PRISMA HEALTH
WELFARE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Updated June 1, 2022

TABLE OF CONTENTS

PRISMA HEALTH
WELFARE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

1. Introduction

Prisma Health maintains the **Prisma Health Welfare Benefits Plan** (the "Plan") for the benefit of its eligible employees, as well as the eligible employees of certain affiliated entities that have adopted the Plan, and their eligible family members. The adopting affiliates are listed as participating employers under the section entitled "General Information About the Plan". Prisma Health, together with the participating employers, are referred to in this booklet as the "Company".

This document, which is updated effective as of June 1, 2022, summarizes important information about the Plan. The Plan provides health and welfare benefits through the component benefit programs described on Prisma Health's benefits website, benefitsformyworld.com, which currently consist of the following:

- Medical Benefit program (including prescription drug and wellness benefits)
- Dental Benefit program
- Vision Benefit program
- Life and Accidental Death and Dismemberment ("AD&D") Benefit programs (including voluntary life and voluntary AD&D benefits)
- Short-Term Disability Benefit and Long-Term Disability Benefit programs (including supplemental short-term disability and supplemental long-term disability benefits)
- Prepaid Legal Benefit program
- Dependent Care Flexible Spending Account ("Dependent Care FSA") program
- Health Flexible Spending Account ("Health FSA") program
- Health Spending Account ("HSA") program
- Supplemental Welfare Benefit programs, including:
  - Accident Insurance Benefit program
  - Critical Illness Benefit program
  - Hospital Indemnity Benefit program
  - Whole Life Benefit program
  - Lifetime Benefit Term with Long-Term Care
  - Emergency Transportation Coverage

Each of the component benefit programs is summarized in a separate certificate of coverage, separate benefits descriptions or other written governing document that is attached and included as part of Appendix A.

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the documents included in Appendix A. This document, together with the documents included in Appendix A, is the summary plan description (SPD) required by ERISA §102 for benefits subject to ERISA. ***This document (sometimes referred to as the "wrap SPD") is***

not intended to give you any substantive rights to benefits that are not already provided by the documents included in Appendix A. You must read the documents in Appendix A and this document together to understand your benefits.

The Plan includes component benefit programs that are subject to ERISA and programs that are not subject to ERISA. Descriptions of component benefits that are not subject to ERISA are included in this SPD for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document. The ERISA-covered benefits programs include the Medical, Dental, Vision, Life, Accidental Death & Dismember, Short-Term Disability, Long-Term Disability, Supplemental Welfare, Prepaid Legal Benefits, and Health FSA programs under the Plan. Although the Dependent Care FSA and the HSA benefit programs are described in this booklet, these benefit programs are not subject to ERISA.

Benefits hereunder are provided pursuant to an insurance contract or other governing written plan document adopted by the Company. If the terms of this SPD conflict with the terms of such plan document, then the terms of the insurance contract or governing plan document will control, rather than this SPD document, unless otherwise required by law.

The Company intends to continue the benefit programs under the Plan indefinitely. However, the Company reserves the right to amend, alter, change, suspend or terminate the Plan (or any of the component benefit programs) at any time.

2. Eligibility, Participation and Enrollment

a. Eligibility Requirements

The Company is responsible for determining eligibility of the employees and their family members to participate in the Plan. The following individuals are not eligible to participate in the component plans described in this booklet:

- Third Party, Leased, Payroll Service or Agency Employees. A third party, leased, payroll service or agency employee means an individual (a) for whom the direct payor of compensation with respect to the performance of services for the Company or an affiliated employer is any outside entity, including but not limited to a payroll service or temporary employment agency, rather than by the Company's internal payroll system; or (b) who is paid directly by the Company, but not through an internal corporate payroll system (e.g., through purchase order accounts); or (c) designated by the Company as an independent contractor, either through the terms of an agreement with such individual or otherwise. The determination whether an individual is a third party, leased, payroll service or agency employee shall be made by the Company, in its sole discretion, based solely upon these criteria, without regard to whether the individual is considered a common law

employee of the Employer or an affiliated employer for any other purpose. Any independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party as an eligible employee will not be considered an eligible employee for periods before the Company implements the reclassification decision, even if the decision applies retroactively for other purposes.

- Union Employees. Persons whose employment is governed by a collective bargaining agreement, unless the collective bargaining agreement provides for their participation in the Plan.

The following table provides a brief summary of the eligibility requirements for the benefit programs and should be read with the benefit program documents attached to this booklet under Appendix A.

Benefit Program	Eligibility Requirements	Waiting Period
Medical	Class I and Class II: Classified as a full-time or part-time employee and employed by the Company on a continuing and regular basis for at least 16 hours per week (12 hours per week in the case of employees approved for participation in the Company's apprenticeship program). Class III: Employed by the Company as a PRN variable hour employee and completes a measurement period of 12 consecutive months, during which the PRN variable hour employee averages 30 hours per week actual work and/or paid leave, FMLA leave or jury duty, whether paid or not, for 12 consecutive months.	Class I and Class II: The last day following the first of the second full pay period following your date of hire or status change to an eligible employment status. Class III: The last day following the first of the second full pay period following your date of hire or status change from the end of the measurement period.
Dental	Classified as a full-time or part-time employee of the Company. PRN employees are not eligible.	First day of the first full pay period following your date of hire or status change to eligible position.
Vision	Classified as a full-time or part-time employee of the Company. PRN employees are not eligible.	First day of the first full pay period following your date of hire or status change to eligible position.

Benefit Program	Eligibility Requirements	Waiting Period
Life and AD&D (including voluntary)	• Classified as a regular employee of the Company; and • Regularly working at least 16 hours each week (12 hours per week in the case of employees approved for participation in the Company's apprenticeship program). *<u>Not eligible</u> – temporary or seasonal employees, leased employees, independent contractors, or full-time members of the armed forces of any country.*	First day of the first full pay period following your date of hire or status change to eligible position.
Short-Term Disability (including supplemental)	• Classified as a regular employee of the Company; and • Actively at work (including regularly scheduled days off, holidays, or vacation days, so long as you are capable of active work on those days) at least 16 hours each week (12 hours per week in the case of employees approved for participation in the Company's apprenticeship program); and • A citizen or resident of the United States or Canada *<u>Not eligible</u> – temporary or seasonal employees, leased employees, independent contractors, full-time members of the armed forces of any country, Midland Resident Employees, and employees who are eligible for Leadership Time Off (LTO)*	Eligible on the first day following 90 consecutive days of employment in an eligible position.

Benefit Program	Eligibility Requirements	Waiting Period
Long-Term Disability (including supplemental)	• Classified as a regular employee of the Company; and • Actively at work (including regularly scheduled days off, holidays, or vacation days, so long as you are capable of active work on those days) at least 16 hours each week (12 hours per week in the case of employees approved for participation in the Company's apprenticeship program); and • A citizen or resident of the United States or Canada *<u>Not eligible</u> – temporary or seasonal employees, leased employees, independent contractors, full-time members of the armed forces of any country, and Midland Resident employees.*	Eligible on the first day following 90 consecutive days of employment in an eligible position.
Health FSA and Dependent Care FSA	Eligible to participate in the Medical Benefits program (see above)	First pay date coincident with or following satisfaction of the eligibility requirements.
HSA	Enrolled in a high deductible health plan under the Medical Benefit program.	None
Prepaid Legal	Classified as a full-time or part-time employee of the Company. PRN employees are not eligible.	First day of the first full pay period following your date of hire or status change to eligible position.
Supplemental Welfare Benefits - Aflac ***(Accident Insurance, Critical Illness, Hospital Indemnity, Whole Life)***	Classified as a full-time or part-time employee and employed by the Company on a continuing and regular basis for at least 16 hours per week. PRN employees are not eligible.	First day of the first full pay period following your date of hire or status change to eligible position.
Supplemental Welfare Benefits - Other ***(Lifetime Benefit Term with Long-Term Care, Emergency Transportation Coverage)***	Classified as a full-time or part-time employee of the Company. PRN employees are not eligible.	First day of the first full pay period following your date of hire or status change to eligible position.

b. Enrollment: Time Limits

While some of the Plan's component benefits are provided automatically to employees, other component benefit programs require completion of application forms, annual elections, or other administrative forms, as described in the documents in Appendix A. For benefits requiring enrollment, new employees must generally enroll within certain time periods after being hired or after first becoming eligible, as described in the documents in Appendix A. Thereafter, enrollment for each component benefit program is generally limited to the annual open enrollment period that occurs before the beginning of each plan year, unless circumstances give rise to special enrollment rights as described immediately below, or unless other enrollment opportunities are available for a particular component benefit program, as described in the documents in Appendix A.

c. Special Enrollment Rights

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the applicable documents in Appendix A. The Plan's Special Enrollment Notice also contains important information about your potential special enrollment rights. Contact the Human Resources Department of Prisma Health if you need another copy of this Notice.

d. Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

e. When Participation Begins

Coverage under the Plan begins once you, as an eligible employee, have completed the necessary enrollment paperwork or when you become eligible for a benefit that does not require enrollment, if earlier. Requirements may vary depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the documents included in Appendix A. Service credit toward eligibility is provided in the case of acquisitions.

f. Participation During Leaves

Except as provided in the documents included in Appendix A, this section describes how your coverage will be continued during certain leaves of absence. Thus, to know whether you will be eligible to continue coverage during a leave of absence, you must review the terms of the applicable insurance policies, certificates of coverage or component plan benefit booklets. If you have any questions, contact the Plan Administrator.

Coverage for you and your eligible dependents may continue under the Plan while you are on an approved leave of absence in accordance with the Company's policies, subject to your payment of the required contributions and the limitations described in this in the Plan or the documents included in Appendix A.

Continued coverage is only available if you continue to make the same premium payments or contributions that you were making immediately before the leave took effect. Your Plan participation will end if you fail to pay the required employee contribution when due. Your Plan participation will end immediately upon your commencement of a leave of absence that is not approved by the Company.

Family Medical Leave Act

Notwithstanding any other provision of this Plan, if you take an approved leave of absence under the FMLA, coverage under the Plan will continue to be made available during such FMLA leave period to you and your covered dependents under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave.

If you do not wish to continue some or all of these benefits during the FMLA leave, you must inform the Company before the start of the leave. If you choose ongoing coverage during FMLA leave, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The obligation to provide ongoing coverage under this Plan for you and your covered dependents on an FMLA leave, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the Company may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event, the Company's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

While you are on an FMLA leave, the Company will continue to make the same contributions toward the cost of coverage continued under the Plan that it would have made had you not taken such leave of absence. The Company will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the Company will have the right to be reimbursed by you for any and all contributions the Company has made on behalf of you and your covered dependents during the leave. In this regard, the Company shall have the right to obtain reimbursement from any funds that the Company might otherwise owe you following your voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued vacation pay or sick

leave pay; or (c) other sources. In addition, the Company shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, the Company shall be entitled to recover from you any required employee contributions the Company has made on behalf of you and your covered dependents during the unpaid leave to ensure continuity of coverage.

The Company may not recover any of its regular contributions made on behalf of you and your covered dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the FMLA leave; or (b) other circumstances beyond your control (as set forth in the Company's policies and procedures).

Upon returning from an approved FMLA leave, coverage under the Plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

Military Leave

Notwithstanding any other provision of this Plan, we will grant a leave of absence to any employee due to military service in the Armed Forces of the United States in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA), and applicable state law. In general, during such a leave of absence under USERRA, you may be eligible to elect to continue group health plan coverage for yourself and your enrolled dependents (if any) for up to 24 months.

More specifically, if you are absent from work for more than 31 days in order to fulfill a period of duty covered by USERRA, you will be treated as having experienced a "qualifying event," as that term is defined under the Plan's COBRA continuation coverage provisions, see below, as of the first day of your absence for such duty. This means that in addition to having the option to elect to continue coverage under COBRA, you will become eligible to elect continuation coverage under USERRA using procedures similar to those required by COBRA. The Plan Administrator or its designee will furnish you with a notice of the right to elect continuation coverage, which will include information about the premiums you will have to pay for such coverage. This notice will allow you the opportunity to elect such coverage for up to 24 months (so long as you continue to be on a leave of absence under USERRA) beginning on the date your USERRA leave commenced. Nothing in the Plan limits your right to continue your coverage under COBRA instead of under this section.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator and providing payment of any required contribution for the health coverage. The election procedures are same as for COBRA; refer to the COBRA section below for more information. However, only the covered employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage. The employee's spouse and dependent children do not have independent election rights under USERRA. This means that if the

employee does not elect continuation coverage under USERRA, his spouse, for example, still may elect continuation coverage under COBRA, but not USERRA. If you do not make your election within 60 days of being provided with the notice mentioned above, you will no longer be eligible to continue coverage under the Plan, except as required by USERRA.

The required contribution will include the amount we normally pay on your behalf if the period of continuation coverage is fewer than 31 days. If not, the required premium will be 102% of the full premium for the level of coverage elected. Premium payments must be made at the same time and in the same manner as those required under COBRA.

If you elect to continue coverage under USERRA, the period of extended group health plan coverage shall run concurrently with the maximum continuation coverage period that may be available under COBRA. Continuation coverage under USERRA will end, however, upon the first to occur of the following: (i) the last day of the 24 month coverage continuation period, (ii) the last day of the period for which timely premium payment is made, (iii) you fail to return to work within the time frame required under USERRA following the completion of your service, or (iv) you lose your rights under USERRA as a result of dishonorable discharge or other conduct under USERRA.

Regardless of whether you continue your health coverage, if you return to your position of employment in the time and manner required under USERRA, your health coverage for you and your enrolled dependents (if any) will be reinstated under the Plan as required under USERRA. No exclusions or waiting period may be imposed on you or your enrolled dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Contact the Plan Administrator for more information regarding the rights under USERRA to continue coverage, as well as reemployment and other rights you may have under USERRA. More information about coverage available pursuant to USERRA is included in the document set forth in Appendix A.

Payment of Premiums

Except as otherwise provided above, if you are receiving pay from the Company during your leave, your scheduled payroll deductions will automatically continue during your leave. If your paycheck does not cover the amount of any regularly scheduled contribution during your leave, you may make an after-tax payment to make up the difference.

If you take an approved unpaid FMLA leave, you may elect either to terminate your coverage and stop making required contributions during your leave, or to continue your coverage if permitted under the terms of the applicable component benefit.

For all unpaid leaves during which coverage is continued, you must arrange to personally pay the amount due on an after-tax basis in accordance with provisions of

the applicable plans.

If the full amount of any required premiums are not made within 30 days after it was due, your coverage under the applicable component benefit options under the Plan will be terminated for the remaining period of your leave of absence, retroactive to the last day for which a required contribution was made, and you will not be eligible for reimbursement of any claims incurred while your coverage was terminated.

If you fail to return from the leave, you will be required to reimburse the Company that portion of the cost of coverage it paid on your behalf during your leave.

g. When Participation Ends

Coverage under a particular component benefit program stops according to the terms and conditions reflected in the documents included in Appendix A. Note that termination of coverage under a particular component benefit program does not necessarily mean all Plan coverage terminates. You (or your covered family member) may still have coverage under another component benefit program.

In general, your coverage under this Plan (including all component benefit programs) terminates on the last day of the month in which you terminate employment with the Company. Coverage under the Plan or a particular component benefit program may terminate earlier if you fail to pay your share of the premiums, if your hours drop below any required eligibility threshold, if you submit false claims, and for certain other reasons described in the documents included in Appendix A.

Coverage for your covered family members stops when your coverage stops. Coverage for a family member will also stop if that family member becomes ineligible (for example, due to divorce or a dependent's attaining the age limit specified for the component benefit) or for other reasons specified in the documents included in Appendix A (such as nonpayment of applicable premiums). It is your responsibility to provide accurate information and to make accurate and truthful statements regarding family status, age, relationships, etc., and to update previously provided information and statements. Failure to do so may be considered an intentional misrepresentation of material fact, and may result in termination of coverage; such termination may be retroactive.

Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

h. Continuation Coverage: COBRA and Other Opportunities

For certain component benefit programs, in the event your Plan coverage for that component benefit terminates, you or your family member(s) may be eligible to continue the coverage for a period of time. There are several types of continuation coverage that may apply to particular component benefit programs, as summarized below and specified in more detail in the documents included as part of Appendix A.

If coverage for you or your eligible family members under a group health plan (medical dental, or vision coverage; health FSA) ceases because of certain "qualifying events" specified in COBRA (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have any questions about your COBRA rights, please read the "Summary of Rights and Obligations Regarding Continuation of Plan Coverage," a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy.

Note also that state law may provide continuation and/or conversion coverage.

3. Summary of Benefit Programs

a. General

The Plan makes the benefit programs available to eligible employees and their family members, as applicable. Eligible employees will have the opportunity to choose from these benefit programs according to their individual needs.

In general, the cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by employee contributions (which may be pre-tax or after-tax, subject to the terms of the cafeteria plan (described below) and applicable component benefit program). The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured component benefit programs, the Company will pay its contribution and forward your contributions to the insurer. With respect to benefits that are self-funded, the Company will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the Company's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

b. Paying for Elected Benefits

In connection with those component plans that require an employee contribution in order to participate, the Company offers a benefit program known as a "cafeteria plan" for eligible employees. A cafeteria plan provides eligible employees with the opportunity to use pre-tax dollars to pay for certain elected benefit programs under the Plan by entering into a salary reduction arrangement.

A participant may elect to pay for or contribute to, as applicable, the following benefit programs with pre-tax dollars:

- Medical Benefit
- Dental Benefit
- Vision Benefit
- Health FSA
- Dependent Care FSA
- HSA

The following benefit programs may only be paid for by participants with after-tax dollars to the extent the employer does not pay the applicable premium:

- Life Benefit
- AD&D Benefit
- Short-Term Disability Benefit
- Long-Term Disability Benefit
- Supplemental Welfare Benefits
- Prepaid Legal Benefit

c. Funding of Benefit Programs

The Medical (including prescription drug) Benefit and Health FSA program under the Plan are "self-funded" by the Company. This means that the Company is responsible for the financing of benefits under these benefit programs. The Company has engaged third party administrators in relation to each of the Medical Benefit and Health FSA programs. *See the Third Party Administrators listed under "Third Party Administrators and Insurance Companies".*

Benefits of the Plan (other than Medical Benefits and Heath FSA) are provided under insurance contracts entered into between the Company or the participant, as applicable, and various insurers. *See the Insurance Companies listed under "Third Party Administrator and Insurance Companies".*

d. Health Savings Account (HSA)

The HSA is not an employer-sponsored employee benefit plan – it is an individual trust or custodial account that an eligible employee may open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223. Consequently, an HSA trustee/custodian, not the Company, will establish and maintain an eligible employee's HSA. The HSA trustee/custodian will be chosen by the eligible employee, and not by the Company.

The Company may, however, limit the HSA providers to whom it will forward pre-tax salary reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative

simplification and shall not be an endorsement of any particular HSA trustee/custodian. An employee's HSA is administered by the applicable HSA trustee/custodian. The Company's role is limited to allowing eligible employees to contribute to their respective HSAs on a pre-tax salary-reduction basis. The Company has no authority or control over the funds deposited in an employee's HSA.

e. Further Information Regarding Benefit Programs

The contracts with, and benefits descriptions provided by, the Insurance Companies and Third Party Administrator describe the types of benefits, scope of coverage, prerequisites to being covered, and other details regarding the benefits. As noted above, a Plan participant must read the documents attached in Appendix A to understand the benefit programs provided under the Plan.

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan), please contact the Human Resources Department of the Company. If you have questions regarding eligibility for a benefit and/or the amount of any benefits payable under a particular benefit program of the Plan, please contact the Third Party Administrator or Insurance Company, as applicable.

4. Claims Procedures

The Third Party Administrators are responsible for evaluating all initial benefit claims under the Medical Benefit program and all benefit claims under the Health FSA. The Plan Administrator is responsible for determining second level claims for the Medical Benefit program. The Insurance Companies are responsible for evaluating all benefits claims under the insured benefit programs of the Plan. Each of the Third Party Administrator and the Insurance Companies will decide any claims in accordance with its reasonable claim procedures, as required by ERISA (as applicable) and other applicable law.

If a claim is denied (that is, not paid in part or in full), the claimant will be notified and may appeal to the applicable Third Party Administrator or Insurance Company, as applicable, for a review of the denied claim. The Third Party Administrator or Insurance Company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. **If a claimant does not appeal on time, he or she will lose the right to file suit in a state or federal court, as the claimant will not have exhausted his or her internal administrative appeal rights (which generally is a condition for bringing suit in court).**

See the documents for the benefit programs attached as Appendix A to this booklet for information about how to file a claim or appeal a denied claim and for details regarding the applicable claims and appeals procedures.

5. Third Party Administrators and Insurance Companies

The following table lists the contact information for the Third Party Administrators and Insurance Companies that administer the Plan's benefit programs. For a current listing, visit www.benefitsformyworld.com.

Third Party Administrators	
Medical	Medical Program Supervisor: Aetna PO Box 981106 El Paso, TX 79998-1106 (833) 860-0395 Pharmacy Program Supervisor: EnvisionRx 2181 East Auroa Road, Suite 201 Twinsburg, OH 44087 (833) 640-2850
Health FSA	WageWorks P.O. Box 14053 Lexington, KY 40512
Insurance Companies	
Dental	Delta Dental of Missouri PO Box 8690 St. Louis, MO 63126 (800) 335-8266
Vision	VSP 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
Short-Term Disability (Basic and Supplemental)	Standard Insurance Company Employee Benefits Department P.O. Box 2800 Portland, OR 97208 (800) 633-8575
Long-Term Disability (Basic and Supplemental)	Standard Insurance Company Employee Benefits Department P.O. Box 2800 Portland, OR 97208 (800) 368-1135
Life and Accidental Death & Dismemberment (Basic and Voluntary)	Standard Insurance Company Employee Benefits Department P.O. Box 2800 Portland, OR 97208 (800) 628-8600

Accident Insurance, Critical Illness, Hospital Indemnity, Whole Life	Continental American Insurance Company P.O. Box 84075 Columbus, GA 31993 (800) 433-3036 *Benefits are offered through Aflac.*
Prepaid Legal	MetLife Legal Plans legalplans.com (800) 821-6400
Emergency Transport Coverage	MASA 800-643-9023

6. General Information About the Plan

Plan Name

The name of the Plan is the "Prisma Health Welfare Benefits Plan"

Type of Plan

The Plan is a group welfare plan. The benefit programs offered under the Plan (other than the HSA benefit program) are subject to ERISA.

Plan Year

The plan year ends each December 31.

Plan Number

The plan number is 501.

Effective Date

The effective date of the Plan is January 1, 2019.

Plan Sponsor: Prisma Health

Employer Identification Number: 82-2595551

Participating Employers

Prisma Health – Upstate
Prisma Health – Midlands
Prisma Health – University Medical Group
Greenville Health Corporation
Auxiliary to Greenville Hospital System
Greenville Health Authority
Richland Memorial Hospital
Prisma Health Medical Group – Midlands
PH ASC HR, LLC – Effective April 1, 2022

Mailings to a participating employer should be sent to the below address, care of (c/o) that participating employer:

Prisma Health
7 Independent Point, Suite 300
Greenville, SC 29615

Plan Administrator

Health and Welfare Benefits Administrative Committee
Prisma Health
7 Independence Point, Suite 300
Greenville, SC 29615
(864) 797-7905

Claims Fiduciaries

See list of "Third Party Administrator and Insurance Companies"

Agent for Service of Legal Process

Prisma Health
Attn: Kelly Crocker
7 Independence Point, Suite 300
Greenville, SC 29615

Service of legal process may also be made on the Plan Administrator.

7. Rights Under ERISA

Participants in the benefits programs under the Plan (other than the HSA) are entitled to certain rights and protections under ERISA. ERISA specifies that all such Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- For group health plans, continue health care coverage for a Plan participant, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

- Review the SPD and the documents governing the Plan or the rules governing COBRA continuation coverage rights, as applicable.

If a Plan participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan participant can take to enforce the above rights. For instance, if a Plan participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court after exhausting the Plan's claims procedures described in the applicable benefit program documents attached to this booklet under Appendix A. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court after exhausting the Plan's claims procedures noted in the booklet.

In addition, if a Plan participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court after exhausting the Plan's claims procedures noted above.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and their beneficiaries. No one, including the Company or any other person, may fire a Plan participant or otherwise discriminate against a Plan participant in any way to prevent the Plan participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan participant is discriminated against for asserting his or her rights, he or she 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 the Plan participant is successful, the court may order the person sued to pay these costs and fees. If the Plan participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan participant should contact either the nearest area 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, at 200 Constitution Avenue, N.W., Washington, DC 20210. The Plan participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

8. Qualified Medical Child Support Orders

As described in the attached Medical Benefit program document(s) under Appendix A, the Medical Benefit program under the Plan extends benefits to an employee's non- custodial child, as required by any qualified medical child support order ("QMCSO") under ERISA Section 609(a). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Human Resources Department of the Company.

9. COBRA Continuation Coverage Rights

If a Plan participant or his or her dependents lose medical, dental and/or vision benefits, coverage may continue under certain conditions. Refer to the relevant terms of the documents attached to this booklet under Appendix A for specific information.

10. Coordination of Benefits

If a Plan participant or his or her dependents are covered by more than one benefit program (whether provided under the Plan or otherwise) that provide for similar benefits, special rules may apply regarding how benefits are covered by the applicable benefit programs under this Plan. Please consult the plan documents attached to this booklet under Appendix A for additional information.

11. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

12. Amendment and Termination of the Plan

Prisma Health has the right to modify, amend or terminate the Plan (or any component benefit program thereof) at any time, in whole or in part.

APPENDIX A

BENEFITS SUMMARIES

All benefit summaries are posted at www.benefitsformyworld.com.

4814-0997-7595, v. 5