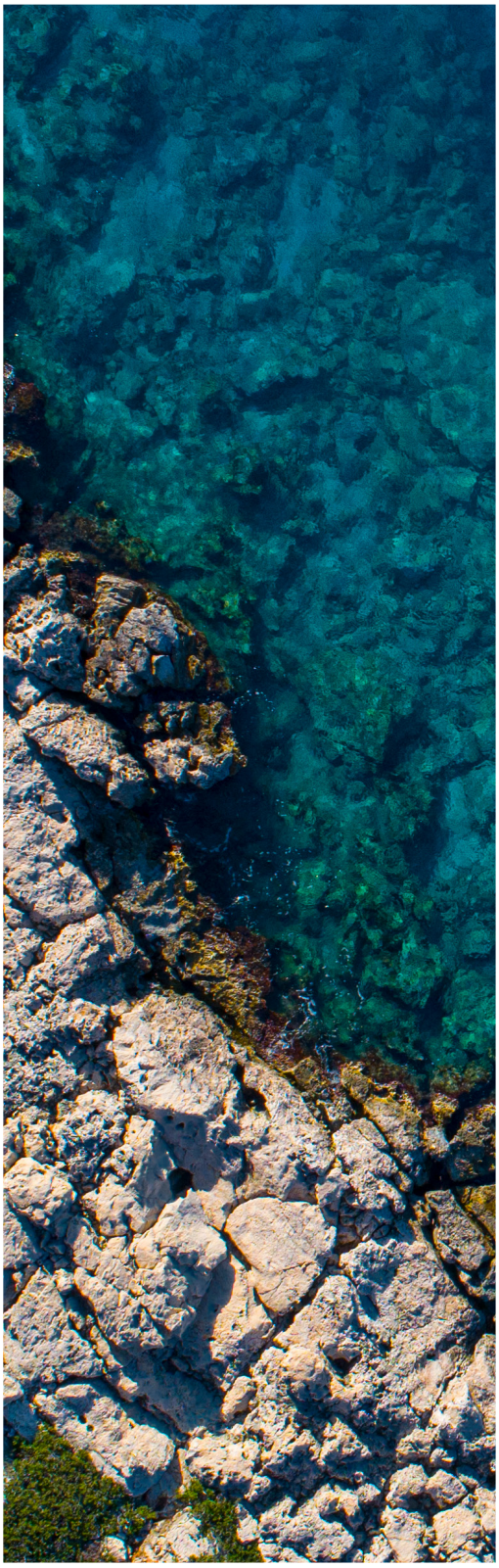
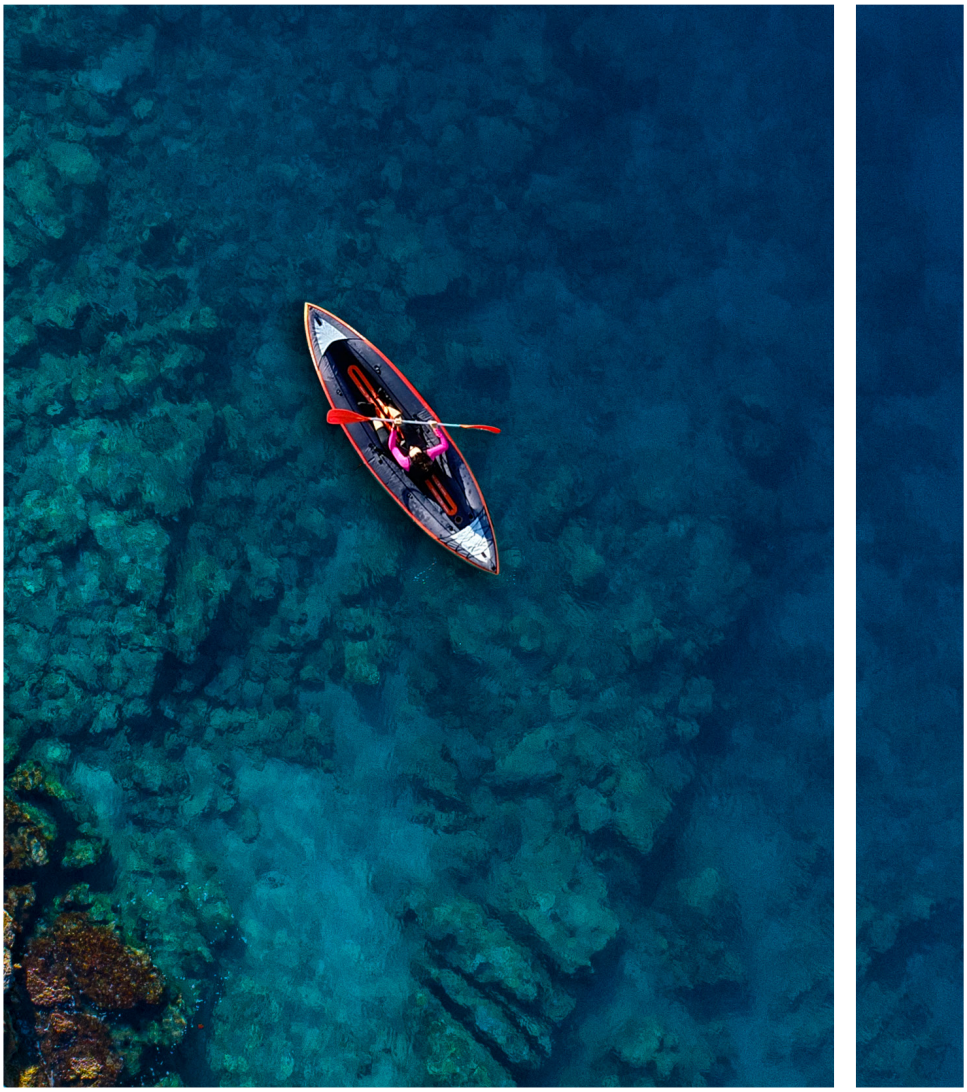
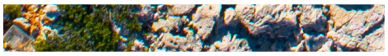
SHANNON

RESIDENT BENEFITS







2024

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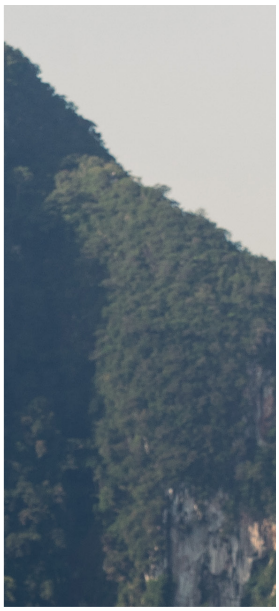
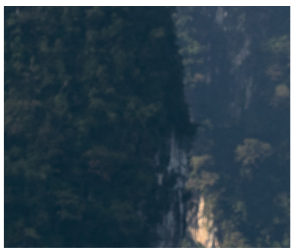
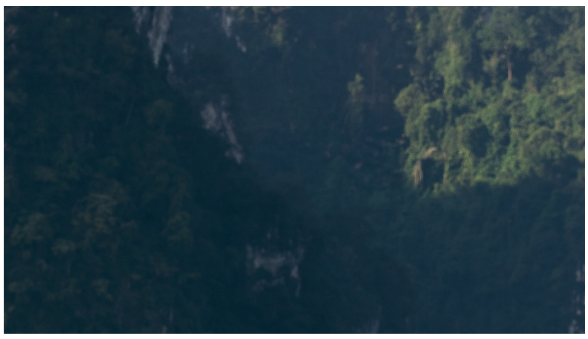
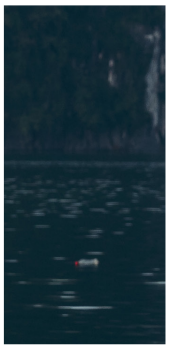
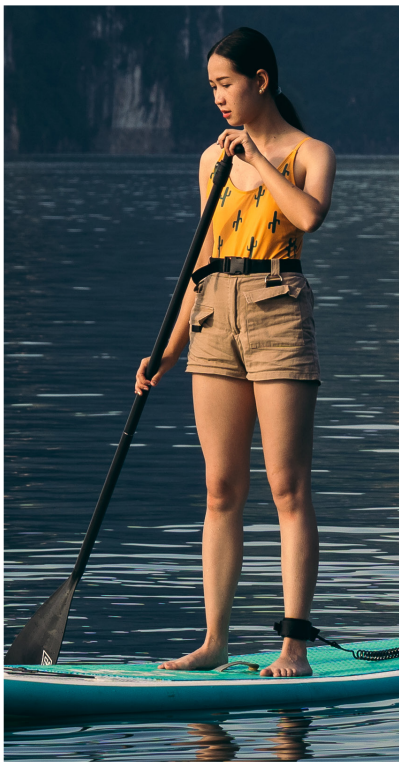
Shannon is proud to support our physicians' overall wellbeing with a variety of benefit options. This guide offers details on our 2024 offerings for you and your family. Contact the Human Resources department with any questions.











See page 45 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Shannon Medical Center. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

WELCOME

Shannon appreciates the hard work and dedication you bring to our team every day. To do our part, we are committed to keeping your benefits affordable and beneficial for you and your eligible family members.

Shannon strives to provide benefits that:

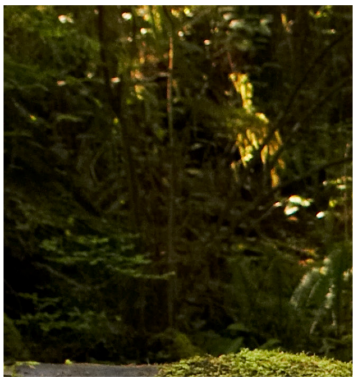
- Meet your needs
- Are easy to understand and use
- Provide excellent value for affordable costs

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

This guide is designed to assist you and your family in making the best choices for your needs in 2024. It contains explanations of each benefit, contact information for benefits vendors, and costs you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

Any questions?

We're here to help. Contact Human Resources at 325-747-5243.



WHAT'S NEW FOR 2024?

Silver Plan

- Network Tier 1 (Shannon) deductible (Individual/Family) is decreasing from $1,000/$2,500 to $0/$0.
- Network Tier 2 (Aetna) deductible (Individual/Family) is increasing from $3,200/$6,800 to $3,500/$7,000.
- Network Tier 2 (Aetna) out-of-pocket maximum (Individual/Family) is increasing from $5,500/$11,000 to $6,000/$12,000.
- Network Tier 1 (Shannon) hospital facility charges at Shannon will be 0% cost share with an exception of emergency room at 20%.
- Network Tier 1 (Shannon) pharmacy coverage is changing to the following:
  - Tier 1 - $5 copay (previously $10 copay)
  - Tier 2 - $50 copay (previously 25% coinsurance up to $50 max)
  - Tier 3/Non-Formulary - $100 copay (previously 50% coinsurance up to $100 max)
- Network Tier 2 (Aetna) pharmacy coverage is changing to the following:
  - Tier 1 - $50 copay (previously $25 copay)
  - Tier 2 - $100 copay (previously $65 copay)
  - Tier 3 - $200 copay (previously $155 copay)

Bronze Plan

- Network Tier 2 (Aetna) out-of-pocket maximum (Individual/Family) increasing from $9,100/$17,900 to $9,450/$18,900.
- Network Tier 1 (Shannon) pharmacy coverage is changing to the following:
  - Tier 1 - $5 copay (previously $10 copay)
  - Tier 2 - $50 copay (previously 25% coinsurance up to $50 max)
  - Tier 3/Non-Formulary - $100 copay (previously 50% coinsurance up to $100 max)
- Network Tier 2 (Aetna) pharmacy coverage is changing to the following:
  - Tier 1 - $50 copay (previously $25 copay)
  - Tier 2 - $100 copay (previously $65 copay)
  - Tier 3 - $200 copay (previously $155 copay)

HDHP

- Network Tier 2 (Aetna) out-of-pocket maximum is increasing from $7,050/$13,600 to $8,050/$16,100.
- Network Tier 1 (Shannon) pharmacy coverage is changing to the following:
  - Tier 1 - $5 copay after deductible (previously $10 after deductible)
  - Tier 2 - $50 copay after deductible (previously 25% coinsurance up to $50 max after deductible)
  - Tier 3/Non-Formulary - $100 copay after deductible (previously 50% coinsurance up to $100 max after deductible)
- Network Tier 2 (Aetna)
  - Tier 1 - $50 copay after deductible (previously $25 copay after deductible)
  - Tier 2 - $100 copay after deductible (previously $65 after deductible)
  - Tier 3 - $200 copay after deductible (previously $155 after deductible)

Other Plan Changes

- Shannon Health Plans now have an enhanced benefit for hearing aids:
  - Receive a discounted cash price for hearing aid devices as Shannon will offer hearing aids at cost to our health plan members.
- Pharmacy delivery will be available through Shannon Pharmacy within San Angelo city limits. See page 22.
- Effective January 1, 2024, GLP-1 and GLP-1/Insulin combinations products will only be available through Shannon Pharmacy.
- Effective January 1, 2024, Air Ambulance (AirMed) Emergent benefit is increasing from $50/year to $60/year.
- Effective January 1, 2024, Air Ambulance (AirMed) Non-Emergent (Fly-U-Home) coverage will be available for purchase. This benefit is $140/year. To enroll in this benefit, you must be enrolled in the Emergent benefit ($60) for a combined total of $200/year.

ELIGIBILITY AND ENROLLMENT

Shannon's benefits are designed to support your and your family's needs.

Eligibility

If you are a full-time or part-time Physician of Shannon, you may be eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

Medical, Dental, Vision, and ID Theft Coverage:

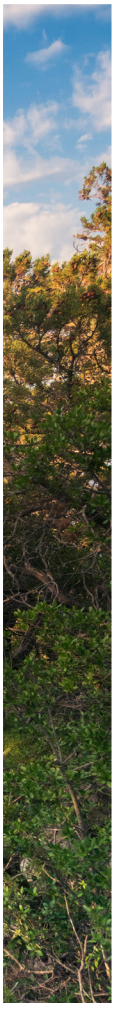
- 30-Day waiting period from eligibility date

Life and Disability:

- First of the month coinciding with or following 30 days

Supplemental Health:

- First of the month coinciding with or following 90 days



Eligible Dependents

Dependents eligible for coverage include:

- Your legal spouse (or common-law spouse where recognized).
- Children under the age of 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

Dependent Verification Requirements

If you add dependents to your benefits, you are required to submit documentation that verifies the dependent meets the plan eligibility requirements. Dependent documentation must be received within 30 days from your hire date, status change date, or following Annual Enrollment deadline. If not received by deadline, your dependents will be removed from your plans and cannot be added to your benefits until next Annual Enrollment or a Qualifying Event occurs.

Now's the Time to Enroll!

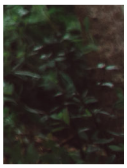
What are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)

- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (Healthcare.gov)
- Turning 26 and losing coverage through a parent's plan



- A change in employment status resulting in a gain or loss of eligibility.
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Shannon's Human Resources with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

WELLNESS

Do you make your good health a priority every day? Shannon is here to help with Shannon Wellness Program. All benefits-eligible physicians and spouses are welcome to participate and the program is completely confidential.

Shannon Wellness Program can guide you through making healthier choices and achieving your lifestyle goals. The program is full of helpful tools such as:

- Health education, programs, and challenges
- Personalized coaching and chronic-condition management tools
- Convenient and secure storage of medical records
- BMI and weight management tools
- Customized calculators

Wellness Discount

The Shannon Wellness Program provides physicians and eligible spouses the opportunity to earn a reward when they engage in key activities to qualify. Visit the Shannon Wellness Program portal to learn more!

Because preventive care is essential to good health, Shannon provides onsite biometric screenings for physicians and eligible spouses. The screening consists of measurements for blood pressure, height, weight, waist circumference, blood lipids (total cholesterol, HDL cholesterol, LDL cholesterol, and triglycerides), glucose test. Your individual results are confidential; Shannon does not have access to this private health information. Not able to participate in the onsite biometric screenings? Get your screening directly through your physician.

A biometric screening provides insight into your long-term health risks to help make better long-term decisions. If you and/or your eligible spouse complete a biometric screening and meet healthy numbers, you may be eligible for a wellness discount on your medical premium. You could also be eligible for other incentives.

Privacy Reminder: Shannon does not have access to individual health information. The Shannon statistics referenced in this communication are aggregate. Personal health information is always treated privately.

Tobacco Credit

If you completed the 2024 Tobacco/Nicotine Affidavit with a "tobacco-free" response for yourself and/or your spouse, the tobacco credit discount of $25/per pay period will be applied to your 2024 benefits.

Quitting is more than an ending — it's a fresh start! If you and/or your spouse did not meet the tobacco-free requirement and are under a physician's care for tobacco/nicotine cessation or are participating in any other tobacco/nicotine cessation program, and have not used tobacco or nicotine products in 6 months or more, you can submit physician or program documented proof to HR via email at wellnesscredit@shannonhealth.org to earn the tobacco credit.

NOTE

According to the CDC, quitting smoking improves your health and quality of life and can even add up to 10 years to your life expectancy!

Notice Regarding Wellness Program

Shannon Wellness Program is a voluntary wellness program available to all employees and medical enrolled spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve participant health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening or annual preventive exam, which may include a blood test for total cholesterol, HDL, LDL, triglycerides, glucose, and cotinine screening. Your blood pressure, height, weight, and waist circumference may also be measured. You are not required to complete the HRA. You are not required to participate in the blood test or other medical examinations. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening or annual preventive exam, which may include a blood test for total cholesterol, HDL, LDL, triglycerides, glucose, and cotinine screening. Your blood pressure, height, weight, and waist circumference may also be measured. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, individuals who choose to participate in the wellness program may qualify for the incentive of up to $100 per month by participating in the biometric screening, meeting identified biometric risk factors and testing nicotine free. Individuals who choose to earn the up to $100 per month tobacco-free credit may complete biometric screening, meeting identified biometric risk factors, and testing nicotine free. See medical rates for details.

Although you are not required to complete only participants who do so may qualify.

Additional incentives may be available for participants who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Shelly Hartin at 325-747-8239 or ShellyHartin@shannonhealth.org.

The information from your HRA The information from your blood test or other medical examinations The information from your HRA or blood test or other medical examinations may be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programming and content. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Shannon may use aggregate information it collects to design a program based on identified health risks in the workplace, Shannon will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Lockton Companies.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Shelly Hartin at 325-747-8239 or ShellyHartin@shannonhealth.org.

SHANNON WELLSTEPS

Employee Wellness Program

Your health and wellbeing is important to us. That is why we are providing WellSteps - a comprehensive wellness program.

Shannon is providing this resource to all full-time and part-time Associates as a fun and engaging way for you to learn new information and try new health-focused habits. You can also earn prizes while completing goals toward healthy living.

We invite you and a loved one to join us and participate in our WellSteps initiatives that we have planned for the next year. Sign in to create your account and get started today!

Go to www.WellSteps.com/Shannon and click "Register." Enter your Shannon email address.

For more information, please email HealthandWellness@shannonhealth.org.

SHANNON Well

EMPLOYEE ASSISTANCE PROGRAM

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

Alliance Work Partners (AWP) is a Shannon-sponsored Employee Assistance Program (EAP), available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home. Services are confidential and available 24 hours a day, 7 days a week.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes six visits per event with a licensed professional. All services provided are confidential and will not be shared with Shannon.

Additional Benefits:

- Online Resources. Access articles, videos, webinars and more through your member website.
- LawAccess. Legal and Financial services provided by a lawyer or financial professional specializing in your area of concern. Available online or by phone.
- WellCoach. Personalized planning and 1-on-1 support, online or by telephone, to help you improve and maintain your health and well-being.
- SafeRide. Reimbursement for emergency cab fare for eligible employees and dependents that opt to use a cab service instead of driving while impaired.

The Program provides referrals to help with:

- Emotional health and well-being
- Alcohol or drug dependency
- Marriage or family relationship problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

The Big Five of Emotional Wellness

PRACTICE MINDFULNESS.

Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.

STRENGTHEN SOCIAL CONNECTIONS.

Reach out to a friend or family member daily — even if it's just a call or text.

GET QUALITY SLEEP.

Keep a consistent sleep schedule and limit electronic use before bed.

IMPROVE YOUR OUTLOOK.

Treat people with kindness, including yourself.

DEAL WITH YOUR STRESS IN HEALTHY WAYS.

Think positively, exercise regularly, and set priorities.

Contact Alliance Work Partners (AWP)
Call: 1-800-343-3822 OR 1-800-334-TEEN (8336)
Online: awpnow.com
Select "Access Your Benefits" and enter registration code: AWP-SMC-2973

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

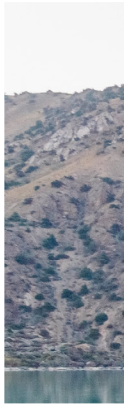
Text "HELLO" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.



NOTE

According to the Centers for Disease Control, nearly 22% of adults received help for mental health in 2021.

MEDICAL BENEFITS

Medical benefits are administered by WebTPA

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your other contributions.

	SILVER PLAN		BRONZE PLAN		HDHP PLAN	
PHYSICIAN CONTRIBUTIONS (PER PAYCHECK)						
	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME	FULL-TIME	PART-TIME
EMPLOYEE ONLY	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
EMPLOYEE + SPOUSE	$272.84	$327.41	$223.80	$256.20	$247.30	$296.76
EMPLOYEE + CHILD(REN)	$192.87	$231.44	$140.63	$181.11	$174.81	$209.78
EMPLOYEE + FAMILY	$420.31	$559.99	$313.96	$364.39	$366.89	$483.53

Note: All rates listed do not include any wellness or tobacco credits.

How to Find a Provider

Visit www.webtpa.com or call Customer Care at 877-305-2432 for a list of WebTPA network providers.

Wellness/Tobacco Credit

Wellness Credit: Physician contributions will be reduced $25 per pay period plus $25 per pay period for your Covered Spouse if Wellness Requirements are met.

Tobacco Credit: Physician contributions will be reduced an additional $25 per pay period for you plus $25 per pay period for your Covered Spouse if Tobacco Requirements are met.

NOTE

To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.

Medical Plan Summary

This chart summarizes the 2024 medical coverage administered by WebTPA. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	SILVER PLAN		BRONZE PLAN		HDHP PLAN	
	SHANNON	AETNA	SHANNON	AETNA	SHANNON	AETNA
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$0	$3,500	$2,000	$5,500	$3,300	$4,500
FAMILY	$0	$7,000	$4,250	$10,500	$7,500	$8,500
COINSURANCE (PLAN PAYS)	80%*	70%*	80%*	70%*	80%*	70%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,500	$6,000	$7,000	$9,450	$6,500	$8,050
FAMILY	$9,000	$12,000	$13,500	$18,900	$12,500	$16,100
SERVICES						
PRIMARY CARE	$20	$20	$35 up to 3 visits, thereafter 20%*	30%*	20%*	30%*
SHANNON ON DEMAND	$10	N/A	$10	N/A	$59	N/A
SPECIALIST SERVICES	$50	$50	20%*	30%*	20%*	30%*
OB/GYN OFFICE VISIT	$35		20%*	30%*	20%*	30%*
OB/GYN OFFICE VISIT (ANNUAL EXAM LIMITED TO 1 PER YEAR)	$0		$0		$0	
MAMMOGRAM (LIMITED TO 1 PER YEAR)	$0		$0		$0	
ANNUAL WELLNESS VISIT (LIMITED TO 1 PER YEAR)	$0		$0		$0	
URGENT CARE	$20		$35, up to 3 visits		20%*	30%*
COLONOSCOPY (FIRST ONE PER CALENDAR YEAR)	$0		$0		$0	
LAB WORK	20%	30%*	20%***	30%*	20%*	30%*
X-RAYS	20%	30%*	20%***	30%*	20%*	30%*
RADIOLOGY	20%	30%*	20%*	30%*	20%*	30%*
INJECTIONS WITH OFFICE VISIT	20%	30%*	20%*	30%*	20%*	30%*
ALLERGY TESTING	20%	30%*	20%*	30%*	20%*	30%*
ALL OTHER PHYSICIAN SERVICES	20%	30%*	20%*	30%*	20%*	30%*
PREVENTIVE VISITS FOR CHILD WITH REQUIRED IMMUNIZATIONS	$0		$0		$0	
MATERNITY BENEFITS						
PHYSICIAN SERVICES FOR OB CARE	20%	30%*	20%*	30%*	20%*	30%*
MATERNITY HOSPITAL	0%	30%*	20%*	30%*	20%*	30%*
ANESTHESIOLOGY	20%	30%*	20%*	30%*	20%*	30%*

HOSPITAL FACILITY SERVICES						
INPATIENT HOSPITAL	0%	30%**	20%*	30%**	20%*	30%**
SKILLED NURSING FACILITY	0%	30%**	20%*	30%**	20%*	30%**
INPATIENT REHAB FACILITY	0%	30%**	20%*	30%**	20%*	30%**
OUTPATIENT SURGERY	0%	30%**	20%*	30%**	20%*	30%**
ALL OTHER HOSPITAL/ FACILITY SERVICES	0%	30%**	20%*	30%**	20%*	30%**
EMERGENCY ROOM						
FACILITY	20%	30%*	20%*	30%*	20%*	30%*
PHYSICIAN	20%*	30%*	20%*	30%*	20%*	30%*
OTHER COVERED SERVICES						
BARIATRIC SURGERY	$4,500 deductible		$4,500 deductible		$4,500 deductible	
CARDIAC REHAB @ SMC	$100	30%*	20%*	30%*	20%*	30%*
CHEMOTHERAPY (IN OFFICE/FACILITY)	20%	30%*	20%*	30%*	20%*	30%*
CHIROPRACTIC CARE (LIMIT 30 VISITS/CALENDAR YEAR)	$50		20%*	30%*	20%*	30%*
DIABETIC TRAINING BY APPROVED PROVIDER	$50 for series	30%*	$50 for series	30%*	20%*	30%*
DURABLE MEDICAL EQUIPMENT	20%	30%*	20%*	30%*	20%*	30%*
PT/OT/ST (LIMIT 20 VISITS/CONDITION/ YEAR)	$30/visit	$50/visit	$30/visit	$50/visit	20%*	30%*
HOME HEALTH CARE	$50/DAY		20%*	30%*	20%*	30%*
VISION EXAM	$50		20%*	30%*	20%*	30%*
HOSPICE CARE	20%	30%*	20%*	30%*	20%*	30%*
LAB, X-RAY, INJECTIONS IN CONJUNCTION WITH OTHER COVERED SERVICES	20%	30%*	20%***	30%*	20%*	30%*
MENTAL HEALTH SERVICES	Covered as any other provider/facility		Covered as any other provider/facility		Covered as any other provider/facility	

*After deductible
**Please see page titled Care Management for important benefit considerations
***Deductible waived

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

Each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

NOTE

Keep healthcare costs down by seeing the right provider for your situation. See page 18 for more information.

Our Plans are Self-Funded

Our medical, dental, and pharmacy plans are self-funded. What does that mean? Rather than paying fixed premiums to an insurance carrier as with fully insured plans, Shannon pays fixed administrative fees to use the carrier's network and pays members' claims from its general assets. This gives Shannon more control over the plan we select for our physicians. Together, the Company and physicians share the cost of healthcare.

Dialysis Coverage

Beginning January 1, 2024, all outpatient dialysis treatments will be reimbursed under the terms of the plan's dialysis benefit program as described in the Plan Document. All dialysis providers will be considered out-of-network providers and all outpatient dialysis claims will be administered under terms of the dialysis benefit plan. Providers will still receive payments that are fair and reasonable but will no longer be paid according to a network contract.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.webtpa.com to learn more.

OUT-OF-POCKET COSTS

These are the types of payments you're responsible for:

Copay

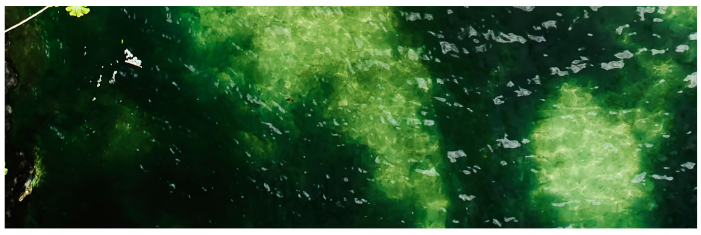
The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

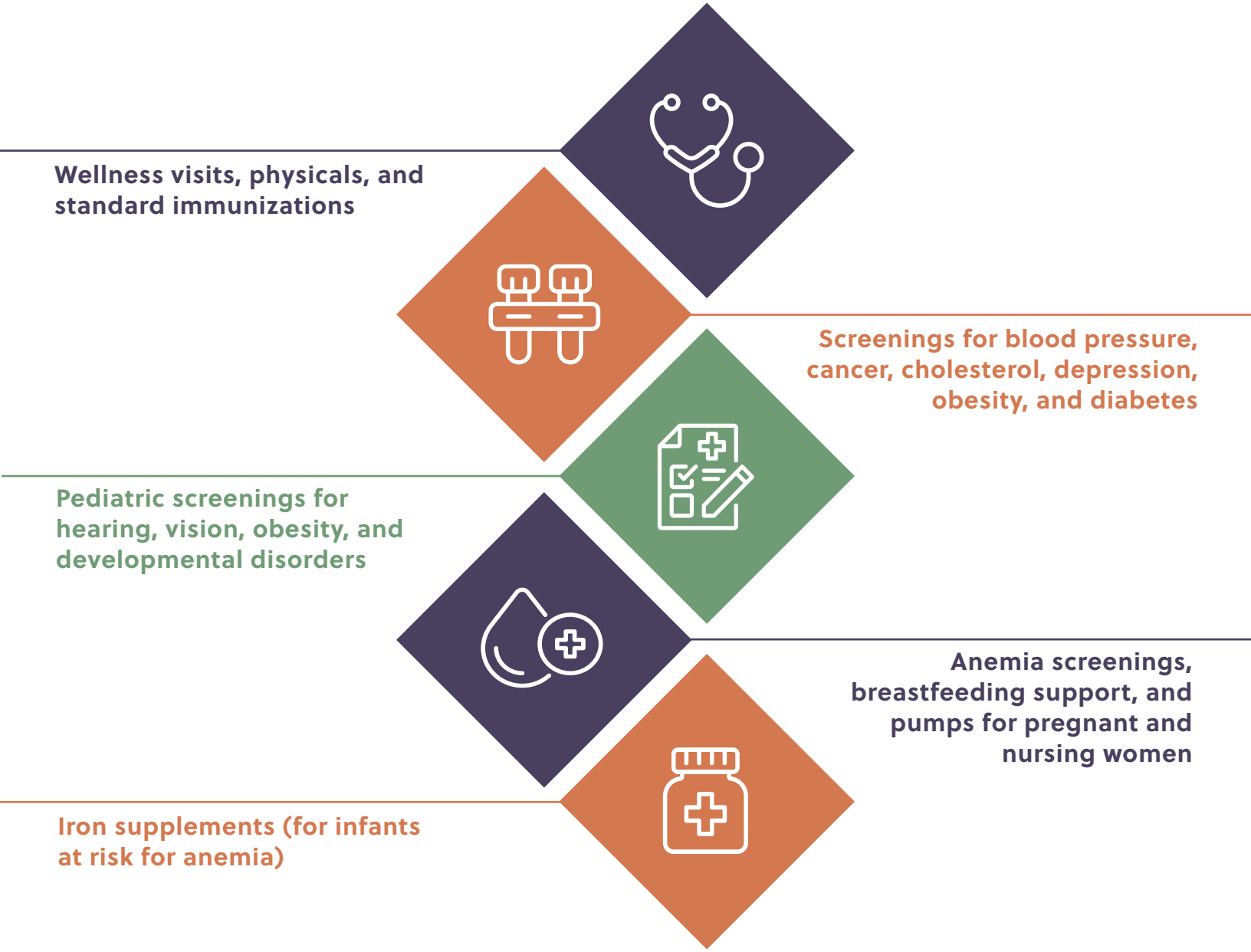


Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

PREVENTIVE CARE

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:



Wellness visits, physicals, and standard immunizations

Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Iron supplements (for infants at risk for anemia)

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults/.

WHERE TO GO FOR CARE

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

TELEMEDICINE ($)

WHEN TO USE

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

TYPES OF CARE*

- Cold & flu symptoms
- Bronchitis
- Urinary tract infection
- Sinus problems

COSTS AND TIME CONSIDERATIONS**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Typically immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

PRIMARY CARE CENTER ($)

WHEN TO USE

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

TYPES OF CARE*

- Routine checkups
- Immunizations
- Preventive services
- Managing your general health

COSTS AND TIME CONSIDERATIONS**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

DO YOUR HOMEWORK

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER ($$)

WHEN TO USE

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

TYPES OF CARE*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns

COSTS AND TIME CONSIDERATIONS**

- Copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but urgency determines order seen and wait time

EMERGENCY ROOM ($$$)

WHEN TO USE

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

TYPES OF CARE*

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

COSTS AND TIME CONSIDERATIONS**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

CARE MANAGEMENT

Shannon strives to deliver associate benefits that embody our mission to provide exceptional healthcare for our family, friends, and neighbors.

The Shannon Health Plan Care Management Team reviews all precertification requests submitted to Communitas and participants in inpatient and outpatient case management.

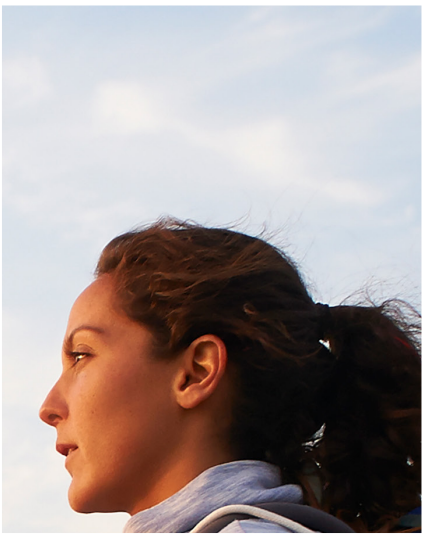
The Shannon Health Care Management Team's goal include:

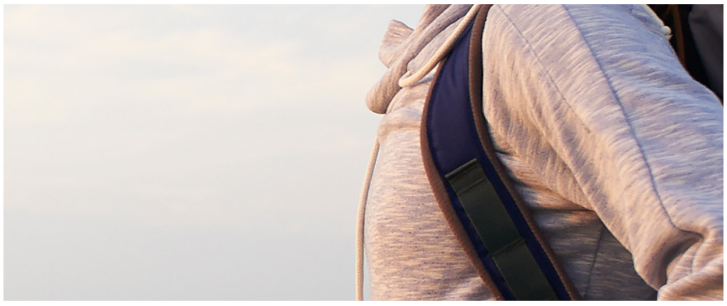
- **Improved member advocacy:** Navigating the healthcare system can be a challenge. Our care management team will answer any questions you may have and direct you to providers who are best fit for your unique healthcare situation.
- **Personalized experience:** We live here too and can help locate local resources to save you time and money and keep you close to home.
- **Onsite and in-person assistance:** We are located in the Women's and Children's Hospital and available 8 AM – 5PM, Monday through Friday to meet by secure email, secure-fax, phone, or in-person.

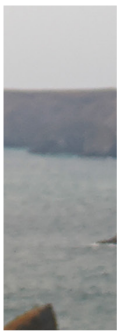
Your providers will work with Communitas and the Shannon Health Plan Care Management Team to authorize your care.

All non-emergent inpatient and outpatient services available at Shannon Medical Center must be pre-authorized if you choose to have those services outside of Shannon. Should a member choose to receive these services outside of Shannon Medical Center without Pre-Authorization Approval, your benefit will be reduced to 50% of allowed charges and you may be subject to a higher out of pocket maximum.

Phone: 325-657-8207
Secure Email: healthplan@shannonhealth.org
Secure Fax: 325-657-8359







SHANNON ON DEMAND

Ready to see you, 24/7

SHANNON ON DEMAND

Shannon On Demand makes it easy for you to talk to a healthcare provider for minor medical needs through a virtual visit in the comfort of your home, office or on the go. Access is private, secure, fast and easy - all from your mobile device or computer.

Our board certified providers are all members of our Shannon Clinic provider family. Our service is available 24/7 anywhere within Texas.

It's easy to get started! Just call **325-747-4848.** Our representative will register you over the phone, collect your insurance information and co-pay and place you in our Virtual Waiting Room. Once the provider is available, you will receive a link to start your visit.

And, you can also get your prescription delivered right to your door in San Angelo if you select **Shannon Pharmacy** or **Medical Arts Pharmacy** during your visit.

To learn more, visit **ShannonOnDemand.com.**

MEDICAL ARTS PHARMACY

SHANNON PHARMACY

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is administered by Navitus. This means you will have one ID card for medical care and prescriptions. You may find information on our benefits coverage and search for network pharmacies by logging on to www.navitus.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Tier 1, Tier 2, Tier 3/Non-Formulary, or Injectables & Specialty Drugs.

	SILVER PLAN		BRONZE PLAN		HDHP PLAN	
	SHANNON	AETNA	SHANNON	AETNA	SHANNON	AETNA
RX DEDUCTIBLE	Individual $100 Family: $200		Individual $300 Family: $600		Medical Deductible Applies	
RETAIL RX (30-DAY SUPPLY)						
TIER 1	$5	$50	$5	$50	$5*	$50*
TIER 2	$50	$100	$50	$100	$50*	$100*
TIER 3/NON-FORMULARY	$100	$200	$100	$200	$100*	$200*
INJECTABLES & SPECIALTY DRUGS	25% coinsurance, up to $250 max	Not covered	25% coinsurance, up to $250 max	Not covered	25% coinsurance up to $250 max*	Not covered

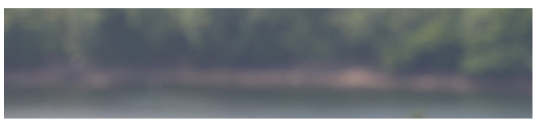
*After deductible

Pharmacy Delivery

Shannon Pharmacy is now offering delivery for your prescriptions filled at our in house pharmacy. Delivery is available within San Angelo city limits. Call your Shannon Pharmacy today for more details!

GLP-1 and GLP-1/Insulin Combination Products

All GLP-1 and GLP-1/Insulin combination products will only be available through Shannon Pharmacy.



HEALTH SAVINGS ACCOUNT

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Health Equity will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible Consumer-Driven Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

NOTE

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax free after retirement.

PRE-TAX PAYCHECK CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS (PRE-TAX)

HSA

TAX-FREE PAYMENTS (FOR QUALIFIED MEDICAL EXPENSES)

UNUSED FUNDS ROLL OVER ANNUALLY

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in Shannon's HSA, you must elect the HDHP with Shannon. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Shannon will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with Health Equity. The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2024, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
TEAM MEMBER	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Shannon provides an HSA employer contribution that will be deposited on a per pay period basis.

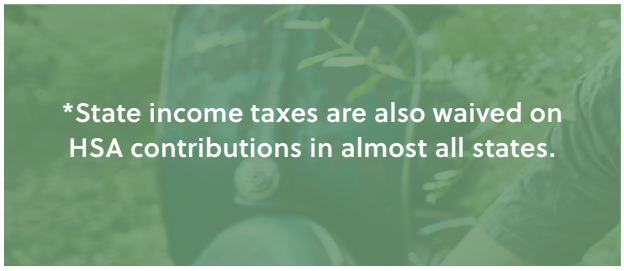
EMPLOYER HSA CONTRIBUTION	
TEAM MEMBER	$20
FAMILY	$25

HSA contributions over the IRS annual contribution limits ($4,150 for individual coverage and $8,300 for family coverage for 2024) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Shannon HSA is established with Health Equity. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.healthequity.com.

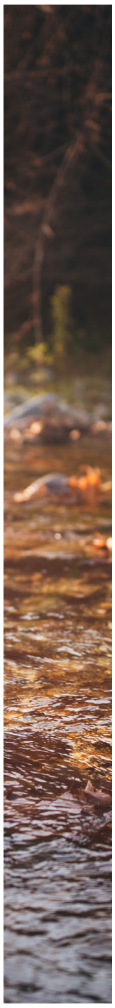


FLEXIBLE SPENDING ACCOUNTS

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.



Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.
- This account covers dependent day care expenses that are necessary for you and your Spouse to work or attend school full time. Examples of eligible dependent care expenses include:
  - In-home babysitting services (not provided by a tax dependent)
  - Care of a preschool child by a licensed nursery or day care provider
  - Before- and after-school care
  - Day camp
  - In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact TaxSaver with reimbursement questions. If you need to submit a receipt, TaxSaver will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.

Grace Period

- Our Company offers a grace period for FSA spending. You have 2½ months after the plan year ends on 12/31/2024 to incur additional expenses and submit them for reimbursement. Therefore, any remaining balance in the previous plan year that ended 12/31/2024 will be used to pay that grace period expense even though the service was provided in the NEW plan year.
- The grace period applies to both the Dependent Care and Healthcare FSAs.

NOTE

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

FSA vs HSA

FLEXIBLE SPENDING ACCOUNTS		HEALTH SAVINGS ACCOUNTS
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	TAXATION	HSA contributions are tax free; the account grows tax free; and funds are spent tax free on qualified expenses.
You can contribute up to $3,050 in 2024 to an FSA. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,150 in 2024 (up to $8,300 for families). Ages 55+ can make an annual $1,000 " catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care)	OTHER TYPES	N/A

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

DENTAL BENEFITS

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Shannon offers affordable plan options for routine care and beyond.

Dental Providers

You have the freedom to choose any dentist, but your choice of dental providers may impact the cost of services provided. Reimbursements are based on Reasonable and Customary (R&C) charges in your geographical area.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Dental Plan Summary

This chart summarizes the dental coverage administered by WebTPA for 2024.

	SHANNON DENTAL	
PHYSICIAN CONTRIBUTIONS (PER PAYCHECK)		
	FULL-TIME	**PART-TIME**
EMPLOYEE ONLY	$0.00	$0.00
EMPLOYEE + SPOUSE	$20.94	$25.12
EMPLOYEE + CHILD(REN)	$20.94	$25.12
EMPLOYEE + FAMILY	$28.21	$33.85
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	
FAMILY	$100	
CALENDAR YEAR MAXIMUM		
PER PERSON	$1,500	
COVERED SERVICES		
PREVENTIVE SERVICES Oral exams, Cleanings, Bitewing X-Rays - Two per calendar year Full Mouth X-Rays, Panoramic X-Ray - One per every three calendar years Fluoride Application - One per calendar year for persons under age 19 Sealants - Limited to a person less than age 14 Space Maintainers - Limited to non-orthodontic treatment **Emergency Care to relieve pain**	$0, Deductible Waived	
BASIC SERVICES Filings, Root Canal Therapy, Denture Adjustments and Repairs Osseous	20%*	
Surgical Extractions of Impacted Teeth**	Medical plan benefit only	
MAJOR SERVICES Crowns, Dentures, Bridges, Repairs to Crowns and Inlays	30%*	
ORTHODONTICS Treatment for Adults & Children	50% after $100 lifetime deductible	
ORTHODONTIC LIFETIME MAXIMUM	$1,000 per person	

*After deductible
**If seeking from an oral surgeon for the removal of impacted teeth, please use an in-network oral surgeon. Refer to the provider directory for a list of surgeons.

VISION BENEFITS (MATERIALS ONLY)

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. Shannon provides you and your family access to quality vision care with a comprehensive vision benefit through VSP.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

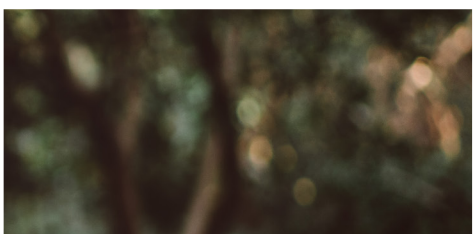
Vision Plan Summary

This chart summarizes the vision coverage provided by VSP for 2024.

VISION PLAN (MATERIALS ONLY)

PHYSICIAN CONTRIBUTIONS (PER PAYCHECK)			
EMPLOYEE ONLY	$2.30	$3.53	
EMPLOYEE + SPOUSE	$4.60	$7.07	
EMPLOYEE + CHILD(REN)	$4.92	$7.56	
EMPLOYEE + FAMILY	$7.86	$12.09	
	STANDARD PLAN	**PREMIUM PLAN**	**FREQUENCY**
PRESCRIPTION GLASSES			
COPAY	$25	$10	Once every 12 months
LENSES			
SINGLE VISION	Included in prescription glasses	Included in prescription glasses	Once every 12 months
BIFOCAL	Included in prescription glasses	Included in prescription glasses	
TRIFOCAL	Included in prescription glasses	Included in prescription glasses	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION**	- $130 allowance, copay does not apply - Contact lens exam (fitting and evaluation)	- $150 allowance, copay does not apply - Contact lens exam (fitting and evaluation)	Once every 12 months
FRAMES			
ALLOWANCE	- 140 allowance for a wide selection of frames - $160 allowance for featured frame brands - 20% savings on the amount over your allowance - $75 Costco frame allowance	- $160 allowance for a wide selection of frames - $180 allowance for featured frame brands - 20% savings on the amount over your allowance - $90 Costco frame allowance	**STANDARD PLAN** Once every 24 months **PREMIUM PLAN** Once every 12 months

**Fitting and Evaluation fee applied to contact lens allowance.

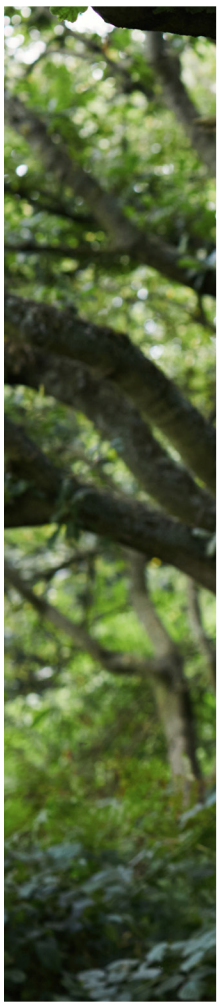


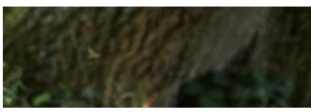
SUPPLEMENTAL HEALTH BENEFITS

Shannon offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any unexpected expenses. Accident coverage through Voya provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits are payable to you to use as you wish.





ACCIDENT COVERAGE

SUMMARY OF BENEFITS*

	LOW PLAN	HIGH PLAN
HOSPITAL ADMISSION	$1,750	$2,000
HOSPITAL CONFINEMENT	$275 per day, up to 365 days	$300 per day, up to 365 days
CRITICAL CARE UNIT CONFINEMENT	$450 per day, up to 15 days	$500 per day, up to 15 days
REHABILITATION FACILITY CONFINEMENT	$200 per day, up to 90 days	$225 per day, up to 90 days
DISLOCATIONS AND FRACTURES	Up to $10,000	Up to $12,000
AMBULANCE	Ground: $400 / Air: $2,000	Ground: $600 Air: $2,500
INITIAL DOCTOR VISIT, URGENT CARE FACILITY TREATMENT OR EMERGENCY ROOM TREATMENT	$250	$300
FOLLOW-UP DOCTOR TREATMENT	$100	$120
CHIROPRACTOR TREATMENT	$60 (up to 6 per accident)	$75 (up to 6 per accident)
X-RAY	$100	$125
MAJOR DIAGNOSTIC EXAMS	$300	$500
BURNS	Up to $20,000	Up to $22,000
OUTPATIENT SURGERY	$250	$300
CONCUSSION	$275	$450
COMA	$18,500	$20,000
SURGERY (OPEN ABDOMINAL OR THORACIC)	$1,500	$2,500
SURGERY (EXPLORATORY OR WITHOUT REPAIR)	$200	$350
BLOOD, PLASMA, PLATELETS	$625	$650

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

PHYSICIAN CONTRIBUTIONS (PER PAYCHECK)

	LOW PLAN	HIGH PLAN
EMPLOYEE ONLY	$5.40	$7.06
EMPLOYEE + SPOUSE	$8.96	$11.55
EMPLOYEE + CHILD(REN)	$10.31	$13.15
EMPLOYEE + FAMILY	$13.87	$17.64

Critical Illness Coverage

Critical Illness coverage through Voya pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Physician: $10,000, $20,000, or $30,000
  - Spouse: 50% of physician benefit
  - Child(ren): $5,000 or $10,000 not to exceed 50% of the physician benefit
- Rates are based on your age and the amount of coverage selected
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion; however, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.
- Wellness Benefit: A $100 wellness benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy, or stress test (once per year per covered person); 50% per child to a maximum of $200 for all children.

PHYSICIAN CONTRIBUTIONS (PER PAYCHECK)

NON-TOBACCO	$10,000	$20,000	$30,000
UNDER 29	$2.95	$4.60	$6.25
30-39	$3.60	$5.90	$8.20
40-49	$7.10	$12.90	$18.70
50-59	$11.40	$21.50	$31.60
60-64	$15.25	$29.20	$43.15
65-69	$21.10	$40.90	$60.70
70+	$30.80	$60.30	$89.80

TOBACCO	$10,000	$20,000	$30,000
UNDER 29	$3.75	$6.20	$8.65
30-39	$5.55	$9.80	$14.05
40-49	$10.85	$20.40	$29.95
50-59	$18.00	$34.70	$51.40
60-69	$24.90	$48.50	$72.10
65-69	$31.65	$62.00	$92.35
70+	$46.10	$90.90	$135.70

SPOUSE CONTRIBUTIONS (PER PAYCHECK)

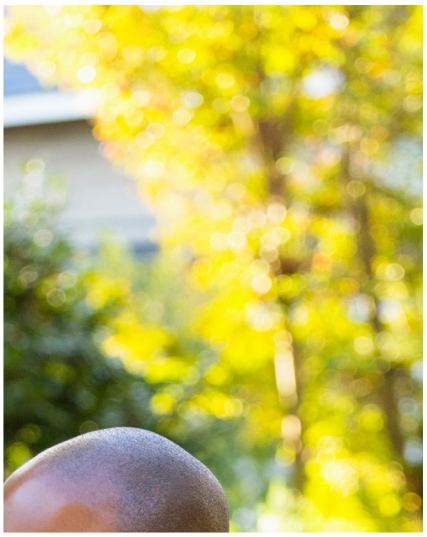
NON-TOBACCO	$5,000	$10,000	$15,000
UNDER 29	$2.38	$3.45	$4.53
30-39	$2.88	$4.45	$6.03
40-49	$4.85	$8.40	$11.95
50-59	$8.20	$15.10	$22.00
60-69	$10.43	$19.55	$28.68
65-69	$14.03	$26.75	$39.48
70+	$19.10	$34.90	$51.70

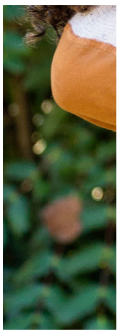
TOBACCO	$5,000	$10,000	$15,000
UNDER 29	$2.88	$4.45	$6.03
30-39	$3.80	$6.30	$8.80
40-49	$7.05	$12.80	$18.55
50-59	$12.70	$24.10	$35.50
60-69	$16.85	$32.40	$47.95
65-69	$21.08	$40.85	$60.63
70+	$26.90	$52.50	$78.10

CHILD CONTRIBUTIONS (PER PAYCHECK)

COVERAGE	$5,000	$10,000
UNDER 25	$0.17	$0.34

COVERED CONDITION	BENEFIT AMOUNT
BASE MODULE	
HEART ATTACK (CARDIAC ARREST IS NOT A HEART ATTACK)	100%
CANCER	100%
STROKE	100%
MAJOR ORGAN TRANSPLANT	100%
CORONARY ARTERY BYPASS	25%
CARCINOMA IN SITU	25%
ENHANCED CANCER MODULE	
BENIGN BRAIN TUMOR	100%
SKIN CANCER	10%
BONE MARROW TRANSPLANT	25%
STEM CELL TRANSPLANT	25%
QUALITY OF LIFE MODULE	
PERMANENT PARALYSIS	100%
LOSS OF SIGHT, HEARING OR SPEECH	100%
COMA	100%
MULTIPLE SCLEROSIS	100%
AMYOTROPHIC LATERAL SCLEROSIS (ALS)	100%
PARKINSON'S DISEASE	50%
ADVANCED DEMENTIA, INCLUDING ALZHEIMER'S DISEASE	50%
HUNTINGTON'S DISEASE (HUNTINGTON'S CHLOREA)	50%
MUSCULAR DYSTROPHY	100%
INFECTIOUS DISEASE	25%
ADDISON'S DISEASE	10%
MYASTHENIA GRAVIS	25%
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)	25%
SYSTEMIC SCLEROSIS (SCLERODERMA)	10%
OCCUPATIONAL HIV OR HEPATITIS B OR C	100%
CHILD DISEASES	
CEREBRAL PALSY, CONGENITAL BIRTH DEFECTS, CYSTIC FIBROSIS, DOWN SYNDROME, GAUCHER DISEASE TYPE II OR III, INFANTILE TAY SACHS, NIEMANN-PICK DISEASE, TYPE IV GLYCOGEN STORAGE DISEASE, SICKLE CELL ANEMIA, TYPE 1 DIABETES, ZELLWEGER SYNDROME	100%





SURVIVOR BENEFITS

It's difficult to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Shannon provides Physicians with Basic Life and AD&D insurance as part of your basic coverage through Lincoln Financial Group, which guarantees that loved ones, such as a Spouse or other designated survivor(s), continue to receive part of an Physician's benefits after death.

Your Basic Life and AD&D insurance benefit is 1.5x your base salary to a maximum of $300,000. If you are a full-time or part-time Physician, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the Lincoln Financial Group insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by Shannon may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible physicians may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC PHYSICIAN LIFE/AD&D	
COVERAGE AMOUNT	1.5x your base salary to a maximum of $300,000
WHO PAYS	Shannon
BENEFITS PAYABLE	In the event of death
MAXIMUM BENEFIT	$300,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY PHYSICIAN LIFE	
COVERAGE AMOUNT	Increments of $10,000, up to 5x your annual salary to a maximum of $1,000,000
WHO PAYS	Physician
BENEFITS PAYABLE	In the event of death, if coverage elected
MAXIMUM BENEFIT	$1,000,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Elections over $350,000
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Increments of $5,000, not to exceed 50% of physician's coverage to a maximum of $500,000
WHO PAYS	Physician
BENEFITS PAYABLE	In the event of spouse death, if coverage elected
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Elections over $50,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000. Dependent children: live birth to age 26
WHO PAYS	Physician
BENEFITS PAYABLE	In the event of child death, if coverage elected
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Voluntary Life and AD&D Insurance

VOLUNTARY LIFE INSURANCE	
RATES/$1,000 (PHYSICIAN/SPOUSE)	
AGE (AS OF JANUARY 1, 2024)	PHYSICIAN/SPOUSE
<30	$0.045
30-34	$0.045
35-39	$0.070
40-44	$0.100
45-49	$0.135
50-54	$0.225
55-59	$0.350
60-64	$0.540
65-69*	$1.030
70-74*	$1.670
75+*	$2.480

*Subject To Age Reduction Schedule

VOLUNTARY AD&D INSURANCE
PREMIUM RATES – $
$0.02 per $1,000

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES – $
$2.40 per month, flat rate

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

INCOME PROTECTION

You and your loved ones depend on your regular income. That's why Shannon offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age. Income protection benefits are only available to eligible physicians.

Basic Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your weekly income to a $1,000 maximum for 11 weeks if you become partially or totally disabled. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

WEEKLY MAXIMUM BENEFIT	**$1,000**
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	11 weeks

Basic Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available for purchase on a voluntary basis. LTD insurance replaces 60% of your monthly income up to $10,000 if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

MONTHLY MAXIMUM BENEFIT	**$10,000**
ELIMINATION PERIOD	12 weeks
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

AIR AMBULANCE BENEFIT - EMERGENT

If you have a medical emergency, our air ambulance helicopters provide medical transport dramatically reducing the time to an emergency treatment facility. By joining our growing community of more than 1,300,000 members — the largest of its kind in the United States — means that you have the support of:

- Over 320 aircraft locations
- Network extending out across 38 states
- Highly skilled nurses, medics and pilots

1. What is the benefit of membership to you?

Membership offers several important benefits: First, as one of more than 3 million members, AirMedCare Network Providers will work on your behalf with your benefits provider to secure payment for your flight, with any uncovered amounts considered to be fully prepaid. As such, members who are transported by AirMedCare Network Providers will not receive a bill for the flight. Importantly, your membership is valid in all of our service areas, so you are covered while traveling in those areas. If they determine air medical transport is needed, and they dispatch one of our ambulance providers, your membership will provide financial coverage.

2. What is included in my membership?

Members receive a welcome packet complete with auto stickers and membership cards. Members have the peace of mind knowing that there will be no out-of-pocket expenses for air medical transport, when flown by an AMCN provider.

3. Is there a limit to the number of flights a member can have in a year?

There is no limit to the number of flights a member may take in a year. Each flight is handled the same way and must be medically necessary.

4. If I am a member and end up being transported by a ground ambulance or another air ambulance service, who is responsible for the bill?

If an AirMedCare Network Provider does not transport you, you will be responsible for payment. Our membership program only covers transports provided by our affiliates.

5. Is a Med-Trans membership considered insurance?

No. Med-Trans is not an insurance company. A Med-Trans membership is not an insurance policy and cannot be considered as secondary insurance coverage or as supplemental coverage to any insurance policy. Membership provides prepaid protection against covered Med-Trans air ambulance transportation costs that exceed a member's health insurance or medical benefits.

7. My insurance company says they will cover 100% so why do I need this membership?

Most insurance companies will pay 100% of what they deem an allowable amount for air ambulance or emergent ground, which does not necessarily mean that the total cost of the transport will be covered. For example, even after insurance pays, you may have a remaining balance due to copay, deductible, coinsurance, or because your insurance's allowable amount does not cover the total charges. Additionally, people frequently change insurance companies and plan designs. You may want to check with your individual insurance company to find out exactly how much they will cover in the case of an AMCN transport. Lastly, your insurance may decide that the flight does not fit a specific parameter covered under your policy and deny payment. Membership will cover the cost of the flight for you, even if your insurance does not.

8. If I have Medicare and a supplemental policy, do I need a membership?

No. Some state laws prohibit Medicaid beneficiaries from being offered membership or accepted into membership programs. As part of our application process, members certify to AirMedCare Network that they are not Medicaid beneficiaries, with AirMedCare Network providers accepting Medicaid as full payment for services rendered.

9. If I have a medical emergency, should I call the Med-Trans Operations Center emergency line or the local 911 service?

Call your local 911 service. The 911 dispatchers are trained to get specific information about the medical emergency from the caller and determine what type of medical transportation best fits the situation, so the best option is to always call the local 911 service first. The local service is more familiar with your location, as well as the availability of the local emergency resources. They may have information to aid you that the AirMedCare Network Provider Operations Centers may not be aware of.

10. How would emergency personnel know that I am an Air Evac member?

When calling emergency personnel, you may make the 911/ground ambulance service aware that you are an AirMedCare Network member so that, in the event they plan to request an air ambulance, they know your preference is for an AirMedCare Network provider. As a member of the AirMedCare Network, you will receive an identification card and stickers for your vehicle and insurance card. All of these items allow emergency personnel to identify that you are an AirMedCare Network member. Regardless of whether emergency personnel know that you are an AirMedCare Network member, we may still be called on to transport you. As earlier indicated, most of our transports are non-member transports.

11. Who determines if and when I will be flown?

If your medical emergency meets certain criteria, such as a heart attack, stroke or a traumatic injury, and the 911 dispatcher determines you would benefit from emergent ground or air medical transport, they may dispatch an air ambulance to your emergency, as well as a ground ambulance. If you require an emergent medical transport from one hospital to another hospital, those transfers are ordered by physicians. In the event that the AirMedCare Network Operations Center receives a call for emergency help from an individual or source other than a healthcare or emergency services agency, AirMedCare Network Providers communication specialists will identify and contact the ground EMS service in the patient's community and ask them to respond to the scene. If they determine air medical transport is needed, they will dispatch one of our air ambulance providers.

12. Does a membership ensure that Med-Trans will fly me, no matter what type of medical care I need?

Air ambulances are valuable and scarce resources that should be reserved for those times when a patient is facing a life-or-limb-threatening emergency and it is in their best interest to get to medical care in a timely fashion. AirMedCare Network Providers will not transport patients by air if air transportation is not believed to be appropriate.

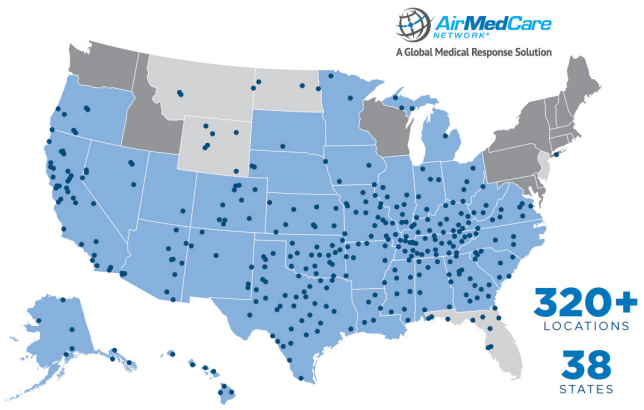
13. Who decides where to fly the patients?

When a helicopter is called, time is of the essence. Patients in life threatening situations often need specialty centers to provide the interventions needed. Med-Trans will take a patient to the closest appropriate medical facility. Whenever possible, physicians or EMS personnel consult with the patient or the patient's families as these decisions are being made.

14. Will a helicopter always be available if I need one?

There may be times when the AMCN provider aircraft in your area is committed to assisting another patient transport or is out of service for maintenance or inclement weather. In those instances, we may be able to call one of our other AirMedCare Network Providers from an adjoining service area. In some cases, however, you may need to be transported by a ground ambulance or another air ambulance service that is not a participating provider in the AirMedCare Network. It is important that you get to the medical care you need as quickly as possible, no matter the mode of transportation, so you will have the best chances for survival and degree of recovery.

Annual Cost: Membership for 1 year is $60 (some counties may have a lower cost). *There are multiple year coverage options and discounts for seniors. See paper application for all membership options.*



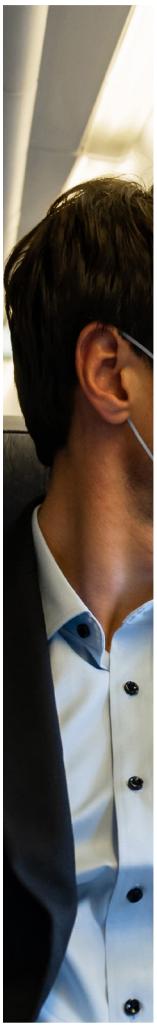
AIR AMBULANCE BENEFIT – NON-EMERGENT

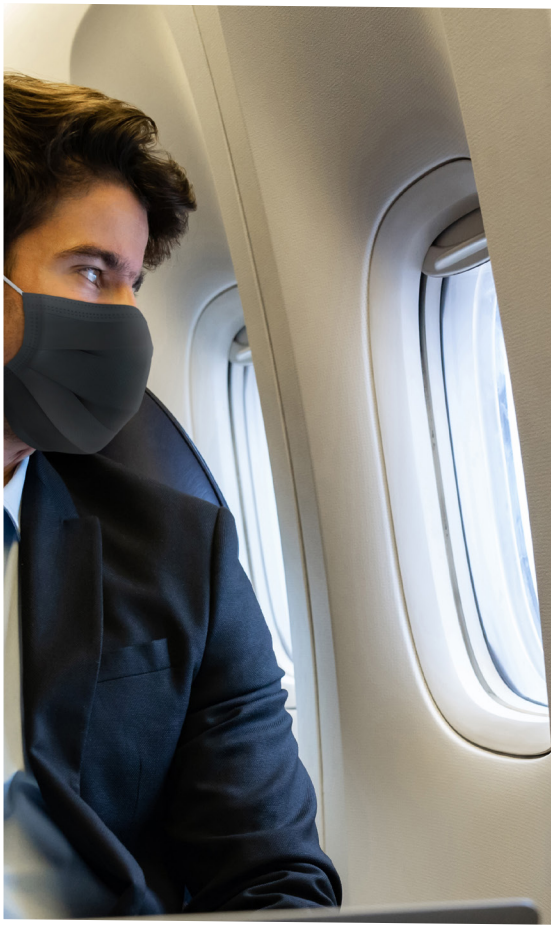
Recover Closer to Home

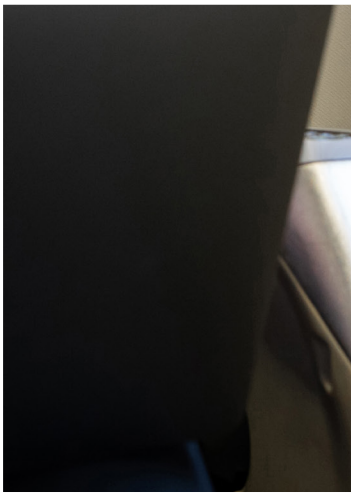
AMCN Fly-U-Home is a must-have membership for frequent travelers or those who may be flown a great distance for treatment in a medical emergency. AMCN Fly-U-Home provides access to a fleet of medically equipped, private aircraft ready to transport you, or anyone living in your household, to your local hospital of choice for recovery, should you become hospitalized more than 150 nautical miles from home. You can travel without worry knowing you have access to these flying ICUs and the highest level of medical care.

AMCN Fly-U-Home membership also provides access to medical referrals, consultations, prescription assistance, and transport of mortal remains. Additionally, members have access to AMCN Fly-U-Home's Logistics Center for information about how and where to obtain medical care while at home or while traveling.

AirMedCare Network is America's largest air ambulance membership network. An AMCN Fly-U-Home membership provides coverage across all 48 contiguous states.







How Does It Work?

1. **CALL TODAY**
   A simple call will begin the process of getting you to the hospital of your choice. All you need is to confirm that the trip requires medical escort and that you will remain a hospitalized inpatient upon landing.
2. **AMCN HANDLES EVERYTHING**
   We're there every step of the way. We'll get you from Hospital A to Hospital B, confirm bed availability, coordinate with your admitting physician, and arrange for the proper aircraft and crew for your treatment and transport.
3. **RECOVER WITH PEACE OF MIND**
   As a member, you will never see a bill for your flight. These flights typically cost tens of thousands of dollars and are rarely covered by insurance. With Fly-U-Home membership, you can focus on recovery, not finances.

Annual Cost:

- Non-Emergent membership for 1 year is $140/year with the election of the emergent plan at $60/year. For both plans, you would pay $200 for annual membership.

RETIREMENT PLANNING

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Contributing to a 401(k) account now can help keep you financially secure later in life. The Shannon 401(k) plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	Shannon 401(k) Plan
RECORDKEEPER	Milliman
WEBSITE	www.millimanbenefits.com
ELIGIBILITY	After three months of services, 1st month of the following
COMPANY MATCH	After 15 months of services, 1st of the following month, Shannon will match your contributions for each dollar you contribute to the plan, up to the first 3% and $0.50 on the dollar for the next 2%.
ENROLL	Visit www.millimanbenefits.com or by calling 888-880-5060. Unless you designate otherwise, a 3% contribution will be taken from your check after you have been employed for three months.

All About 401(k)

This employer-sponsored retirement account can help your future self by saving money — tax free — from your paycheck. The sooner you participate in a 401(k), the more time your assets have to grow.

Eligible physicians can invest for retirement while receiving tax advantages. After 15 months of services, 1st of the following month, Shannon will match your contributions for each dollar you contribute to the plan, up to the first 3% and $0.50 on the dollar for the next 2%. Administrative services are provided by Milliman. You may start making pre-tax contributions into the plan after three months of services, 1st month of the following.

Pre-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions are taken out before taxes each pay period, which will lower your annual taxable income. Pre-tax contributions grow on a tax-deferred basis and you won't pay taxes on these dollars until a distribution is taken at retirement. If you choose the available Roth 401(k), contributions are deducted from your paycheck after taxes — so although you are paying taxes on those dollars now, you won't pay taxes when you withdraw during retirement.

Contributing to the Plan

The deferred contribution limit set annually by the IRS.

If you are age 50 or older this year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. See your plan administrator for details.

Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in and you won't be subject to penalties for overcontributing.

IDENTITY THEFT PROTECTION

Shannon wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Identity Theft Protection

Identity theft protection is available on a voluntary basis. There is a new identity fraud victim every two seconds. Protect yourself with LifeLock. LifeLock monitors millions of transactions every second, alerting you to suspicious activity by text, phone, or email. This plan offers a full set of features to help protect you and your covered family members against identity theft.

You have two options to choose from — Benefit Essential or Benefit Premier.

LifeLock membership features:

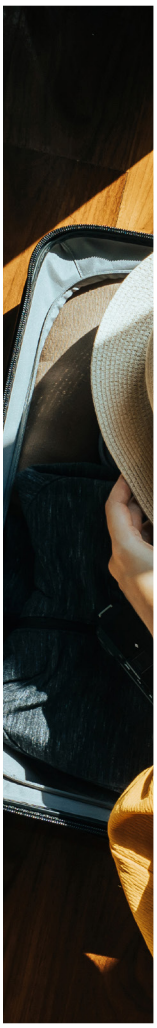
- Identity Alert System
- Lost-wallet protection
- Address change verification
- Privacy Monitor
- Live member service support
- Identity-restoration support
- Data-breach notifications

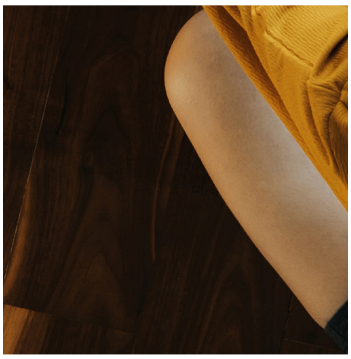
This plan is available via payroll deduction and is yours to keep if you retire or leave Shannon.

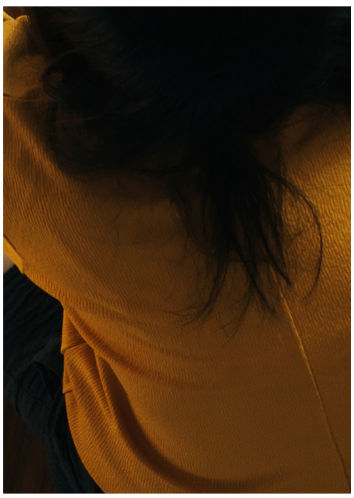
BENEFIT ESSENTIAL	PREMIUM PER PAYCHECK
EMPLOYEE ONLY	$3.75
EMPLOYEE + FAMILY*	$7.49

BENEFIT PREMIER	PREMIUM PER PAYCHECK
EMPLOYEE ONLY	$4.99
EMPLOYEE + FAMILY*	$9.49

*Covering one or more family members







Child Development Center

Full-Time Child Care for Children of Shannon Team Members

Enrollment Eligibility

Full-time Shannon Team Members and providers are qualified to enroll children. Enrollee must be parent or legal guardian assigned by the court of the child(ren) enrolled in care. If child care demands exceed availability, children will be placed on waitlists on a first-come, first-serve basis.

Note: Contractors, travelers, and individuals employed by partnerships with Shannon are not eligible.

Center Details

- Full-time care | Ages: 6 weeks through K-Prep (Infant, Toddler, Twos, and K-Prep)
- Managed by Bright Horizons, an expert in employer sponsored child care
- Hours of Operation: Monday-Friday, 5:30 am - 7:30 pm
- Engaging curriculum, catered meals, and snacks developed by a dietician
- Texas DFPS Licensed Child Care Center - 1739558

Cost

Tuition rates are based on Annual Household Income (AHI). A 10% discount will be applied to your account when you enroll multiple children. Additional financial assistance is available to families who qualify. Please see the QR code and link below for more information.

LOWER THAN MARKET RATES

Registering Your Child

To register your child or learn more, please visit **www.brighthorizons.com/shannon** or scan this QR code with your cell phone camera

Financial Assistance

To apply for additional financial assistance, please visit **www.cvworkforce.org/356/Child-Care-Application** or scan this QR code with your cell phone camera

37 E. HARRIS AVE.
SAN ANGELO, TX

Bright Horizons

SHANNON

325.747.7577

Shannon@BrightHorizons.com

REV060223

Child Development Center

Daily Drop-In Child Care for Children of Shannon Team Members

Enrollment Eligibility

Full-time Shannon Team Members and providers are qualified to become an enrollee. The enrollee must be scheduled to work at Shannon the day of child drop-in. The enrollee must be the parent or legal guardian of the child enrolled. Available daily as classroom space permits. Child(ren) must be well and free of transmittable illness on the day of care. Enrollee must have completed all registration paperwork prior to care.

Note: Contractors, travelers, and individuals employed by partnerships with Shannon are not eligible.

Center Details

- Ages: 6 weeks through K-Prep (Infant, Toddler, Twos, and K-Prep)
- Managed by Bright Horizons, an expert in employer sponsored child care services
- Hours of Operation: Monday-Friday, 5:30 am - 7:30 pm
- Engaging curriculum, catered meals and snacks developed by a dietician
- Texas DFPS Licensed Child Care Center - 1739558

Cost

- Waived Registration Free for drop-in care
- Tuiton Fee: $39 per child/per day
- Drop-in care rate must be paid prior to care date
- Drop-in care is limited to no more than two (2) days per week, unless additional days are otherwise approved

Registering Your Child

To register your child or learn more, please visit **www.brighthorizons.com/shannon** or scan this QR code with your cell phone camera

SHANNON

Bright Horizons.

325.747.7577 **Shannon@BrightHorizons.com**

37 E. HARRIS AVE. SAN ANGELO, TX

REV060223

DISCOUNTS ON YOUR BILL AT SHANNON

When utilizing a Shannon facility, on top of the great benefits using the Shannon Tier of coverage, you could receive a 25% discount on your bill. See below for details!

PURPOSE:

To assist Shannon Physicians and their immediate family members with paying their bills in a timely manner.

POLICY:

Shannon Physicians that set up payroll deduction, or pay 75% of their estimate for a procedure, either in the hospital or the clinic, will receive a 25% discount. Payroll deduction forms can be completed when estimate is given, at registration or in the Business Office.

Services can be covered under Shannon's insurance or the spouse's insurance.

- Discount does not apply to copays
- Discount does not apply to cosmetic services or bariatric surgery
- Payroll deduct must be set up within 30 days of the procedure
- Balance owed must be greater than $300
- Balance due must be paid within 12 months
- Discount does not apply to dates of service prior to October 1, 2020

A unique adjustment code will be used for reporting purposes — **Employee Prompt Pay Discount.**

The payroll deduction form signed under this agreement should be emailed to PayrollDeductForm@Shannonhealth.org. Account will be monitored and appropriate discounts applied after insurance pays. The Business Office will forward payroll deduction form to appropriate payroll department via same email.

Monthly payments under these specific arrangements will be in addition to any existing payroll deduction on outstanding balances.

If the employee leaves Shannon, for any reason, without completing payment of the balance due under this arrangement, discounts may be removed and normal collection efforts followed.

Required Notices

Important Notice from Shannon Medical Center About Your Prescription Drug Coverage and Medicare under the WebTPA Silver, Bronze, and HDHP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Shannon Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Shannon Medical Center has determined that the prescription drug coverage offered by the WebTPA Silver, Bronze, and HDHP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Shannon Medical Center coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Shannon Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Shannon Medical Center changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	Shannon Medical Center
Contact—Position/Office:	Human Resources
Address:	120 E Harris Ave. San Angelo, TX 76903
Phone Number:	325-747-5243

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 325-747-5243.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 325-747-5243.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 325-747-5243.

IMPORTANT CONTACTS

Medical
WebTPA
877-305-2432
www.webtpa.com

Pharmacy
Navitus
866-333-2757
www.navitus.com

Supplemental Health (Accident, Critical Illness)
Voya
877-236-7564
www.voya.com

Telemedicine
Shannon On Demand
325-747-4848
www.ShannonOnDemand.com

Dental
WebTPA
877-305-2432
www.webtpa.com

Vision (Materials Only)
VSP
800-877-7195
www.vsp.com

Health Savings Account
Health Equity
866-346-5800
www.healthequity.com

Flexible Spending Accounts
TaxSaver Plan
800-328-4337
www.taxsaverplan.com

Life and AD&D
Lincoln Financial Group
855-818-2883
www.lfg.com

Disability
Lincoln Financial Group
855-818-2883
www.lfg.com

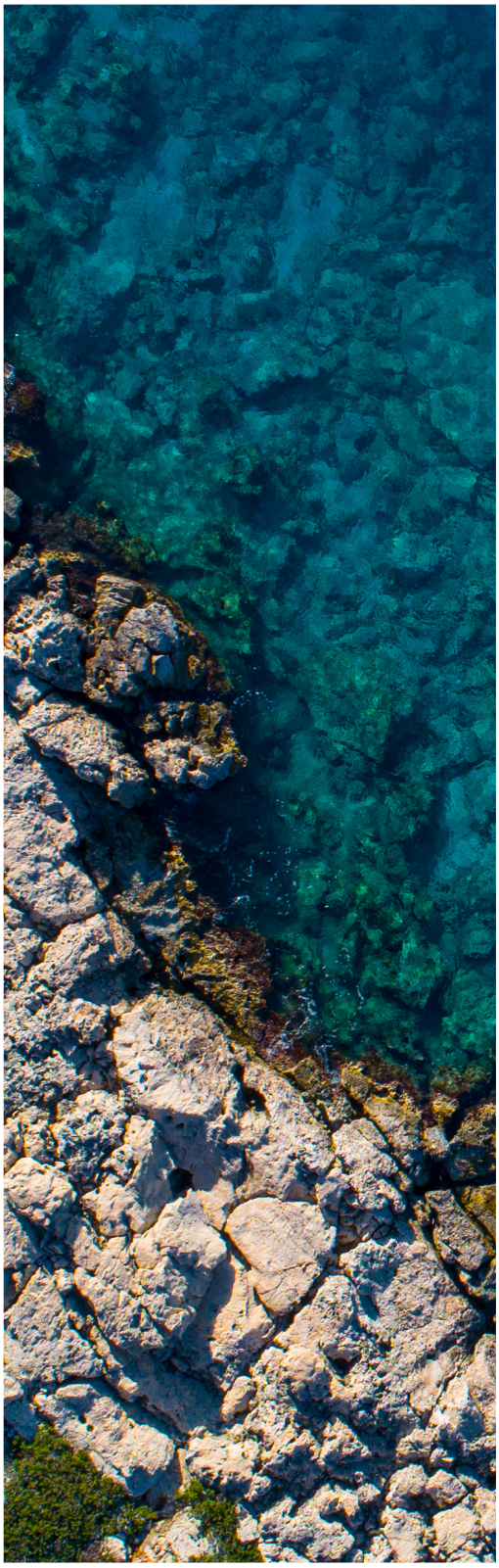
Retirement
Milliman
888-880-5060
www.millimanbenefits.com

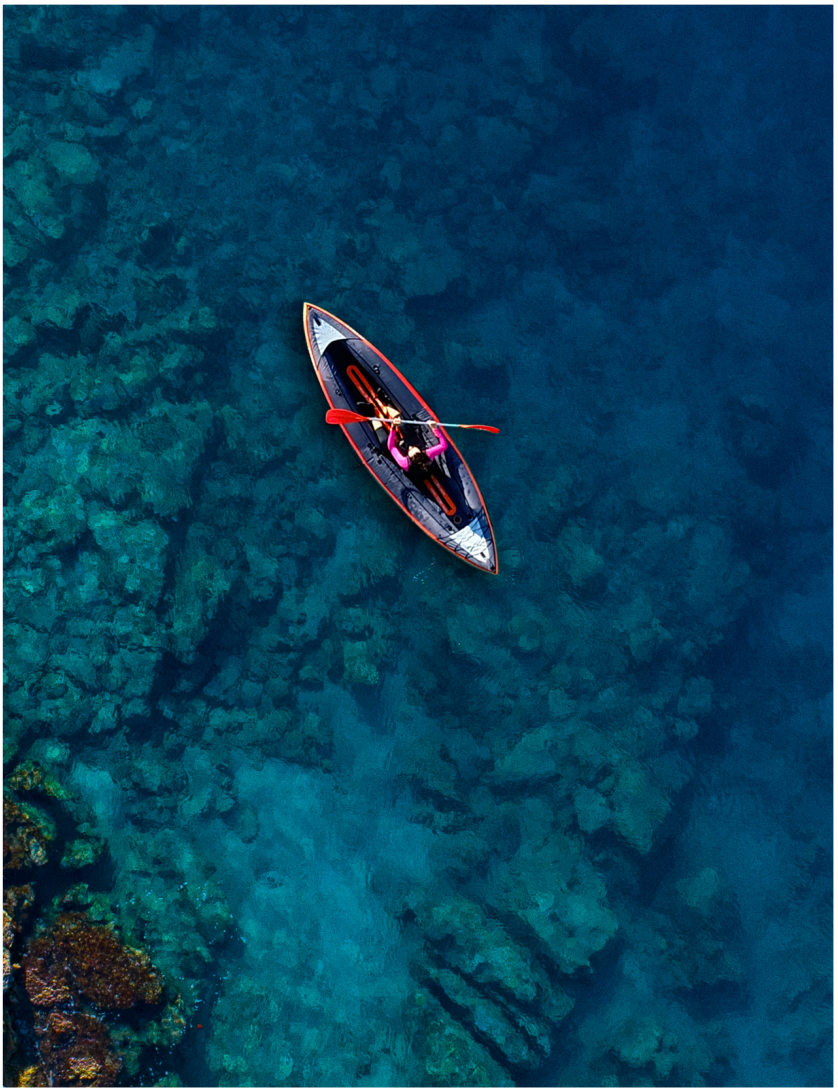
Employee Assistance Program
Alliance Work Partners
800-343-3822 OR
800-334-TEEN (8336)
www.awpnow.com
Registration code: AWP-SMC-2973

Identity Theft Protection
LifeLock
800-607-9174
www.lifelock.com

Shannon Human Resources
122 S. Oakes Street, Suite 201
San Angelo, Texas 76903
325-747-5243
benefits@shannonhealth.org

Shannon Care Management
201 E. Harris Ave
San Angelo, TX 76903
325-657-8207
healthplan@shannonhealth.org





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