan"). National HealthCare Corporation ("NHC" or the "Company") will update this information to the extent it changes materially and will make available the updated information to each participant who has been given a copy of this document and who is affected by the changed information.

NHC has filed with the United States Securities and Exchange Commission (the "SEC") a Registration Statement on Form S-8 relating to the shares of NHC's common stock that may be issued or transferred pursuant to the ESPP (the "Registration Statement"). The Registration Statement incorporates by reference certain documents filed by NHC with the SEC, and those documents are incorporated by reference in this Information Summary. You may receive without charge a copy of any of the incorporated documents as well as copies of any documents distributed to stockholders of NHC generally by writing to us at 100 E. Vine Street, Murfreesboro, Tennessee 37130, Attn: Investor Relations.

THESE SECURITIES HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION OR ANY STATE SECURITIES COMMISSION NOR HAS THE SEC OR ANY STATE SECURITIES COMMISSION PASSED UPON THE ACCURACY OR ADEQUACY OF THIS PROSPECTUS. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

This document constitutes part of a Prospectus covering securities that have been registered under the United States Securities Act of 1933, as amended (the "Securities Act").

The date of this Prospectus is June 30, 2020.

TABLE OF CONTENTS

The statements contained herein are intended to help you to understand provisions of the ESPP and include summaries of certain provisions of the ESPP. These statements do not purport to be complete and are qualified in their entirety by references to the provisions of the ESPP. If additional information about the ESPP or its administrators is required, please refer to the full text of the ESPP, which is included as part of the 2020 Plan and is attached as Exhibit A. A copy of the 2020 Plan is also available for examination at NHC's principal office located at the address indicated below. You may also, upon request, obtain additional information about the ESPP by directing your request to National HealthCare Corporation, Attention: Investor Relations, 100 E. Vine Street, Murfreesboro, Tennessee 37130, telephone number (615) 890-2020. All capitalized terms not defined herein have the meanings set forth in the ESPP. In the event of a conflict between the information in this description and the terms of the ESPP, the ESPP shall control.

INTRODUCTION

National HealthCare Corporation ("NHC" or the "Company") is a Delaware corporation, having its principal executive offices at 100 E. Vine Street, Murfreesboro, Tennessee 37130. This Information Summary relates to shares of NHC's common stock, par value $0.01 per share ("Common Stock" or "Share"), which may be offered to participants pursuant to the Employee Stock Purchase Plan (the "ESPP"), which is a sub plan of the National HealthCare Corporation 2020 Stock Incentive Plan (the "2020 Plan"). The ESPP is intended to qualify for favorable tax treatment under Section 423 of the Internal Revenue Code of 1986, as amended (the "Code").

DESCRIPTION OF THE ESPP

General Plan Information

The principal features of the ESPP are summarized below, but such summary is qualified in its entirety by reference to the ESPP itself, which is set forth in the 2020 Plan, a copy of which is attached as Exhibit A and incorporated herein by reference.

Under the ESPP, Employees (as defined below) who enroll in the ESPP will authorize the Company to make payroll deductions as specified by the Employee to be credited to his or her contribution account under the ESPP. The purchase period (the "Plan Year") begins on the first day of the calendar year and ends on the last trading day of the calendar year. At the end of the Plan Year, stock is purchased for a price per share as determined by the Board, but not less than eighty-five percent (85%) of the fair market value of a share of stock on the beginning of the Plan Year or the end of the Plan Year, whichever is lower.

As used herein and in the ESPP, (i) the term "Employer" means the Company and any corporation during any period in which such corporation is a "subsidiary corporation" as that term is defined in Section 424(f) of the Code with respect to the Company that the Committee designates to be subject to this ESPP; (ii) the term "Employee" means any person who, at the time an option under this Employee Stock Purchase Plan is granted to such person, is an "employee" of the Employer, as such term is used in Section 423 of the Code and described in United States Treasury Regulations ("Regulations") Section 1.421-1(h)(1); and (iii) the term "Employee Member" means an Employee of the Employer who has met the conditions and provisions for becoming an Employee Member as provided in the ESPP.

The ESPP is not subject to the provisions of the Employee Retirement Income Security Act of 1974.

Administration

The ESPP is administered by the Board of Directors of the Company (the "Board") and is generally subject to the administrative procedures and other rules set forth in the 2020 Plan, except as specifically modified in the ESPP sub plan. The Board has the authority in its discretion to make any rules, regulations and procedures that may be necessary for the administration or functioning of the ESPP, and its interpretations and decisions with respect to the ESPP are final. The Board may appoint such other persons as it deems appropriate to administer the ESPP.

You may, upon request, obtain additional information about the ESPP and its administration by contacting NHC at:

National HealthCare Corporation
Attn: Investor relations
100 E. Vine Street
Murfreesboro, Tennessee 37130
Telephone number: (615) 890-2020

Securities to be Offered

The maximum number of shares of Common Stock that can be issued under the ESPP is 250,000 shares. The maximum number of shares that can be purchased by any one employee during a purchase period may not exceed $25,000 divided by the fair market value of the stock on the grant date. The grant date is the first day of the purchase period.

UNLESS OTHERWISE EXPRESSLY PROVIDED IN THE ESPP, IN THE 2020 PLAN OR IN AN APPLICABLE AWARD AGREEMENT, ANY GRANT MADE UNDER THE ESPP, AND THE AUTHORITY OF NHC'S BOARD OF DIRECTORS TO AMEND, ALTER, ADJUST, SUSPEND, DISCONTINUE OR TERMINATE ANY SUCH GRANT OR TO WAIVE ANY CONDITIONS OR RIGHTS UNDER ANY SUCH GRANT, SHALL CONTINUE AFTER THE TENTH ANNIVERSARY OF THE EFFECTIVE DATE OF THE 2020 PLAN.

Who May Participate

All Employees are eligible to participate in the ESPP on his or her date of employment. In addition, all employees of subsidiaries of the Company that are designated by the Board to be subject to the ESPP are eligible to participate in the ESPP. Otherwise, neither the Board nor the Compensation Committee of the Board (the "Committee") has any discretion to determine who is eligible to participate in the ESPP. Any Employee who wishes to participate in the ESPP must complete a Request for Participation form and file such form with the Employee's Employer in accordance with procedures established by the Board. By filing such form, an Employee will thereby become an Employee Member and will be bound by the terms of the ESPP and other applicable provisions of the 2020 Plan, included any amendments thereto.

Participant Elections

Each eligible Employee may elect to participate in the ESPP by authorizing a payroll deduction in an exact number of dollars per period of not less $10.00 per pay period. Deductions will begin on the first pay period after receipt of the Request for Participation form at the corporate offices, but no later than March 31 in any Plan Year, unless otherwise extended by the Board.

Election Changes or Withdrawal from ESPP

An Employee Member may discontinue or change his or her contribution rate during the Plan Year by providing written notice to the Company on such forms as provided by the Company. Such discontinuance will become effective within thirty (30) days following the Company's receipt of notice. If an Employee Member discontinues contributions during the Plan Year, he or she may not again elect to make contributions during the remainder of such Plan Year. Further, an Employee Member may withdraw some or all of said Employee Member's prior contributions once at any time

during the Plan Year without being terminated from the 2020 Plan. However, if contributions are withdrawn a second time during the Plan Year, no further contributions will be permitted during that Plan Year by that Employee Member. Regardless of such discontinuance of contributions or withdrawals, any balance to the Employee Member's credit on the exercise date will be used to purchase shares of Common Stock in accordance with the ESPP.

Purchases of Stock

On the last trading day of the Plan Year, the Employee Member's contribution account will be used to purchase the number of whole shares of Common Stock of the Company equal to the Employee Member's contribution account divided by the purchase price. Any money remaining in the Employee Member's contribution account because it is not sufficient to purchase a whole share will remain in the account to be used in the next Plan Year unless the Employee Member requests that the balance be returned to him or her.

Purchase Price

The purchase price is as determined by the Board, but not less than eighty-five percent (85%) of the lesser of the fair market value of the Common Stock on the first day of the Plan Year or the last day of the Plan Year.

Shareholder Rights

Each Employee Member in the ESPP will (a) be regarded as the owner of each share purchased for his or her account from the date of purchase; (b) possess all voting rights associated with ownership of a share of Common Stock and (c) be entitled to any dividends paid with respect to such shares.

Rights on Retirement, Death or Termination of Employment

In the event of an Employee Member's termination of employment during the Plan Year, except by reason of death or retirement, his or her participation in the ESPP will terminate immediately, and the Employee Member's contribution account balance will be paid to such Employee Member as soon as practical thereafter. If the Employee Member dies or retires during the Plan Year, the Employee Member or his or her estate may withdraw the Employee Member's contribution account balance. If the Employee Member or his or her estate does not elect to withdraw the Employee Member's contribution account balance, the contribution account balance will be used to purchase shares at the end of the Plan Year.

Non-Transferability

The option rights granted to any Employee Member under the ESPP are not subject to assignment or alienation, other than by will or the laws of intestate succession. Any attempted assignment, transfer or alienation by an Employee Member will be disregarded by the Company.

Amendment and Termination

The Board may at any time or from time to time amend the ESPP in any respect, or terminate the ESPP; provided, however, that the Board may not, without the approval of a majority of the outstanding shares of Common Stock of the Company entitled to vote at a meeting of the shareholders, amend the ESPP to increase (except for increases due to adjustments in accordance with

Section 7 of the 2020 Plan) the aggregate number of shares of Common Stock which may be issued under the ESPP or change the class of Employees eligible to participate in the ESPP.

The ESPP will be suspended in the event that a tender offer is made to the shareholders of the Company, and the Board's determination that such tender offer is made shall be conclusive. During a suspension, no contributions will be accepted and all contribution account balances will be refunded to Employee Members. The Board may thereafter reactivate the ESPP at any time.

No Liens

No lien has been made or may be created on either the options granted to an Employee Member under the ESPP or the shares received by an Employee Member through the exercise of options.

CERTAIN FEDERAL INCOME TAX CONSEQUENCES

The following discussion of the federal tax consequences associated with the ESPP is necessarily general and does not include all aspects of federal income tax laws which may be relevant to any Employee Member in the ESPP. Accordingly, each Employee Member should consult a tax advisor to determine all tax effects.

The ESPP is intended to qualify as an "Employee Stock Purchase Plan" as defined in Section 423 of the Code. If a holding period requirement and an employment requirement are met, rights issued to an Employee Member under such plans do not result in taxable income to the Employee Member either upon the grant of rights or upon their exercise even if the exercise price is less than the fair market value of the stock at the time of exercise. However, the lesser of (a) the difference between the fair market value of the shares on the date of disposition or death and the price paid for the shares, or (b) the difference between the fair market value of the shares on the date of grant and the exercise price on that date, will be treated as compensation income in the year in which the Employee Member disposes of such shares of stock (provided the holding period requirement is met) or in the year of the Employee Member's death (whenever occurring) if the Employee Member's death occurs while owning such shares. If the holding period requirement is not met because the Employee Member disposes of such shares of stock prior to two years after the grant of the right or within one year of the purchase of the stock or the employment requirement is not met because at all times during the period beginning with the date of the granting of the option and ending on the day 3 months before the date of exercise he or she is not an Employee of the Company or its subsidiaries, he or she will realize ordinary compensation income to the extent of the difference between the exercise price and the fair market value of the stock at the date the right was exercised.

Neither the issuance nor exercise of rights under the ESPP nor the subsequent qualifying disposition of shares of stock acquired under the ESPP will create an item of income or deduction to NHC. However, if the Employee Member realizes ordinary income in the amount of the difference between the exercise price and the value of the shares at the time of exercise by reason of a disqualifying disposition, then NHC will be entitled to a deduction at the same time and in the same amount. If upon the sale of the shares by the Employee Member, gain is realized over the amount paid for the shares plus any amount treated as ordinary compensation income to the Employee Member, such gain, under current tax laws, would be capital gain.

EACH PARTICIPANT IN THE ESPP SHOULD CONSULT WITH HIS OR HER OWN TAX ADVISOR WITH RESPECT TO THE TAX EFFECT OF PARTICIPATION IN THE ESPP SUB PLAN UNDER THE 2020 PLAN AND THE DISPOSITION OF STOCK ACQUIRED PURSUANT TO PARTICIPATION IN THE ESPP SUB PLAN, AS IT IS

NOT FEASIBLE TO DISCUSS ALL FEDERAL, STATE AND LOCAL TAX IMPLICATIONS THEREOF.

INCORPORATION OF CERTAIN DOCUMENTS BY REFERENCE

The following documents filed by the Company with the SEC, pursuant to the Exchange Act, are hereby incorporated by reference and shall be deemed to be a part hereof from the date of filing of such document:

(1) The Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2019, filed with the SEC on February 21, 2020 (including portions of the Registrant's definitive Proxy Statement for the 2020 Annual Meeting of Stockholders, filed with the Commission on April 6, 2020);

(2) The Company's Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2020, filed with the Commission on May 7, 2020;

(3) The Company's Current Reports on Form 8-K filed with the Commission on February 14, 2020, May 11, 2020 and May 12, 2020; and

(4) The description of the Company's Common Stock contained in Exhibit 4.2 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2019, filed with the Commission on February 21, 2020.

Except to the extent that information therein is deemed furnished and not filed pursuant to the Exchange Act, all documents filed by the Company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Exchange Act after the date hereof and prior to the filing of a post-effective amendment to the Registration Statement which indicates that all securities offered hereby have been sold or which deregisters all securities then remaining unsold, shall be deemed to be incorporated by reference herein and to be a part hereof from the date of filing of such documents. Any statements contained in a document incorporated or deemed to be incorporated by reference herein shall be deemed to be modified or replaced for purposes hereof to the extent that a statement contained herein (or in any other subsequently filed document which also is incorporated or deemed to be incorporated by reference herein) modifies or replaces such statement. Any statement so modified or replaced shall not be deemed, except as so modified or replaced, to constitute a part hereof.

Notwithstanding the foregoing, information furnished under Items 2.02 and 7.01 of any Current Report on Form 8-K, including the related exhibits, is not incorporated by reference in this Prospectus or the related Registration Statement.

AVAILABLE INFORMATION

The Company is subject to the informational requirements of the Exchange Act and in accordance therewith, we file annual, quarterly and current reports and other information with the SEC. Such information may also be accessed electronically by means of the SEC's home page on the Internet at http://www.sec.gov. The SEC maintains an Internet site at http://www.sec.gov that contains the reports and other information we file electronically. Our website address is www.nhccare.com. Please note that our website address is provided as an inactive textual reference only. We make available free of charge, through our website, our Annual Report on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, and all amendments to those reports

as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. The information provided on or accessible through our website is not part of this Prospectus.

Additional information about the ESPP or the 2020 Plan and its administrators, copies of any documents incorporated herein by reference to the Registration Statement on Form S-8, and copies of any other documents required to be delivered pursuant to Rule 428(b) of the Securities Act are available without charge to any participant in the ESPP, upon written or oral request. Your requests should be directed as follows:

National HealthCare Corporation
Attn: *Investor Relations*
100 E. Vine Street
Murfreesboro, Tennessee 37130
Telephone number: (615) 890-2020

EXHIBIT A

National HealthCare 2020 Omnibus Equity Incentive Plan

28308506.1

Tuition Reimbursement

NHC's Tuition Reimbursement Program operates on the premise that continuing education is mutually beneficial for both the partner and the employer. Participation in the program signals a commitment to work for NHC after completion of academic work sponsored and financially supported by NHC.

The company may support partial or full reimbursement of tuition costs for academic work completed at vocational schools, community colleges, and state colleges and universities. The company may also share tuition expenses with partners who wish to attend a private university.

Reimbursement is given for tuition costs only, with additional financial aid available for books through The Foundation for Geriatric Education (TFGE).

Reimbursement is made upon completion of the course (typically each semester). Students are required to submit grades and tuition receipts prior to receiving reimbursement. To qualify for reimbursement, a grade of C or above is required.

Upon entering the program, a written contract is entered into between the partner and their employer.

The contract commits partners to a specified number of years of service with NHC or an NHC affiliated company in exchange for the tuition reimbursement.

Whether you're a CNA wanting to become an LPN and/or RN or a non-nursing partner pursuing a new career in the long-term care field, the NHC Tuition Reimbursement Program may be the key to your future career goals.

Please note: Every NHC & NHC affiliated employer may not participate in this plan every year. Ask your employer for their current plan participation.

Payroll Selection

There are two ways to receive your pay: Direct Deposit or Comdata Paycard. You are free to choose either method. You should take time to review this section before making a selection.

Option 1 - Direct Deposit to a Personal Bank Account: Your pay is deposited directly into a personal checking account, savings account, or non-checking account (for example, paycards that are not Comdata) every payday.

You have the choice of two accounts in the direct deposit program. The second account may be used for a credit union, savings account, checking account, etc. and must be a specified dollar amount.

- If you only have 1 account in the direct deposit program, the entire amount of your paycheck will be deposited into Account 1.
- If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Account 2. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.
- If you have 2 accounts and close or change Account 1, Account 2 will be suspended until Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Account 1.

Option 2 – **Comdata Paycard:** Pay is loaded directly and electronically into your Comdata Account every payday. You may access available funds by using the Comdata Paycard.

Comdata Paycard features:

- You can take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
- You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. Locations may be found by visiting www.allpointnetwork.com.
- You can use the paycard to make purchases and get cash back with those purchases.

These options give you more control over your pay. Among key benefits inherent in both Direct Deposit and the Comdata payroll options:

- **Immediate access:** pay is automatically deposited into a personal bank account or a Comdata Account every payday. You will be able to access your pay immediately -- rain, snow or shine – and avoid the hassles of waiting to pick up a check or waiting in line to cash it.
- **Savings:** these options give you instant and convenient ways to access your pay, and can even help eliminate check cashing and money order fees.
- **Safe**: your pay is automatically placed in your account, giving you peace of mind – you don't have to worry about lost checks or stolen cash.

Contents of Payroll Selection:

Payroll Selection Form

Direct Deposit FAQs

Comdata Paycard Program Enrollment Kit:

- Comdata Paycard Program Features
- Enrollment and Activation Instructions
- Frequently Asked Questions
- Fee Schedule

PAYROLL SELECTION FORM

See Reverse Side for Instructions.

Location#: _____ XXX - XX -_____ _____
Social Security Number **Partner Name (Please Print)**

Direct Deposit Choice

☐ I select the Direct Deposit Choice and would like my pay deposited to the following bank account(s)

ACCOUNT 1

☐ Begin Deposit ☐ Change Information ☐ Cancel

Bank Name: _____

Account Type: _____
(C for Checking or Paycards ; S for Savings)

*Account Number:_____
*(Attach void check for Checking Account. For Savings and nonchecking accounts attach a bank letter or specification sheet which contains ABA and account numbers that will be valid for ACH transactions. Deposit tickets are not accepted.)

ACCOUNT 2

☐ Begin Deposit ☐ Change Information ☐ Cancel

Amount $ _____

Bank Name: _____

Account Type: _____
(C for Checking or Paycards ; S for Savings)

*Account Number:_____
*(Attach void check for Checking Account. For Savings and nonchecking accounts attach a bank letter or specification sheet which contains ABA and account numbers that will be valid for ACH transactions. Deposit tickets are not accepted.)

Tape Void Check for Direct Deposit Choice Below

Comdata Paycard Choice

☐ I select the Comdata Paycard and would like my employer to **enroll** me in a Comdata Account and **deposit** my pay into the Account. I understand that there are fees for certain transactions. I have reviewed and agree to the Comdata Fee Schedule.

ACCOUNT 1

☐ Begin Deposit ☐ Cancel

Bank Name: Comdata

Account Type: C

Account Number:_____

ACCOUNT 2

☐ Begin Deposit ☐ Change Amount ☐ Cancel

Amount $ _____

Bank Name: Comdata

Account Type: C

Account Number:_____

Payroll Authorization

I authorize my employer to disburse my pay by Direct Deposit or Comdata according to the selection(s) above. In the event my employer deposits funds by mistake into my account, I authorize my employer to direct the financial institution or service to return such funds. This authorization will remain in effect until I have filed a new selection form.

Partner Signature:_____ Date_____/_____/_____

Verified By:_____ ___/___/___
Bookkeeper's Initials Date

CD Official Use Only

Pre-Notification _____ **Active** _____

DD Official Use Only

Pre-Notification _____ **Active** _____

960 Forms 10/18

Instructions for Payroll Selection Form

There are two ways to receive your pay: Direct Deposit or Comdata Paycard. You are free to choose either method. You should take time to review the Payroll Selection section of the Partner Benefits Handbook and the options outlined on this form before selecting the method you choose to use.

The center will provide the 4-digit location number. Complete the last 4 digits of your Social Security Number and print your Name.

Direct Deposit Choice: Check this box and complete the appropriate portion of this section if you choose Direct Deposit.

Account 1 and Account 2:
You have the choice of two accounts in the direct deposit program. The first account is used for the balance of your pay. The second account may be used for a credit union, savings account, checking account, etc. and must be a specified dollar amount.

- If you only have 1 account in the direct deposit program, the entire amount of your paycheck will be deposited into Account 1.
- If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Account 2. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.
- If you have 2 accounts and close or change Account 1, Account 2 will be suspended until Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Account 1.

Begin, Change, Cancel: Check the appropriate box:

- Begin Deposit
- Change Information
  - ✓ If you have a bank account change, mark this box to stop the direct deposit transaction to the current account and initiate a prenotification process for the new account.
  - ✓ If you want to change the $ Amount for Account 2, mark this box. Changes to $ Amount for Account 2 do not initiate a prenotification process.
- Cancel

Bank Name: Enter the appropriate financial institution name.

Account Type: Enter C (for Checking or non-Comdata Paycards) or S (for Savings).

Account Number: Enter the correct Account Number.

- If you choose checking account, you **must** attach a voided check or bank letter to the Selection Form. Deposit tickets will not be accepted.
- If you choose savings and/or nonchecking account, you **must** attach an authorized bank letter or specification sheet that contains ABA# and account numbers that will be valid for Direct Deposit (ACH) transactions. The account information on the checks and deposit slips for savings and nonchecking accounts are **likely** to be **invalid** for ACH transactions. Deposit tickets will not be accepted.

Comdata Paycard Choice: Check this box if you want to enroll in the Comdata Paycard and have your employer load your pay into your Comdata account each pay day. You can access funds by using a Comdata Paycard at locations shown on the Comdata location finder tool at www.cardholder.comdata.com. Details are included in the Comdata Paycard Program Enrollment Kit.

Comdata Paycard: There is no monthly charge for the paycard. You can take the card to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee. You may also withdraw cash for free at thousands of Allpoint Network ATMs. Locations may be found by visiting www.allpointnetwork.com. Fees may apply for ATM transactions other than In-Network ATMs. You can also use the card to make purchases and get cash back with those purchases.

Account 1 and Account 2: You must choose between Account 1 and Account 2.

- Choose Account 1 if the Comdata account is your primary account.
- Choose Account 2 if the Comdata account is your secondary account and Direct Deposit Account 1 is your primary account. You must specify a specific dollar amount.
  - ✓ If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Comdata Account 2. Any remaining amount will be deposited into Direct Deposit Account 1. If the entire amount of your paycheck is less than the designated amount in Comdata Account 2, all of your paycheck will be deposited into Direct Deposit Account 1.
  - ✓ If you have 2 accounts and close or change Direct Deposit Account 1, Comdata Account 2 will be suspended until Direct Deposit Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Direct Deposit Account 1.

Begin, Change, Cancel: Check the appropriate box:

- Begin Deposit
- Change Amount
- Cancel

Bank Name: This section has been prefilled with the financial institution name.

Account Type: This section has been prefilled with C (for Comdata Paycards)

Account Number: Enter the correct Account Number only if you Cancel Account 1 or Account 2, or Change Amount for Account 2.

Signature Information: You **must** sign and date the form. Submit the completed form to your supervisor.

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Direct Deposit

1. **What are the advantages of Direct Deposit?**
   - Free
   - Timeliness of check receipt
   - Convenience and accessibility
   - Safety
   - Reliability
   - Confidentiality
   - Potential Savings

   Direct Deposit is the safest, most convenient way to be sure that your paycheck is immediately deposited into your account each payday.

   No more hectic trips to deposit your check, no more waiting in teller lines. And if you're sick on payday, or away from home, you have the peace of mind knowing that your paycheck will be automatically deposited into your account. No special arrangements are needed. With Direct Deposit, you'll never have to worry about lost, stolen or damaged checks. You may even have savings if you currently pay fees to get your check cashed.

2. **What will I receive every pay period instead of a check?**

   The same stub as you currently receive and a non-negotiable copy of your check. The non-negotiable check includes the amounts deposited into Account 1 and Account 2 (if applicable).

3. **How do I get my money?**

   The same way you normally would, by making a withdrawal from your financial institution; either in person, by check, by debit card or ATM card. Once the funds are direct deposited in your financial institution, all options are the same as your current options.

4. **What if I do not have a bank account?**

   To participate in Direct Deposit, you must have some kind of account set up with an ACH financial institution. Some of the ACH financial institutions offer accounts that are set up to receive only Direct Deposit payroll checks without the charges and transactions associated with a checking or savings account. The institution will provide you with a means to withdraw all of your payroll check on each payday every two weeks on Tuesday. There also may be some no cost options available to you through your employer sponsored credit union plan. The Comdata Paycard is also available if you cannot obtain a bank account.

5. **Must my account be with a bank?**

   No, all financial institutions that accept ACH (Automated Clearinghouse) transfers are acceptable. These may include (but not all inclusive) banks, credit unions, savings and loan institutions, and investment brokers. There are over 21,000 financial institutions that are members of the ACH network.

6. **Can the Direct Deposit be made into any account or is a checking account required?**

   It can go into EITHER a checking or savings account. The Payroll Selection Form has specific instructions for different account types.

7. **Can I deposit some of my payroll check into my checking account and another portion into my savings account?**

   Yes, you may have two accounts in the direct deposit program. You may designate a specified dollar amount to be deposited into Account 2 as your credit union, checking, or savings account, etc. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.

8. **When will the deposit be available for withdrawal?**

   In the absence of mechanical failures, it will be available on each payday at the beginning of your financial institution's business day. Funds should always be "collected" and available since it is an ACH transfer/Direct Deposit.

9. **How common are errors?**

   Because of the electronic transmission, errors are minimized. If they do occur, there are specific audit trails that will be followed. The NHC Payroll Department will work directly with the bank that holds the NHC payroll account to trace and correct all errors as soon as administratively possible.

10. **Will I have a bank record showing that the deposit was made into my account?**

    The Direct Deposit should show on your bank statement as a deposit or an addition to your account on each payday. Terminology differs between financial institutions to indicate a payroll direct deposit.

11. **Does NHC charge for participation in the Direct Deposit Plan?**

    No. It is a free NHC benefit available to each partner receiving a paycheck.

12. **Are there any charges or savings related to Plan participation?**

    Financial institutions normally do not assess fees for processing Direct Deposits. You may actually recognize savings, especially if you have previously paid a fee to get your paycheck cashed; i.e. a charge from a bank in which you have no account, a charge from a check cashing establishment or a check cashing charge from a grocery store or other retail store.

13. **How do I sign-up or enroll in the Direct Deposit Plan?**

    You must complete a Payroll Selection Form and follow detailed instructions on the form. Depending on when the Payroll Selection Form is received by the NHC Payroll Department the enrollment processing may take 2-3 pay periods. You will continue to receive a negotiable paper check until the process is complete.

14. **What happens if I change financial institutions or accounts?**

    You should submit a new Payroll Selection Form and mark the "Change Information" box and submit the appropriate complete information and new additional forms as needed. The Direct Deposit to your account will be stopped, and you will receive a negotiable paper check until the process for the new account is complete. You should allow 2-3 pay periods for the change. You should not close a current account until you are sure that the requested change has been made.

    If you have 2 accounts and you close Account 1, Account 2 will be suspended until Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Account 1.

15. **Can I cancel participation in the Direct Deposit Plan?**

    Yes, at any time. You should submit a new Payroll Selection Form and mark the "Cancel" box. Participation will be cancelled as soon as administratively possible after receipt by the NHC Payroll Department. Your current account should not be closed until after you receive the first "real" (negotiable) paper check after submitting the cancellation.

16. **Am I required to participate in the Direct Deposit Plan?**

    Currently there is no participation requirement, although our company policy is to pay by direct deposit. For your benefit, and that of all partners, NHC would like for all partners to take advantage of this free and efficient benefit.

17. **Does my payroll information have any impact on the Direct Deposit Plan?**

    Yes. Accurate and timely Payroll Selection Forms, additional required forms, and bank change requests are all very important for you to receive your biggest benefit from the Direct Deposit Plan.

Comdata Paycard Program

Enrollment Kit

Contents:

Comdata Paycard Program Features
Enrollment and Activation Instructions
Frequently Asked Questions
Fee Schedule

Customer Service

Toll-Free Phone: 1-888-265-8228

Comdata Paycard Program Features

Accommodates individuals that do not have a bank account.

- Everyone is eligible.
- No credit checks or applications necessary.

Features unique to Comdata Paycard Program:

- Comdata Paycard Program has no NSF fees.
- The Comdata Paycard is a prepaid account that does not allow purchases for more than the available balance. You will receive a User Guide with your paycard that provides tips for making purchases.

Easy access to money in the Comdata Account with reliability of receipt on Tuesday payday. Pay is loaded directly and electronically into your Comdata Account every payday. You may access available funds by using a Comdata Paycard.

- Comdata Paycard features:
  - ✓ You may take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
  - ✓ You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. You may find locations by visiting www.allpointnetwork.com, using the Comdata Prepaid mobile app or logging into the cardholder website at www.cardholder.comdata.com. Fees will apply for ATM transactions at locations not listed on the website.
  - ✓ You may make purchases at millions of Mastercard merchants worldwide. You can use the paycard to make purchases and get cash back with those purchases.

Four ways to check your balance for FREE

- Text Messaging - Sign up to receive text message alerts of your payroll loads and card usage when you call 1-888-265-8228. Sign up when you activate your card.
- Customer Service - Call Comdata automated system (called the IVR – Interactive Voice Response system) at **1-888-265-8228,** enter your Comdata card number, enter your activation code (date of birth, MM/DD/YYYY).
- Mobile App - Download the Comdata Free Prepaid Mobile App and check your balance – available for both iPhone and Android devices. Also, use the App to locate surcharge free ATMs and view most recent transactions.
- Cardholder Web - You must register and create an account on the Comdata Cardholder Website, www.cardholder.comdata.com, to check your balance on the Internet.

Other Comdata Payroll Card Program Benefits

- Portability: Do you have another employer and want to have those payroll funds deposited to your paycard? To add funds to your card, log into www.cardholder.comdata.com and click “Direct Funding” to access your Routing and Account Numbers. Provide those numbers to your employer. Eligibility may vary.
- Companion Card: The primary cardholder can order a Companion Card for a one-time fee. The primary cardholder and companion share the same balance. The card can be used anywhere Mastercard is accepted. The primary cardholder can order the card from www.cardholder.comdata.com.

Enrollment and Activation Instructions

Enrollment is quick and easy – you're already approved
No credit check or approval process is necessary.

Enrolling in the Comdata Paycard Program
Complete the Payroll Selection Form and return it to the center bookkeeper.

NHC will provide you a card to use until your personalized card arrives by mail to the home street address on file in the payroll system and will arrive in about two weeks. The Welcome Packet includes:

- Comdata Paycard and Card Carrier
- User Guide
- Fee Schedule

If your address changes before your card arrives or you want to change the mailing address to a PO Box, immediately contact the customer service center at 1-888-265-8228.

After the enrollment process, all future communication regarding the Comdata Account should be directed to Comdata Customer Service (Toll-Free Phone: 1-888-265-8228). Questions regarding the pay amount on the check stub should be directed to the employer.

Activating your Comdata Account
When you receive the card from the bookkeeper, you must ***immediately*** call 1-888-265-8228 to activate. Follow the instructions provided in your card packet. Your activation code is your date of birth in MM/DD/YYYY format.

Keep your paycard secure. You will need your Paycard number to access your account information over the phone or online.

After the account is activated, you may access your pay that has been deposited into your Comdata Account. Pay stubs will be available at the receptionist's desk each payday as normal.

If you do not receive your personalized card packet within 15 business days, call Customer Service to let them know you have not received your personalized card.

Frequently Asked Questions

Q. What is a Comdata Account?

A. If you don't have a personal bank account, your pay can be loaded directly into a Comdata Account every payday. This easy-to-use payroll solution enables you to access your funds by using a Comdata Paycard. Comdata Paycard features:

- You may take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
- You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. You may find locations by visiting www.allpointnetwork.com, using the Comdata Prepaid mobile app or logging into the cardholder website at www.cardholder.comdata.com. Fees will apply for ATM transactions at locations not listed on the website.
- You may make purchases at millions of Mastercard merchants worldwide. You can use the paycard to make purchases and get cash back with those purchases.

Q. How do I know how much money is in my Comdata Account?

A. You can check your Account balance for free online www.cardholder.comdata.com, or by phone (1-888-265-8228), Comdata Prepaid mobile app or enroll for text messaging.

Q. Do I get a statement?

A. No, you may login to the Cardholder website at www.cardholder.comdata.com and view transaction activity.

Q. Do I get a new Paycard every pay day?

A. No, your pay is deposited into your Account every payday. You can use your existing Paycard to access the money in your Account at that time.

Q. Do I have to pay a sign-up fee to get a Paycard?

A. No. It is a free benefit offered by your employer.

Q. Is there a monthly fee for the Paycard?

A. No.

Q. What is Portability?

A. Portability allows you to have another employer place earned wages on your payroll card. To add funds to your card, log into www.cardholder.comdata.com and click "Direct Funding" to access your Routing and Account Numbers. Provide those numbers to your employer. Eligibility may vary.

Q. What happens if I stop working here?

A. Your employer will deposit your last pay. You may continue to use your Account with other employers.

Q. I don't want to pay any fees, what can I do?

A. You may withdraw your money at no charge using one or a combination of the free services and transactions listed on your Fee Schedule. An additional fee or surcharge may be applied by an Out-of-Network owner or operator. To find a surcharge free or In-Network Allpoint ATM, please visit www.allpointnetwork.com.

Q. How do I know if I got my pay, and how much? What do I do if the amount is wrong?

A. Your employer will provide a check stub for you. If your pay amount is incorrect or if your pay is not on your card, contact your employer. In addition, you can check your Account balance one of the following ways for FREE:

- Text Messaging - Sign up to receive text message alerts of your payroll loads and card usage when you call 1-888-265-8228. Sign up when you activate your card.
- Customer Service - Call Comdata automated system (called the IVR – Interactive Voice Response system) at **1-888-265-8228,** enter your Comdata card number, enter your activation code (date of birth, MM/DD/YYYY).
- Mobile App - Download the Comdata Free Prepaid Mobile App and check your balance – available for both iPhone and Android devices. Also, use the App to locate surcharge free ATMs and view most recent transactions for free!
- Cardholder Web - You must register and create an account on the Comdata Cardholder Website, www.cardholder.comdata.com, to check your balance on the Internet.

Q. What happens if I lose my Paycard or if it is stolen?

A. Contact Comdata customer service immediately (Toll-Free Phone: 1-888-265-8228).

Q. What do I do if I lose or forget my PIN?

A. A PIN is important since it safeguards your account at the ATM and PIN-accepting retailer. If you do lose or forget your PIN, contact Comdata customer service immediately (Toll-Free Phone: 1-888-265-8228).

Q. Does my employer know where I spend my money?

A. No, your employer does not have access to any of your Account information including purchases and other transactions.

Q. What happens if I need to return a purchase?

A. Each merchant location has its own return policy and will handle the return in the same manner as any other transaction. You may receive a credit to your Paycard, a cash refund, or a store credit. It may take up to one week for a credit to appear.

FEE SCHEDULE

Comdata Payroll Card Pricing – Cardholder Fees

Get Cash	
ATM Withdrawal, In-Network	**$0.00**[2]
ATM Withdrawal, Out-of-Network	**$1.75**[2]
Bank Teller Withdrawal (at participating banks where Mastercard is accepted)	**$0.00**[1]
Spend Money	
Point of Sale Transactions: Signature-Based	**$0.00**[2]
Point of Sale Transactions: PIN-Based	**$0.00**[2,3]
Comchek Draft	**$3.00**[4]
Account Information	
Customer Service: Web, IVR, or Live Operator (including card balance and transaction history)	**$0.00**
Text Alerts	**$0.00**[5]
ATM Balance Inquiries, Declines	**$3.00**[2]
Other	
Lost Card Replacement (One free per year)	**$5.00**[3]
Companion Card (upon request)	**$5.00**
Card-to-Bank Transfer	**$0.00**
Cross-Border Currency Fee (International Transactions)	**1.1%**[6]

The Comdata fees listed above represent the maximum amount that Comdata may charge. Comdata reserves the right to reduce or waive a fee at its option. Some fees may be reduced or not charged according to limitations or prohibitions under applicable laws and regulations.

[1] Available at all banks that participate in the Mastercard® network.

[2] ATM operators outside of Comdata's surcharge free ATM network and other places where you use your card may charge fees that will be deducted from your card balance. To find locations within the surcharge-free network, visit http://www.allpointnetwork.com/locator.aspx

[3] Except where a fee for this transaction is prohibited by applicable law or a lesser amount is required by applicable law.

[4] Third-parties may charge you an additional fee to cash a Comchek.

[5] Your wireless telecom service provider may charge you to receive text messages.

[6] If you use your card outside of the United States, or if you debit funds or make a purchase in a currency other than US Dollars, the amount deducted from your card will be converted into US Dollars. A charge of 1.1% of the original transaction amount will be deducted from your card in US Dollars. The charge is independent of and in addition to any other transaction fee indicated above. Not all cards are eligible for use outside the United States. For information regarding this feature, please call 1.888.265.8228

Credit Union

Each employer offers an opportunity for partner membership with a local Credit Union.

Direct Deposit participation is required for your employer to electronically transmit funds to your credit union. You may choose to transmit your entire pay (Account 1 on Payroll Selection Form) or a designated dollar amount (Account 2 on Payroll Selection Form) to your credit union. Funds can be used for any services offered by the credit union.

The service is voluntary and provides immediate access on payday to all funds deposited from direct deposit.

Credit unions offer a wide variety of financial services including checking accounts, savings accounts, Christmas Club accounts, and a wide range of loans; i.e. mortgage, auto and personal loans.

Credit union membership is normally available to all family members as well as to the partner.

Information about your local credit union is available through the Business Office where you work.

Partner Discounts

Entertainment, Retail & Other Discounts

National HealthCare Corporation partners have access to exclusive discounts and special offers from top brands nationwide. Savings and offers for shopping, services, entertainment, travel and much more!

There are two ways to take advantage of savings and offers:

1) Go to TicketsAtWork.com. Click on the "Login" Box at the top of the homepage. You will then be prompted to create a username and password, and enter the company code NHCBENEFITS. Once enrolled you will have unrestricted access to the savings!
2) You may also contact TicketsAtWork by calling customer service at 800-331-6483.

NHC employers and its affiliates make these services available to partners as a convenience, as well as a possible money saving opportunity. They should be used at each partner's discretion.

Other Discounts

NHC does not negotiate or contract for special offers, savings or discounts with local or nationwide businesses. However, some businesses may make savings or offers available to certain employers in their community. When you make a purchase, feel free to ask if the business offers discounts to employees of your employer, knowing that those discounts are always at the discretion of the business.

NHC and its affiliates, do not have business relationships with any of the discount providers. Neither does NHC endorse any of the providers, their events or their services.