SUMMARY

for

Navicent Health Employee Health Clinic

Effective January 1, 2023

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NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY

Atrium Health Navicent complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). Atrium Health Navicent does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Atrium Health Navicent:

- 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, contact Secure Health powered by MedCost Benefit Services Customer Service at 1-800-648-7563.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (800) 204-2085.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800)204-2085.

繁體中文 (Chinese): 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 (800) 204-2085.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 204-2085.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 204- 2085 번으로 전화해 주십시오.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 204-2085.

العربية **(Arabic)**:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 204-2085

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 204-2085.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 204-2085.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 204-2085.

ગુજરાતી (Gujarati): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો**

(800) 204-2085.

ប្រយ័ត្ន៖ **(Mon-Khmer Cambodian)**: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 204-2085 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 204-2085.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 204-2085 पर कॉल करें।

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 204-2085.

日本語 (Japanese): 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。(800) 204-2085 まで、お電話にてご連絡ください。

INTRODUCTION

This Summary Plan Description describes the Clinic benefits provided under the Navicent Health Employee Health Clinic (the “Clinic”). All decisions regarding health care provided at the Clinic are up to the Plan Participant and his or her physician. There may be circumstances when a Plan Participant and his or her physician determine that health care which is not covered by the Clinic is appropriate.

Changes in the Clinic may occur in any or all parts of the benefits under the Clinic including copays, limitations, eligibility and the like.

Atrium Health Navicent (the “Employer”) fully intends to maintain the Clinic indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Clinic at any time and for any reason.

Purpose

- This document is the Summary Plan Description for the Clinic and the Clinic is a component plan under the Navicent Health Inc. Health and Welfare Plan, Plan No. 501 (the “Plan”).
- The Clinic is designed to provide Plan Participants with on-site health care benefits.
- The Clinic is not to be construed as a contract for or a guarantee of employment. Nothing in the Clinic shall be deemed to:
  - Affect the right of the Employer to discipline or discharge any Plan Participant at any time.
  - Affect the right of any Plan Participant to terminate his or her employment at any time.
  - Give the Employer the right to require any Plan Participant to remain in its employ.
  - Give the Plan Participant the right to be retained in the employ of the Employer.

Exclusive Benefit

- The Clinic is subject to ERISA and is established and shall be maintained for the exclusive benefit of eligible Plan Participants and their dependents.
- Coverage under this option will take effect for an eligible Plan Participant when the Plan Participant satisfies all of the eligibility requirements of the Employer.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- The Clinic is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change terms and conditions of the Clinic.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after time when written proof of loss is required to be furnished to the Third Party Administrator.
- Should any part of this Summary Plan Description for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Summary Plan Description has been executed with the invalid portion thereof eliminated.

This summary plan description (SPD) only summarizes the provisions of the formal Plan document and does not attempt to cover all of the details contained in the Plan document. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official Plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official Plan document, the provisions set forth in the Plan document will govern in all cases. If you wish to review the Plan document, please refer to the section of this SPD entitled "YOUR RIGHTS" which discusses your ability to review the Plan Document.

GENERAL INFORMATION

TYPE OF ADMINISTRATION: The Clinic is a self-funded group health plan and the administration is provided through a Third Party Administrator. The funding for the benefits is derived from the funds of the Employer and per-visit fees paid by Plan Participants.

PLAN NAME: Navicent Health Employee Health Clinic, a component benefit plan of the Navicent Health Inc. Health and Welfare Plan (also known as the Central Georgia Health Systems, Inc. Health and Welfare Plan), Plan No. 515

TAX ID NUMBER: 58-2149127

CLINIC EFFECTIVE DATE: December 1, 2016

EMPLOYER INFORMATION:
Atrium Health Navicent
777 Hemlock Street
Macon, Georgia 31201
(478) 633-1000

AGENT FOR SERVICE OF LEGAL PROCESS
Atrium Health Navicent
777 Hemlock Street
Macon, Georgia 31201

THIRD PARTY ADMINISTRATOR
Group Number: SH700
MedCost Benefit Services
PO Box 25307
Winston-Salem, NC 27114-5307

CLAIMS ADMINISTRATOR
Group Number: SH700
MedCost Benefit Services
PO Box 25307
Winston-Salem, NC 27114-5307

GENERAL PROVISIONS

Plan Participants should contact Atrium Health Navicent to obtain additional information, free of charge, about the Clinic's coverage or any aspect of benefits or requirements. Atrium Health Navicent is responsible for determining and providing the benefits of the Clinic, not the Third Party Administrator.

ELIGIBILITY

Eligibility Requirements for Plan Participant Coverage
All employees of the Employer ("Teammates") are eligible beginning on their first day of employment and such employees' Dependents age 18 and above are eligible when the Teammates are eligible and enrolled in an Atrium Health Navicent Health Plan.

TERMINATION OF COVERAGE

Coverage will end automatically upon the earliest of the following dates. In certain circumstances, a Plan Participant may be eligible for COBRA continuation coverage. See the section Coverage Continuation Rights under COBRA.

- the date the Plan is terminated;
- the date the covered Teammate ceases to be eligible for coverage under this Plan; and
- the date the covered Teammate retires or dies.

Employer-Approved, Non-FMLA Leave of Absence / Layoff / Disability
While continued, coverage will be that which was in force on the last day worked as an eligible Teammate. However, if benefits reduce for others in the class, they will also reduce for the continued person. The Plan reserves the right to choose a different plan for continuing coverage; however, any such plan will not be discriminatory.

Continuation during Personal Non-FMLA Leave of Absence
If a personal leave of absence is approved by the Employer as defined in the Employer's "Leave of Absence" policies, a Teammate will be allowed to continue health insurance coverage and other benefits made available to Teammate's who have taken on leave.

Continuation during Family and Medical Leave (FMLA) and Military Leave (USERRA)
Regardless of the established leave policies mentioned above, if the Employer is subject to FMLA and USERRA regulations, this Plan shall at all times comply with the FMLA and USERRA as promulgated in regulations issued by the Department of Labor. Teammates should contact their Human Resources Department or the Plan Administrator for additional information or a copy of the Employer's written policy regarding compliance with FMLA and USERRA.

BENEFITS DESCRIPTION

When you're at work and health symptoms arise, the Clinic is available for convenient, reliable and cost- effective care. Our Advanced Practice Providers (APP) treat illnesses including cold, cough, bronchitis and flu; ear, sinus, and upper respiratory infections; seasonal allergies; or minor injuries such as splinters, sprains or cuts, and occupational injuries/illnesses as well as manage your chronic conditions such as blood pressure, cholesterol, diabetes, tobacco cessation and asthma. Please see the Questions and Answers section at the back of this booklet or visit the Benefits Department with questions or for more details.

An Advanced Practice Provider, also commonly known as a mid-level provider, will provide care at each Clinic location. The APP is supervised by a licensed physician in the State of Georgia and, under the rules, can practice independently. The APP can diagnose and treat injuries and illnesses and write certain levels of prescriptions, if needed.

Please note: Annual wellness physicals can be performed by an AAP.

The Clinic is available to all Teammates of the Employer. Spouses and Dependents (age 18 and above) of Teammates and such spouses and Dependents who are enrolled in an Atrium Health Navicent Health Plan may access care from the Clinic locations.

All Teammates and covered spouse and Dependents pay the same fee for services. There are no fees for visits as a result of occupational injuries / illnesses.

Fees for Clinic visits range from $0 to $40 depending on the level of service, if enrolled Atrium Health Navicent Health Plan, and annual Deductible status. Plan Participants may use their applicable Health Savings Account, Flexible Spending Account or LiveWELL Incentive Account to pay for services. After the Deductible is met Plan Participants enrolled in the Atrium Health Navicent Health Savings Plan pay a fee of $15 that applies toward the Out-of-Pocket Maximum. Plan Participants on the Co-Pay plan pay a fee of $15 that applies toward the Out-Of-Pocket Maximum.

A Virtual Visit benefit through Virtual OnDemand is available to all Atrium Health Navicent Plan Participants. Plan Participants, Spouses and Dependents) of Plan Participants enrolled in the Atrium Health Navicent Health Plan may access virtual care from the Virtual OnDemand platform. The Virtual Visit benefit provides a Plan Participant (including Dependents) with the opportunity to communicate his or her health concerns and questions by speaking directly with a medical provider on-line at the mutual convenience of the Plan Participant and the provider. Note, for Plan Participants enrolled in the Plan, please refer to the Schedule of Benefits in the Summary Plan Description. Virtual care can be scheduled via MyAtrium or by calling 478-633-1547 (LiveWELL Care Macon) / 478-776-4039 (LiveWELL Care Baldwin). Virtual OnDemand is available Monday – Friday from 8am-5pm and can be scheduled via MyAtrium.

SERVICES NOT PROVIDED

The following services are NOT PROVIDED under the Clinic:

Pediatric Well-Checks- The Clinics will not offer pediatric well-checks or child immunizations. We recommend you use your primary care provider or pediatrician for these visits.

Immunizations – The Clinic will offer immunizations to covered Teammates and covered Dependents but will not offer pediatric immunization services. The clinic will offer flu shots during flu season and TB testing when medically necessary.. Note, if you are enrolled and are covered under the Atrium Health Navicent Medical Plan, immunizations are covered at 100 percent.

Please note: This Option does not provide any Coordination of Benefits with any plan of health care coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA contains provisions giving certain former Plan Participants, Spouses and Dependent children the right to temporary continuation of health coverage.

Beneficiary

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event. A Qualified Beneficiary may be a Plan Participant, the Plan Participant's Spouse and Dependent children. COBRA continuation coverage is provided subject to your eligibility for coverage.

Qualifying Events

"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for Plan Participants are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **Spouses** are:

- Termination of the covered Plan Participant's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered Plan Participant
- Covered Plan Participant becoming entitled to Medicare
- Divorce or legal separation of the covered Plan Participant
- Death of the covered Plan Participant

The types of Qualifying Events for **Dependent children** are the same as for the Spouse with one addition:

- loss of "Dependent child" status under the Plan rules.

Periods of Coverage

Qualifying Events	Beneficiary	Coverage
Termination Reduced hours	Teammate Spouse Dependent child	18 months
Teammate entitled to Medicare Divorce or legal separation Death of covered Teammate	Spouse Dependent child	36 months
Loss of "Dependent child" status	Dependent child	36 months

COBRA outlines procedures for Plan Participants and family members to elect continuation coverage and for Employers and plans to notify beneficiaries. The Qualifying Events contained in the law create rights and obligations for Employers, plan administrators and qualified beneficiaries.

Qualified Beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices
An initial general notice must be furnished to Covered Plan Participants, their Spouses and newly hired Plan Participants informing them of their rights under COBRA and describing provisions of the law.

Specific Notices
Specific notice requirements are triggered for Employers, Qualified Beneficiaries and plan administrators when a Qualifying Event occurs. Employers must notify plan administrators within 30 days after a Plan Participant’s death, termination, reduced hours of employment, or entitlement to Medicare.

A Qualified Beneficiary must notify the Plan Administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a Qualifying Event, must automatically provide a notice to Plan Participants and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a Qualifying Event has occurred.

Election
The election period is the time frame during which each Qualified Beneficiary may choose whether to continue health care coverage under an Employer's group health plan. Qualified Beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the Qualified Beneficiary.

A covered Plan Participant or the covered Plan Participant’s Spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary. Each Qualified Beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a Qualified Beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

Covered Benefits
Qualified Beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation

coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under plans maintained by the Employer. Assuming a Qualified Beneficiary had been covered by three separate health plans of his former Employer on the day preceding the Qualifying Event, that individual has the right to elect to continue coverage in any of the three health plans.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

A change in the benefits under the plan for active Plan Participants may apply to Qualified Beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

Duration of Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for Qualifying Events due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a Qualifying Event and can end when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.
- The Employer ceases to maintain any group health plan.
- Coverage is obtained with another Employer group health plan
- A beneficiary is entitled to Medicare benefits.

Special rules for disabled individuals may extend the maximum periods of coverage. If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the Qualified Beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to Qualified Beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Paying for COBRA Coverage
Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 % of the cost to the plan for similarly situated individuals who have not incurred a Qualifying Event. Premiums reflect the total cost of group health coverage, including both the portion paid by Plan Participants and any portion paid by the Employer before the Qualifying Event, plus 2% for administrative costs.

For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the plan's total cost of coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The Plan must allow you to elect to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the Pan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1st and coverage for January could not be canceled if payment is made by

January 31st.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the Pan. The Plan, however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to Deductibles, catastrophic and other benefit limits.

CLAIMS PROCEDURE

You should submit a written claim for benefits to whoever is designated to the Claims Administrator. If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You have 180 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the Plan:

- provides for a special hearing, or
- the decision must be made by a group that meets only on a periodic basis.

Contact the Plan Administrator for more information on filing a claim for benefits. Complete plan rules are available from Employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS

A detailed description of an Employee's Privacy Rights is found in the ***Joint Notice of Privacy Practices –Atrium Health – Group Health Plan and Medical Reimbursement Plan***, which has been distributed to each Plan Participant covered under the Clinic.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that requires group health plans to protect the privacy and security of your confidential health information. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a related federal law that expanded the HIPAA privacy, security, and breach notification requirements. As a group health plan subject to ERISA, the Clinic will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration, or as required or permitted by law. A description of how the Clinic uses and discloses your protected health information, and your rights and protections under HIPAA's privacy rules, is set forth in the plan's Notice of Privacy Practices, which can be obtained by contacting Atrium Navicent Benefits Administration. The Clinic also will comply with applicable requirements under the HITECH Act, which include providing notice to affected individuals if the Plan or its business associates discover a breach involving unsecured protected health information.

ERISA STATEMENT OF RIGHTS

In 1974, Congress passed the Employee Retirement Income Security Act (ERISA) to safeguard the interests of participants in employee benefits plans and their beneficiaries.

As a participant in the Plan, you have certain rights and protections under ERISA, as explained in the following statement adapted from U.S. Department of Labor regulations. The Endowment is required by law to furnish you with this statement as part of this SPD. ERISA provides that all Plan participants are 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 Fund Office, 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 Benefit Security Administration.

- Obtain, upon written request to the Plan Administrator, 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 Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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, 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 or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a welfare 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 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, if, for example, it finds that your claim is frivolous.

Assistance with Your Questions

- If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

Atrium Health Navicent
LiveWELL Care Clinic
Questions and Answers

What are the LiveWELL Care Clinics?

Whether you are **at work or at home** when health symptoms arise, **LiveWELL Care Clinics** are available for convenient, reliable and cost-effective care. Our advanced clinical practitioners can perform annual wellness physicals, treat cold and flu symptoms, ear or sinus infections, seasonal allergies, and occupational injuries/illnesses. LiveWELL Care Clinic locations are one part of the Atrium Health Navicent commitment to your health. Each location is available to you whether you are at work or at home.

Locations

LiveWELL Care Clinic Locations	Hours of Operation	Make an Appointment
LiveWELL Care Macon 781 Spring Street, Suite 230 Macon, GA 31201	Monday – Friday 8am – 5pm	478-633-1547 MyAtriumHealth.org
LiveWELL Care Baldwin 821 North Cobb Street Milledgeville, GA 31061	Monday – Friday 8am – 5pm *Closed 12pm-1pm for lunch	478-776-4039 MyAtriumHealth.org

Additional information can be found on PeopleConnect, Human Resources, Health & Well-Being, On-Site Care.

General Information

Are LiveWELL Care Clinics only for Plan Participants who work at that location?
Access to LiveWELL Care is available for use by all Plan Participants and Spouses and Dependents of the Atrium Health Navicent Health Plans (ages 18 and above), whether you work at the site, live near the site or simply need to receive care.

What type of provider will be available at LiveWELL Care Clinics?
A nurse practitioner or physician assistant, also known as an advanced clinical practitioner (APP), provides care at these locations. APPs are supervised by a licensed physician in the State of Georgia and can practice independently. An APP can diagnose and treat injuries and illnesses and write certain levels of prescriptions, if needed.

Services Provided

LiveWELL Care Clinics provide a convenient option if you experience rapid onset of illness with symptoms that are expected to last for a short duration with treatment, including:

- Annual wellness physicals
- Cold, cough, bronchitis and flu
- Ear, sinus and upper respiratory infections
- Seasonal allergies
- Minor injuries (splinters, sprains, cuts, etc.)
- Additional access point for treatment of occupational injuries/illness

Additional services include:

- Pre-diabetes A1C screening
- Chronic Condition Management (blood pressure, cholesterol, diabetes, asthma)
- Certain outside Labs
- Medication Dispensing
- Injections (including allergy shots)

Can I use LiveWELL Care Clinics if I get sick at home?
Yes. Any location is available to you. Simply make an appointment and visit the location most convenient to home or work.

What if I am too sick to drive to a LiveWELL Care Clinic?
If you prefer, you may see a provider Monday-Friday from 8am-5pm through Virtual OnDemand. Patients can also schedule a telephonic or video visit through the Clinic during regular clinic hours. The same providers you would see during an office visit are also the providers who will handle appointments through a virtual visit. For more information on LiveWELL Care Clinic Virtual Visit call your local clinic at 478-633-1547 (LiveWELL Care Macon) / 478-776-4039 (LiveWELL Care Baldwin) or go to www.MyAtriumHealth.org

Can I get my routine prescription refills from the LiveWELL Care Clinic?
Yes. Some routine prescription medications and refills can be obtained. Schedule an appointment by phone or through MyAtrium.org to see a provider.

Can I get my routine labs at LiveWELL Care Clinic?
Yes. Routine labs can be completed at the Clinics.

Can I get immunizations?
Yes. Immunization services are offered. Note, if you enroll and are covered under an Atrium Health Navicent Health Plan, immunizations are covered at 100 percent.

Can I get my annual wellness physical at a LiveWELL Care Clinic?
Yes. Plan Participants and Spouses and Dependents on an Atrium Health Navicent Health Plan may receive Annual wellness physicals.

Can the LiveWELL Care Clinic be used for a break area if I have a migraine?
The clinic cannot be utilized as a break or rest area.

Eligibility

Who is eligible to use LiveWELL Care Clinics?
All full-time, part-time Teammates and Spouses and Dependents of Teammates enrolled in the Atrium Health Navicent Health Plan are eligible.

Making an Appointment

How do I make an appointment?
Call LiveWELL Care Clinics in Macon or Baldwin or visit your MyAtrium account. See page 18 for a list of locations and hours. To make an appointment when closed, call the respective number above to be routed to the after- hours Telehealth service or schedule through MyAtrium.org.

Can I just walk in?
Yes. Walk-ins are welcome, although appointments are preferred.

Costs and Insurance

How much will a visit to a LiveWELL Care Clinic cost?
Cost for a visit depends on level of service, health plan enrolled, and annual deductible status.

	Co-Pay Plan	Health Savings Plan	Teammates Not on the Atrium Health Navicent Plan
Office Visit	$15	Before Deductible: $40 After Deductible: $15	$40
Injection	$15*	$15*	$15*
Lab only visit	$5*	$15*	$15*
Medication Dispensing	$0	$0	$0
Plan Name Option E-Visit/Virtual Visit	$0	Before Deductible: $10 After Deductible: $0	$10

*Copays for Allergy, Injection, and Lab visits will be waived when the service is billed with an office visit.

Can I use other insurance through a different employer?
No. Outside insurance is not accepted.

Are services eligible for Flexible Spending Account (FSA) or Health Savings Account (HSA) reimbursement?
Yes, FSA or HSA debit cards will be accepted. Documentation will be provided for submission of manual claims, if requested.

Can a payroll deduction be accepted as payment?
Yes. Plan Participants may use a payroll contribution to pay for services at the clinics

Do I have to pay at the time of visit, or can I be billed?
Payment is expected at the time of service by debit or credit card, payroll contribution, FSA debit card, HSA debit card or LiveWELL Incentive Account, if applicable.

What to Bring to Your Appointment

What will I need when I visit a LiveWELL Care Clinic?
Your Teammate ID badge and Atrium Health Navicent Health Plan insurance card, if applicable, will need to be presented at the time of service. You should also be prepared to provide your Teammate ID number. Payment is expected at the time of service. For payment options, please see above for costs and insurance information.

What if I forget my badge?
You must be able to provide photo identification and an Atrium Health Navicent Plan Participant ID number at the time of appointment.