At Encompass Health, we continually strive to provide a high-quality, comprehensive benefits package to our valued employees. That includes working to balance the rising costs of benefits with the growing needs of our employees in one of our nation’s most challenging times.

Our employees are dedicated and committed to providing the highest standards of excellence – in turn, we are committed to caring for you and your future. Our focus is to provide you with the tools and resources that will allow you to make awareness choices – to strive to be healthy, stay healthy and lead a healthy lifestyle.

This booklet includes the relevant information you’ll need when making the best decisions for you and your family.
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This booklet is intended to be a summary of the benefit plans. It does not include all provisions, exclusions and limitations of each plan. If there is a discrepancy between this document and the contract or policy issued by the carrier, then the terms of the contract or policy will govern.

Summary Plan Description (SPD)
A Summary Plan Description, or SPD, outlines the eligibility, schedule of benefits and items that are covered or excluded by the benefit plan. The SPDs for all benefit plans are located on the Encompass Health Intranet on the Benefits Home page at: http://insidenew.encompasshealth.com/corporate/benefits
Eligibility

Generally, the benefit plan eligibility includes full-time employees and part-time benefit-eligible employees. There are certain other plans described herein that other employee designations may elect.

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted – if you have not elected coverage, you will have no coverage for the remainder of the year.

When coverage begins
Coverage will be effective on the date of eligibility (hire date/change of status date). Changes to the initial enrollment can be made within the first 31 days of eligibility. The effective date for coverage changes made within the first 31 days of eligibility is the date the form is signed by the employee.

When coverage ends
Coverage will end on the date an employee terminates employment, the date an employee changes to a non-benefit eligible class or when an employee goes out on a leave of absence.

Eligible members
Eligible members that you may include in your health insurance coverage are listed below. You must provide proper documentation for each member within two weeks of the coverage effective date (see Dependent Eligibility Verification section in this booklet). Without proper documentation, your eligible members will not be covered.

• Your legal spouse
• Your same or opposite sex domestic partner, provided he or she meets the domestic partner requirements
• An unmarried or married child* up to age 26
• An unmarried, incapacitated child* who is age 26 and over; is not able to support himself; and depends on you for support, if the incapacity occurred before age 26.

* A child is defined as your natural child; stepchild; legally adopted child; child placed for adoption; or, other child for whom the employee has permanent legal custody.

Domestic partners/same-sex spouses
For your domestic partner to be covered under the medical plan (including the Prescription Drug Program) and the dental and vision programs, you and your domestic partner must:

• Consider each other life partners
• Both be age 18 or older
• Not be blood related
• Have lived together for at least 12 months
• Share the same permanent address and provide your driver’s licenses listing the common address
• Have joint responsibility for each other’s welfare and be mentally competent
• Not be legally married to or in a domestic partnership with anyone else
• Not have had another domestic partner within the past six months
• Share necessities of life and financial interdependence

Domestic Partners must complete the “Affidavit Declaring Domestic Partnership Status” and submit at least two of the following documents:

• A joint bank account, credit account or loan
• Joint vehicle ownership
• Joint ownership, mortgage or lease of a residence
• Evidence of common household expenses, such as utilities or phone
• Wills naming each other as executor and/or beneficiary
• Granting each other power of attorney
• Designating each other as a beneficiary under a retirement benefit account or evidence of other joint financial responsibility.

You must submit a Domestic Partner Affidavit with the specified documentation above to obtain coverage.

Unless your domestic partner qualifies as a “dependent” under the Internal Revenue Code, you may be treated as receiving “imputed income” for federal income tax purposes with respect to the benefits provided to your domestic partner. Imputed income is the difference between the value of the benefit provided to your domestic partner and the amount that you have paid for that benefit. You must pay federal income taxes (including Social Security tax and Medicare tax) on your imputed income. Similar treatment may apply for state and local income-tax purposes, to the extent applicable. For more information on federal, state or local taxation of domestic partner or same-sex spouse benefits, please contact your tax advisor.
**Qualified event changes**

Changes to benefit elections during the year are permitted only with a “qualifying event.” A qualifying event includes:

- Marriage
- Divorce/legal separation or termination of domestic partner status
- Addition of newborn
- Death of dependent
- Court ordered coverage for dependent child only
- Dependent child has lost coverage
- Significant change in health coverage offered to employee and dependent
- Spouse/domestic partner commencement or termination of employment
- Change in eligibility of employee or spouse
- Unpaid leave of absence by employee or spouse

A change in coverage based on one of the reasons above must be made within 31 days of the event. The form needed to complete the change is provided on the Benefits home page.

**If approved, when the qualifying event change is effective**

The effective date of the coverage change will be the date the employee requests the change (based on the date the form is signed). Changes due to marriage, divorce, birth or adoption are effective the date of the actual qualifying event.
Medical and prescription drug plans

There are two traditional PPO medical plans and a High Deductible Health Plan option to choose from through Blue Cross Blue Shield of Texas. The Core and Plus traditional PPO medical plans and the High Deductible Health Plan (HDHP) include prescription drug coverage and require an annual deductible be met before the coinsurance coverage is applied. The premium for the medical plan and prescription drug coverage appear as one deduction amount on the paycheck. The rates are listed in the table below.

Some important differences between the traditional PPO plans and the High Deductible Health Plan are as follow:

<table>
<thead>
<tr>
<th>What you should KNOW:</th>
<th>PLUS PPO</th>
<th>CORE PPO</th>
<th>High Deductible Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health plan comparison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PLUS PPO plan has the <strong>lowest deductible</strong> but the member pays the <strong>highest premium</strong> per check. Members pay out-of-pocket until the deductible is met.</td>
<td>The CORE PPO plan has a <strong>lower deductible</strong> but the member pays a <strong>higher premium</strong> per check. Members pay out-of-pocket until the deductible is met.</td>
<td>The HDHP has the <strong>highest deductible</strong> but the member pays the <strong>lowest premium</strong> per check. Members pay out-of-pocket until the deductible is met (including prescription drugs).</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Single</td>
<td>$ 500</td>
<td>$2,000</td>
<td>Single</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$4,000</td>
<td>Family</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Plus PPO plan has a <strong>higher out-of-pocket</strong> (OOP) expense. Once the OOP has been met the <strong>plan pays at 100%</strong>.</td>
<td>The Core PPO plan has a <strong>highest out-of-pocket</strong> (OOP) expense. Once the OOP has been met the <strong>plan pays at 100%</strong>.</td>
<td>The HDHP has a <strong>lowest out-of-pocket</strong> (OOP) expense. Once the OOP has been met, the <strong>plan pays at 100%</strong>.</td>
<td></td>
</tr>
<tr>
<td><strong>OOP Max</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td>Single</td>
<td><strong>$4,000</strong></td>
<td><strong>$ 6,000</strong></td>
<td>Single</td>
</tr>
<tr>
<td>Family</td>
<td><strong>$8,000</strong></td>
<td><strong>$12,000</strong></td>
<td>Family</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RX expenses have a <strong>separate annual deductible of $100</strong> (doesn't apply to generic).</td>
<td>RX expenses have a <strong>separate annual deductible of $150</strong> (doesn't apply to generic).</td>
<td>RX expenses are counted <strong>towards</strong> the annual deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once the deductible is met the covered medical expense is paid at <strong>90% in-network and 50% out-of-network</strong>.</td>
<td>Once the deductible is met the covered medical expense is paid at <strong>70% in-network and 50% out-of-network</strong>.</td>
<td>Employee is responsible for the <strong>FULL Cost</strong> of their healthcare expenses, until the annual deductible is met.</td>
<td></td>
</tr>
<tr>
<td><strong>Co-Pay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits co-pay <strong>$30</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Savings Account (HSA)!</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSA is only available to HDHP plan participants.</td>
<td>HSA is only available to HDHP plan participants</td>
<td>An HSA can be used for <strong>current and future</strong> medical expenses. If elected, the company contributes up to <strong>$500</strong> each year to participating employees. Employer contributions will reflect on each check. Employees own this account. All unused funds roll over each year.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> PPO participants may elect the medical FSA (up to $2000/year)</td>
<td><strong>Note:</strong> PPO participants may elect the medical FSA (up to $2000/year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Plus Medical Plan</td>
<td>Core Medical Plan</td>
<td>HDHP Medical Plan</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Annual Deductible Individual/Family</td>
<td>$500/$1,000</td>
<td>$1,500/$3,000</td>
<td>$3,000/$6,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90%</td>
<td>70%</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Out-of-Pocket Annual Maximum Individual/Family</td>
<td>$4,000/$8,000</td>
<td>$5,000/$10,000</td>
<td>$3,000/$6,000</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$30 (no deductible)</td>
<td>$30 (no deductible)</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% no deductible or copay</td>
<td>100% no deductible or copay</td>
<td>No charge; deductible does not apply</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>$300 copay; 90% after deductible and copay</td>
<td>$500 copay; 70% after deductible and copay</td>
<td>100% after calendar year deductible is met</td>
</tr>
</tbody>
</table>

**Out-of-Network benefits are available in the Plus and Core plans, with a higher individual annual deductible and a 50% coinsurance.**

### Medical/Rx Employee Cost Per Paycheck* (24 Deductions/Year)

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Plus</th>
<th>Core</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$94.92</td>
<td>$56.39</td>
<td>$48.47</td>
</tr>
<tr>
<td>Employee + Spouse/Domestic Partner</td>
<td>$227.48</td>
<td>$166.41</td>
<td>$142.52</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$217.51</td>
<td>$157.54</td>
<td>$134.92</td>
</tr>
<tr>
<td>Employee + Family**</td>
<td>$265.95</td>
<td>$190.72</td>
<td>$161.69</td>
</tr>
</tbody>
</table>

*Paycheck deductions are on a before-tax basis and cover benefits in arrears.

**Includes employee + spouse/domestic partner and child/children.

### Blue Cross Blue Shield's Access for Members℠ (BAM℠)

Participants in the Blue Cross Blue Shield Medical Plans are encouraged to register on the website at [www.bcbstx.com/member](http://www.bcbstx.com/member) to get information about your health benefits, anytime and anywhere. You can use your computer, phone or tablet to access the Blue Cross and Blue Shield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM). The services available include accessing your claim statements locating a provider and requesting ID cards.

Participants also have access to Blue Cross resources such as: Member Rewards administered by Vitals, Virtual Visits powered by MDLIVE and Well onTarget.

Member Rewards: Minimize your out-of-pocket costs and get cash rewards when a lower cost, quality provider is selected from several possibilities.

Virtual Visits: Access board-certified doctors around the clock for non-emergency health issues. Connect by mobile app, online video or telephone.

Well onTarget: Set personal health and wellness goals and track your progress, access self-directed health courses or connect with a wellness coach.

### Mobile app information

The mobile app is available on the [App Store](https://apps.apple.com) and [Google Play](https://play.google.com).
Prescription drug coverage

Prescription drug coverage through Blue Cross Blue Shield of Texas is included with the medical plan election. More than 53,000 pharmacies (most major chain and independent drug stores) participate nationwide.

Retail program

Under the Prescription Program, you will need to present your ID card when visiting a participating pharmacy. You will also be required to pay a copay for each drug purchase. After the appropriate copay has been paid, your pharmacy will electronically file your claim for you and Blue Cross will pay the remaining balance.

You can find important information to help you manage your pharmacy benefits on Blue Cross Blue Shield of Texas’s website, www.bcbstx.com. In addition to helping you find a participating pharmacy, you can look up drugs covered by your plan, find Preferred Brand Drugs, learn about generic drugs and find other important information about your prescription drug coverage.

Mail order program

Mail Order Prescription Drug Service includes drugs which are used to treat chronic conditions and are taken for 30 days or longer. Through this service, your medication can be delivered directly to your home or other specified address.

Mail Order Contact Information

Customer Service: 877 794-3574
Website: http://www.myprime.com

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Encompass Health Benefits Enrollment Change Form located on the Benefits home page and return to your Human Resources department with documentation to support the qualifying event. Once enrolled in a medical and prescription plan option, this election cannot be changed until the next annual enrollment period.

Rx Summary

<table>
<thead>
<tr>
<th>Purchased at Participating Pharmacy</th>
<th>Plus</th>
<th>Core</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Rx Deductible (Maximum of 2 per family)</td>
<td>$100 Plus Medical Plan (does not apply to generics)</td>
<td>$150 Core Medical Plan (does not apply to generics)</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$10 copay with no deductible</td>
<td>$10 copay with no deductible</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Brand Name Drugs on Preferred List</td>
<td>$45</td>
<td>$45</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Brand Name Drugs Not on Preferred List</td>
<td>$60</td>
<td>$60</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$100</td>
<td>$100</td>
<td>100% after calendar year deductible is met</td>
</tr>
</tbody>
</table>

Purchased Using Mail Order (90-Day Supply)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Rx Deductible</td>
<td>None</td>
<td>None</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Brand Name Drugs on Preferred List</td>
<td>$135</td>
<td>$135</td>
<td>100% after calendar year deductible is met</td>
</tr>
<tr>
<td>Brand Name Drugs Not on Preferred List</td>
<td>$180</td>
<td>$180</td>
<td>100% after calendar year deductible is met</td>
</tr>
</tbody>
</table>
**ID cards**
Blue Cross will mail ID cards to homes of participants within two weeks of enrollment.

**Dependent eligibility verification**
It is Encompass Health’s fiduciary responsibility to ensure the claims paid by the health insurance plans are for dependents who meet the dependent definitions outlined by the plans. You must provide certain documentation on each member you wish to cover in the medical and dental plans within two weeks of the coverage effective date. The required documentation for your spouse, domestic partner, and/or children must accompany your Benefits Enrollment Form. Members without proper documentation will not be covered.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Acceptable Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Spouse</td>
<td>• Copy of top half of the front page of the employees’ most recently filed federal tax return that includes this spouse (black out all financial information); or&lt;br&gt;• If married and filing separately, provide a copy of both spouses’ federal tax returns that reflects the same address; or&lt;br&gt;• If unable to provide tax returns, a copy of the marriage certificate and one of the following:&lt;br&gt;- Documentation of joint ownership of residence&lt;br&gt;- Documentation of joint tenants on lease of residence&lt;br&gt;- Copy of both driver’s licenses reflecting same address&lt;br&gt;- Current bank/credit card statement (within the past 12 months) with both spouses names</td>
</tr>
<tr>
<td>Children (under the age of 26)</td>
<td>• Natural Child – Copy of birth certificate showing employee’s name&lt;br&gt;• Stepchild – Copy of birth certificate showing employee’s spouse’s name; and a copy of marriage certificate showing the employee and parent’s name&lt;br&gt;• Legal Guardian, Adoption – Copy of Affidavits of Dependency, Final Court Order with presiding judge’s signature and seal, or Adoption Final Decree with presiding judge’s signature and seal</td>
</tr>
<tr>
<td>Domestic Partner (see Encompass Health Domestic Partner Guidelines for qualifications)</td>
<td>• Completed Encompass Health Affidavit declaring domestic partner status; and&lt;br&gt;• Copy of driver’s license listing same residence as employee; and&lt;br&gt;• Demonstrate financial interdependency by providing copies of at least two of the following documents:&lt;br&gt;- Ownership of a joint bank account, credit account or loan obligation&lt;br&gt;- Common ownership of a motor vehicle&lt;br&gt;- Joint ownership of a residence or lease agreement&lt;br&gt;- Evidence of common household utilities&lt;br&gt;- Execution of wills naming each other as executor and/or beneficiary&lt;br&gt;- Granting each other durable powers of attorney&lt;br&gt;- Designation of each other as beneficiary under a retirement account</td>
</tr>
</tbody>
</table>

**Special beginnings program**
Special Beginnings is a prenatal wellness program which helps ensure you or your spouse/domestic partner and baby receive the best possible healthcare during pregnancy. This program is administered by Blue Cross and Blue Shield of Texas. As a Blue Cross member, participation in Special Beginnings is available to you or your spouse/domestic partner as part of your health plan. There is no additional charge for participation in this special program. The program is administered by registered nurses with experience in prenatal care, labor and delivery, and newborn care. You or your spouse/domestic partner will receive special attention throughout the pregnancy, and can enjoy the fact that Special Beginnings nurses are available to answer questions and offer support. Useful gifts that educate and support healthy habits are provided as part of Special Beginnings. These gifts underscore the importance of proper prenatal care in simple, easy-to-understand terms, and help you understand the changes and challenges that accompany pregnancy.

**For more information**
Refer to the Blue Cross Blue Shield Medical Plan Booklet or Prescription Drug Plan located on the Benefits home page on the Encompass Health intranet for specific benefit coverage, copayments for Encompass Health and non-Encompass Health facilities, deductibles and provider networks.

**Blue Cross Blue Shield contact information**
Blue Cross Blue Shield Customer Service: 800 521-2227<br>Medical Preauthorization: 800 441-9188<br>Provider Network: 800 810-2583<br>Website: Medical/Pharmacy - www.bcbstx.com<br>The BCBS of Texas App is available on Google Play or the App Store or text BCBSTX to 33633.
Dental plan

Encompass Health’s dental benefits are offered to full-time and part-time benefit-eligible employees and are administered by MetLife. The plan includes a core dental plan and several buy-up options.

- Additional $500 in annual benefits payable (brings total payable to $1,500 annually)
- Add orthodontic coverage for your children – $1,500 lifetime maximum benefit
- Or you may add both buy-up options to your Core Dental Plan.

Orthodontic coverage

Orthodontic benefits for your children up to age 19 are available to you as a buy-up option. The benefit is 20% of your orthodontic lifetime maximum and 50% of each monthly payment, up to a $1,500 lifetime maximum per child as long as you are actively covered on the plan. See the Orthodontic brochure on the Benefits home page, or call MetLife for more information.

For more information

The MetLife Plan booklet and summary detailing covered procedures and rates are located on the Benefits home page on the Encompass Health Intranet. This plan coordinates benefits with other group dental plans.

ID cards

MetLife does not produce identification cards. Your dentist will verify and access your dental coverage through MetLife for you.

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted — if you have not elected coverage, then you will have no coverage for the remainder of the year.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Benefits Change Request Form located on the Benefits home page and return to your Human Resources department with documentation to support the qualifying event. You may not add or drop a buy-up option for any reason during a plan year. Your next opportunity to make this change will be during the next annual enrollment period.

Dependent eligibility verification

It is Encompass Health’s fiduciary responsibility to ensure the claims paid by the medical and dental plans are for dependents who meet the dependent definitions outlined by the plans.

You must provide certain documentation on each member you wish to cover in the medical and dental plans. The required documentation for your spouse, domestic partner, and/or children must accompany your Benefits Enrollment Form. Members without proper documentation will not be covered. The Benefits Enrollment Form lists the acceptable documents for each member type.

MetLife contact information

Customer Service: 800 942-0854
Website: http://mybenefits.metlife.com
mobile app is available on the App Store and Google Play.

Dental Summary

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Annual Deductible</th>
<th>Preventive Care</th>
<th>Basic Restorative</th>
<th>Major Restorative</th>
<th>Annual Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50 per individual</td>
<td>100% with no deductible</td>
<td>80% after annual deductible</td>
<td>50% after annual deductible</td>
<td>$1,000/per person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>Employee Only</th>
<th>Employee + Family**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>$3.10</td>
<td>$15.50</td>
</tr>
<tr>
<td>Core + $500</td>
<td>$4.60</td>
<td>$18.65</td>
</tr>
<tr>
<td>Core + Child Orthodontics</td>
<td>N/A</td>
<td>$45.50</td>
</tr>
<tr>
<td>Core + $500 + Child Orthodontics</td>
<td>N/A</td>
<td>$48.65</td>
</tr>
</tbody>
</table>

*Paycheck deductions are on a before-tax basis and cover benefits in arrears.
**Includes employee + spouse/domestic partner and child/children.
 Vision plans

Encompass Health offers full- and part-time benefit-eligible employees a choice of two vision carriers - Vision Service Plan (VSP) and Superior Vision Plan.

For more information

VSP and Superior Vision Plan both have a nationwide network of providers and include benefits for annual exams, contact lenses and glasses. Each carrier offers a base plan and an enhanced buy-up option that provides greater allowances for frames and contacts. Refer to each plan’s brochures located on the Benefits home page for benefit coverage, frequency of use and copays.

You may visit each carrier’s website to see a listing of the eye care providers in your area. The website address for each plan is listed in the contact section below.

Vision plans cost per paycheck*

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>VSP</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Base</td>
<td>Buy-Up</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$4.15</td>
<td>$5.26</td>
</tr>
<tr>
<td>Employee + Family**</td>
<td>$10.15</td>
<td>$12.85</td>
</tr>
</tbody>
</table>

*Paycheck deductions are on a before-tax basis and cover benefits in arrears. **Includes employee + spouse/domestic partner and child/children.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Benefits Change Request Form located on the Benefits home page and return to your Human Resources department with documentation to support the qualifying event. You may not change vision plans for any reason during a plan year. Your next opportunity to make this change will be during the next annual enrollment period.

How to use your plan

Once enrolled in a vision plan, you may call a provider within the vision plan carrier’s network you elected to make your eye appointment. The provider will contact your vision carrier to verify coverage. No paperwork is required by you. At your appointment, pay the provider directly the copays and cost of any non-covered items.

Vision Service Plan

• 24,000+ providers in network nationwide
• Network consists of ophthalmologists and optometrists
• Provider search on website
• Affiliate providers (i.e. Visionworks, Pearle Vision, Costco Optical)
• No ID cards or claim forms needed — network doctor will verify benefits with VSP

VSP contact information

Customer Service: 800 877-7195
Website: www.vsp.com

Superior Vision Plan

• 27,000+ providers in network nationwide
• Network consists of:
  • Ophthalmologists
  • Optometrists
  • National and regional chains and independent optical companies (i.e. Wal-Mart Vision Centers, LensCrafters, Target Optical and Costco Optical)
• Provider search on website
• No ID cards or claim forms needed—network doctor will verify benefits with Superior

Superior contact information

Customer Service: 800 507-3800
Website: www.superiorvision.com

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted – if you have not elected coverage, then you will have no coverage for the remainder of the plan year.
Flexible spending accounts

Flexible Spending Accounts are tax-advantaged accounts that allow eligible employees to set aside pre-tax deductions to build up cash for eligible expenses (day care or healthcare expenses). These plans allow you to reduce your taxable income by the amount you contribute. Money deposited into your Flexible Spending Account(s) must be used during the plan year for appropriate expenses.

Medical flexible spending account

The Medical Flexible Spending Account (FSA) allows full-time and part-time benefit-eligible employees to set aside up to $2,000 in pre-tax payroll deductions to pay for eligible healthcare expenses. The Medical FSA allows you to reduce your taxable income by the amount you contribute.

The Medical FSA allows reimbursement for most health, dental and vision care expenses not reimbursed by any other insurance plan. You do not have to participate in a Encompass Health sponsored medical plan to participate in the Medical FSA. The Medical FSA plan contains a grace period, which allows you to use money left in your account at the end of 2018 to pay expenses incurred in 2019 through March 15, 2019. Claims reimbursement for the 2018 plan year must be submitted by March 31, 2019. In other words, the grace period allows you to access funds from the prior plan year to pay for expenses incurred in the current plan year for up to two and a half months after the previous plan year ends.

Examples of covered expenses
- Copays and deductibles
- Orthodontics
- Glasses/contact lenses

Examples of non-covered expenses
- Healthcare expenses covered by other plans
- Cosmetic services or surgery
- Insurance premiums

Dependent care spending account

The Dependent Care Spending Account allows full- and part-time employees to set aside up to $5,000 in pre-tax payroll deductions to build up cash for eligible dependent childcare expenses. This plan allows you to reduce your taxable income by the amount of the Dependent Care Spending Account contributions.

The Dependent Care Spending Account allows a family to receive reimbursement for expenses associated with the care of a dependent child under age 13. In addition, reimbursement may be received for a spouse who is physically or mentally incapable of caring for himself or herself, while you are at work.

Examples of covered expenses
- Licensed nursery
- Day care facilities
- After school day care program
- Childcare inside or outside of your home

Examples of non-covered expenses
- Child support payments
- School tuition
- Food, clothing or entertainment
- Overnight camp expenses

Enrolling
- After an election is made, it cannot be changed during the plan year without a qualifying family status change.
- The Medical Flexible Spending Account cannot be decreased for any reason, unless within 31 days of enrollment.
- Re-enrollment into the Spending Account Plan(s) is required each calendar year.

Enrolling late or discontinuing participation

Enrollment into any of the spending accounts must be made within 31 days of hire, or within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Encompass Health Flexible Spending Accounts Change Request Form located on the Benefits home page and return to your Human Resources department with documentation to support the qualifying event.

Participation in Medical Flexible Spending Account cannot be cancelled, or contributions decreased during the plan year, unless within 31 days of enrolling. An election amount may be increased if requested within 31 days of a qualifying event.
Participation in the Dependent Care Spending Account cannot be cancelled or changed unless requested within 31 days of a documented qualifying event.

Claims reimbursement
1. Log in to your online account at www.connectyourcare.com.
2. Click “Claims from Insurance Plans” under “Payments and Reimbursements.” Click on “Claims from Insurance Plans.”
3. Here, you will choose whether to turn auto-pay on or off. If auto-pay is on, all medical and prescription claims will be reimbursed automatically, according to Encompass Health’s auto-pay reimbursement schedule. This setting can be changed at any time. If auto-pay is off, health plan claims that are ready to be paid will display prominently on the home page.

To pay these claims, simply:
• Click on the health plan claim to view the claim details.
• Decide to pay or not pay the claim and the amount to pay. Claims not paid immediately can be filed for future payment.
• Review and confirm payment. Please see the benefits home page for additional information.

For more information
IRS regulations govern the spending accounts. Refer to each of the spending account plan booklets, located on the Benefits home page for more information.

Connect Your Care contact information
866 808-1444
Fax: 866 879-0812
Website to file claims: www.connectyourcare.com
mobile app is available on the App Store and Google Play.

COBRA

Continuation of coverage through COBRA
Certain status changes will cause an employee to become ineligible to remain on the Encompass Health group health insurance plans. Once we are notified of a change in status, you will automatically receive a COBRA notification from Benefit Concepts. These changes in status include termination of employment, change to an ineligible class or going on a leave of absence. Employees may elect to continue their current coverage at the full cost of the plan for up to a period of 18 months.

COBRA notification letters are also sent to the dependent of an employee if we have been notified to remove a spouse from the plan due to divorce, or if BCBS has determined that a child is over the age of 26. Dependents may elect to continue their current coverage at the full cost of the plan for up to a period of 36 months.

Benefit Concepts contact information
Customer service: 800 969-2009
Email: info@benefitconcepts.com
Election Form Fax: 866 629-6389

Basic Life Insurance
Encompass Health provides Basic Term Life Insurance benefits to full-time employees in an amount equal to one times your annual base pay at no cost to you. Refer to the Encompass Health Basic Life Insurance Booklet for full details of coverage and limitations.

Enrolling
Employees are required to name a beneficiary for the Basic Life Insurance benefits. The beneficiary information is to be retained at Unum Life Insurance Company. Beneficiary changes can be made at any time by contacting Unum.
Optional group term life insurance

Additional insurance is available to full-time employees. The additional insurance plans are Group Term Life Insurance and Dependent Life Insurance. Refer to the plan booklets for full details of coverage and limitations.

Employee group term life insurance

You may purchase Group Term Life Insurance on yourself from one to five times your base annual pay. Coverage up to two times your annual base pay (maximum of $500,000) is guaranteed without providing medical evidence of good health, if coverage is elected during the first 31 days of eligibility. You may apply for benefit levels over the guaranteed coverage amount by providing medical evidence of good health satisfactory to Unum. The cost for this life insurance is based on your age and the approved coverage amount (see age chart in this section).

<table>
<thead>
<tr>
<th>Age</th>
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<tr>
<td>30-34</td>
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<td>70-74</td>
<td>$1.852</td>
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<tr>
<td>75+</td>
<td>$3.075</td>
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<table>
<thead>
<tr>
<th>Coverage Amount</th>
<th>Monthly Cost</th>
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</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$0.65</td>
</tr>
<tr>
<td>$10,000</td>
<td>$1.30</td>
</tr>
<tr>
<td>$15,000</td>
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<td>$20,000</td>
<td>$2.60</td>
</tr>
<tr>
<td>$25,000</td>
<td>$3.25</td>
</tr>
</tbody>
</table>

Spouse/domestic partner group term life insurance

You may purchase Group Term Life Insurance for your spouse/domestic partner (under age 75) in $10,000 benefit increments up to $100,000. Coverage for your spouse/domestic partner cannot exceed 100% of your benefits amount (basic + optional term life). You can select spouse coverage up to $30,000 without providing medical evidence of good health, if coverage is elected during the first 31 days of eligibility. Coverage over $30,000 may be purchased by providing medical evidence of good health to Unum. The cost for this life insurance is based on your age and the approved coverage amount (see age chart in this section). Rates change as the insured enters a higher age category. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

Child term life insurance

You may purchase Term Life Insurance for your dependent child (up to age 19, or 26 if a full-time student) in $5,000 benefit increments up to $25,000. Coverage for your child cannot exceed 100% of your benefit amount (basic + optional term life). The cost for this life insurance is determined by the elected coverage amount (see rate table in this section).

Enrolling

Enrollment into the optional term life insurance plans must be made within 31 days of hire date or a change to full-time status. Unum does not require proof of insurability on amounts elected during this period up to the guaranteed coverage amount. Coverage amounts elected which are over the guaranteed coverage amount require the insured to provide medical evidence of good health satisfactory to Unum. Complete the online Benefit Enrollment Form to enroll in these plans.

Enrolling late or discontinuing coverage

Enrollment into the optional term life insurance plans beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage is during annual enrollment at year-end and will require medical evidence.
of good health satisfactory to Unum. You may cancel coverage at any time by completing the Benefit Change Request Form located on the Benefits home page.

Unum Life Insurance contact information
Customer service: 800 421-0344

Voluntary accidental death and dismemberment insurance

Voluntary Accidental Death and Dismemberment Insurance (AD&D) is available to full-time employees. AD&D insurance provides around-the-clock protection in the event of an accident. Refer to the plan booklet for full details of coverage and limitations.

Employee accidental death and dismemberment insurance

You may purchase AD&D insurance in benefit amounts from $25,000 to $300,000. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section). You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

Spouse/domestic partner accidental death and dismemberment insurance

You may purchase AD&D insurance on your spouse/domestic partner in benefit amounts from $25,000 to $300,000. Coverage for your spouse/domestic partner cannot exceed 100% of your benefit amount. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section).

Child accidental death and dismemberment insurance

You may purchase AD&D insurance on a dependent child (if under age 26 and a full-time student) in benefit amounts from $5,000 to $30,000. Coverage for your child cannot exceed 100% of your benefit amount. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section).

Enrolling

Enrollment into the voluntary AD&D insurance plans must be made within 31 days of hire date or a change to full-time status. These plans do not require proof of insurability. Complete the online Benefits Enrollment Form to enroll in these plans.

Enrolling late or discontinuing coverage

Enrollment into the voluntary AD&D insurance plans beyond the initial 31 days from benefits eligibility will not be accepted. The next opportunity to apply for this coverage is during annual enrollment at year end. You may cancel coverage at any time by completing the Benefits Change Request Form located on the Benefits home page.

Unum Life Insurance contact information
Customer service: 800 421-0344

<table>
<thead>
<tr>
<th>Coverage Amount</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$0.50</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1.00</td>
</tr>
<tr>
<td>$75,000</td>
<td>$1.50</td>
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<tr>
<td>$100,000</td>
<td>$2.00</td>
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<td>$125,000</td>
<td>$2.50</td>
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<td>$150,000</td>
<td>$3.00</td>
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<td>$175,000</td>
<td>$3.50</td>
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<td>$5.50</td>
</tr>
<tr>
<td>$300,000</td>
<td>$6.00</td>
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<tr>
<td>Coverage Amount</td>
<td>Monthly Cost</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>$5,000</td>
<td>$0.10</td>
</tr>
<tr>
<td>$10,000</td>
<td>$0.20</td>
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<tr>
<td>$15,000</td>
<td>$0.30</td>
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<tr>
<td>$20,000</td>
<td>$0.40</td>
</tr>
<tr>
<td>$25,000</td>
<td>$0.50</td>
</tr>
<tr>
<td>$30,000</td>
<td>$0.60</td>
</tr>
</tbody>
</table>

**Short-term disability plans**

The Short-Term Disability (STD) plans are voluntary plans which provide partial income replacement for full-time employees who are unable to work due to illness, pregnancy or injury. These plans are not offered to employees in states where disability coverage is provided or mandated by the state (CA, HI, NJ, NY, PR or RI).

**Option 1: 60% STD benefit plan - 14-day waiting period**

This plan provides you with a weekly benefit amount equal to 60% of your base weekly earnings up to a maximum of $500 per week. The benefit waiting period is 14 calendar days and the maximum benefit duration is 24 weeks. The premiums are calculated based on your age and base monthly salary. Please refer to the premium chart on the next page for the approximate monthly cost.

**Option 2: 50% STD benefit plan - 30-day waiting period**

This plan provides you with a weekly benefit amount equal to 50% of your base weekly earnings up to a maximum of $500 per week. The benefit waiting period is 30 calendar days and the maximum benefit duration is 22 weeks. The premiums are calculated based on your age and base monthly salary. Please refer to the premium chart on the next page for the approximate monthly cost.

**Enrolling**

To enroll, complete the Short-Term Disability section of the online Benefits Enrollment Form within 31 days of your hire date or change of status to full time. Enrollment into the plan beyond the initial 31 days will not be accepted. The next opportunity to apply for coverage will be during annual enrollment at year end and will require medical evidence of insurability satisfactory to Unum.

**Enrolling late or discontinuing coverage**

Enrollment into the Short-Term Disability plans beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage will be during annual enrollment at year end and will require medical evidence of insurability satisfactory to Unum. You may cancel existing coverage at any time by completing the Benefits Change Request Form located on the Benefits home page.

**Reporting a disability claim**

The benefit waiting or elimination period to receive disability benefits depends on the option you elect. For Option 1, there is a 14-day waiting period, and for Option 2 there is a 30-day waiting period.

Call Unum’s Claim Intake at 800 723-8500 to file a disability claim. For a scheduled or planned disability (due to surgery or pregnancy), you may call up to two weeks in advance of your disability. The Encompass Health Control/Group number is 467565.

Paid Time Off (PTO) may be used during the applicable 14- or 30-calendar day waiting period. However, you cannot receive both PTO and disability payments at the same time during the disability benefit period.
### Short-term disability plan - 60% of gross weekly wages with 14-day waiting period.*

<table>
<thead>
<tr>
<th>Monthly Salary</th>
<th>Weekly Benefit</th>
<th>Monthly Premium by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>18 - 29</td>
</tr>
<tr>
<td>$541 - $722</td>
<td>$100.00</td>
<td>$6.90</td>
</tr>
<tr>
<td>904 - 1,083</td>
<td>150.00</td>
<td>10.35</td>
</tr>
<tr>
<td>1,084 - 1,264</td>
<td>175.00</td>
<td>12.08</td>
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<td>1,265 - 1,444</td>
<td>200.00</td>
<td>13.80</td>
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<td>1,626 - 1,806</td>
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<td>1,987 - 2,167</td>
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<tr>
<td>2,168 - 2,527</td>
<td>350.00</td>
<td>24.15</td>
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<tr>
<td>2,528 - 2,889</td>
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<tr>
<td>3,251 - 3,612</td>
<td>500.00</td>
<td>34.50</td>
</tr>
</tbody>
</table>

### Short-term disability plan - 50% of gross weekly wages with 30-day waiting period.*

<table>
<thead>
<tr>
<th>Monthly Salary</th>
<th>Weekly Benefit</th>
<th>Monthly Premium by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>18 - 29</td>
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<td>3,901-4,334</td>
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<td>22.00</td>
</tr>
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</table>

* $500 / Week Maximum Benefit
Long-term disability plans

The Long-Term Disability (LTD) plans provide partial income replacement for full-time employees who are unable to work due to illness or injury. Coverage in the company provided plan is effective the date of your six-month anniversary if you have continued to meet the eligibility requirements.

Pre-existing conditions

During the first 12 months of coverage, no long-term disability benefits will be paid for a disability that is due to a pre-existing condition. A pre-existing condition is an injury or illness for which you received medical treatment, consultation or diagnostic measures, prescribed drugs or medications, or for which you followed treatment recommendations during the three months prior to your effective date of coverage. See the plan booklet for additional information on coverage, limitations and exclusions.

Company paid benefit:
50% LTD benefit plan - $10,000 monthly max

Encompass Health provides full-time employees, at no cost, long-term disability coverage in the amount of 50% of your base monthly earnings, up to a maximum of $10,000.

Buy-Up Option:
Additional 10% LTD benefit plan - $10,000 monthly max

Full-time employees may purchase an additional 10% of long-term disability coverage up to a maximum of $10,000 in monthly benefits.

<table>
<thead>
<tr>
<th>Age</th>
<th>Per $100 of Your Monthly Base Salary</th>
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</thead>
<tbody>
<tr>
<td>Less than 25</td>
<td>$0.06</td>
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<td>25-29</td>
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<td>30-34</td>
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<td>$0.40</td>
</tr>
<tr>
<td>70 and over</td>
<td>$0.40</td>
</tr>
</tbody>
</table>

Enrolling

Once eligible, enrollment in the 50% plan is automatic and requires no forms.

To purchase the additional 10% buy-up plan, select this plan on your Benefits Enrollment Form. The premiums for this plan will not be deducted from your check until you have met the six-month eligibility waiting period.

Coverage for either of these plans will become effective the date of your six-month anniversary, if you have continued to meet the eligibility requirements during this period.

Enrolling late or discontinuing coverage - buy-up option

Enrollment into the buy-up plan beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage will be during annual enrollment at year end and will require evidence of insurability satisfactory to Unum. You may cancel existing coverage at any time by completing the Benefits Change Request Form located on the Benefits home page.

Reporting a disability claim

The benefit waiting or elimination period to receive disability benefits is approximately 26 weeks or 180 calendar days.

Call Unum’s Claim Intake at 800 723-8500 to file a disability claim. The Encompass Health Control/Group number is 467564. The mobile app is available on the App Store or Google Play.
The life insurance products and disability coverages are issued by Unum Life Insurance Company of America, 2211 Congress, Portland, Maine 04122. This description is intended to be a summary of your benefits and does not include all policy provisions, exclusions and limitations. A book-certificate with complete information, including limitations and exclusions, will be provided. If there is a discrepancy between this document and the booklet certificate issued by Unum, the terms of the booklet-certificate will govern.

Paid time off

Encompass Health offers full-time and benefit-eligible part-time employees paid time-off benefits ("PTO"). Paid time-off benefits are a combination of the traditional vacation and sick time benefits. Benefit-eligible employees accrue PTO hours each time they receive a paycheck, beginning with their first paycheck. In addition, full-time employees receive 56 hours of holiday time each calendar year. Eligible part-time employees receive 28 hours of holiday time each calendar year. Holiday time is in addition to accrued PTO.

Paid time-off hours are accrued based on actual hours paid during a pay cycle, multiplied by the applicable hourly accrual rate. An employee’s accrual rate is based on the applicable PTO schedule and the employee’s eligible service. The eligible service date may be adjusted for break in service or periods of ineligibility.

Employees will continue to accrue PTO up to a maximum of one times the annual amount. Once this maximum amount is reached, the employee will stop accruing until PTO time is used and the balance is reduced to less than the maximum amount.

Schedule 1 – exempt positions*

<table>
<thead>
<tr>
<th>Years of Eligible Service</th>
<th>Hourly Accrual Rate</th>
<th>Hours Earned Per Pay Period**</th>
<th>Maximum Accrual</th>
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<td>3-4.999</td>
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<td>7.08</td>
<td>184</td>
<td>23</td>
</tr>
<tr>
<td>5-9.999</td>
<td>0.1038</td>
<td>8.30</td>
<td>216</td>
<td>27</td>
</tr>
<tr>
<td>10+</td>
<td>0.1192</td>
<td>9.54</td>
<td>248</td>
<td>31</td>
</tr>
</tbody>
</table>

Schedule 2 – Non-Exempt Positions

<table>
<thead>
<tr>
<th>Years of Eligible Service</th>
<th>Hourly Accrual Rate</th>
<th>Hours Earned Per Pay Period**</th>
<th>Maximum Accrual</th>
<th>Annual Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2.999</td>
<td>0.0500</td>
<td>4.00</td>
<td>104</td>
<td>13</td>
</tr>
<tr>
<td>3-4.999</td>
<td>0.0692</td>
<td>5.54</td>
<td>144</td>
<td>18</td>
</tr>
<tr>
<td>5-9.999</td>
<td>0.0846</td>
<td>6.77</td>
<td>176</td>
<td>22</td>
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<tr>
<td>10+</td>
<td>0.1000</td>
<td>8.00</td>
<td>208</td>
<td>26</td>
</tr>
</tbody>
</table>

*Plus the following clinical positions: RN, LPN, LVN, PT, LPTA, OT, COTA, RRT, CRT, SLP, SLPA, Pharmacist, Sleep Lab Technologist, Rad Technologist

**(Based on 80 hours)

Retirement investment plan - 401(k)

Take full advantage of the company matching contribution for your 401(k). Encompass Health’s match is 50% of the first 6% of pay contributed to the plan.

The Encompass Health Retirement Investment Plan is a plan qualified by the IRS and operating under Department of Labor regulations. The plan allows employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account subject to the normal maximum limits set by the IRS. If you will turn 50 or older, you are eligible to make an additional pre-tax “catch-up contribution.”

Benefits

Employees direct the investment of their contributions and the company matching amounts. Participants receive quarterly statements outlining account activity and balances. Online access is also available for on demand account review and changes using the workplace.schwab.com website. The earnings in the plan accumulate tax-deferred until retirement or withdrawal. The Encompass Health plan also features a loan provision, which allows participants to borrow their own money without an IRS penalty and repay themselves through payroll deduction.
Roth option

Your plan includes a Roth option. If you decide to make Roth contributions, they will be deducted from your paycheck after taxes. Your contributions and earnings will grow tax-free, and you will not pay taxes on the money when it’s withdrawn—provided that any distribution from the plan account occurs at least five years following the year you make your first Roth contribution, and you have reached age 59½ or have become disabled. If you die, your beneficiary will not owe taxes on the plan account balance either. Federal law limits the dollars you can contribute every year.

Company match

A 50% matching contribution is applied to the first 6% of salary deferred into the plan. You will receive 50 cents on every dollar that you contribute up to 6% of your compensation each payday. Any contributions greater than 6% of an employee’s salary are not matched. Any money you contribute into the plan is always 100% vested. However, a vesting schedule does apply to the Encompass Health company match. The vesting schedule for ownership of the company match is three years in which you work 1,000 hours each year. Specific plan information is available in the Summary Plan Document (SPD).

Investment advice

Retirement plan advice is provided by the plan through GuidedChoice® at no additional cost to you. Let the investment advisors help you get started saving for retirement, or fine tune your investment selections to meet your retirement goals. You can access the service by calling Schwab Participant Services at 800 724-7526.

Who is eligible?

Full- and part-time employees at least 21 years of age.

Rollovers

The plan accepts rollovers from other qualified plans at any time.

Enrolling

There is no eligibility waiting period.

Eligible employees can enroll into the plan at any time by going to the Schwab website at workplace.schwab.com (your ID is your social security number and your pin number is your four-digit month and birth date), or by calling Participant Services at 800 724-7526.

Once enrolled, you may make changes to your salary deferral percentage and investments at any time by contacting Schwab online or by phone.

Manage your account - go paperless – it’s easy!

Save time and resources by viewing your retirement statements, reports, regulatory notices and transaction confirmations online by signing up to receive your 401(k) Plan communications electronically. It makes it easy to organize and stay on top of your account details and activity. Once you enroll at workplace.schwab.com, go to Manage Account > E-Services and make your selections for paperless delivery.

Don’t forget to designate your beneficiary when you enroll

It only takes a minute to go online and designate a beneficiary for your account. In the event of your death, your vested plan account balance will be paid to your designated beneficiary (ies), so be sure to make your designations when you enroll. Once you enroll at workplace.schwab.com, choose Quick Links from the top right of the home page, then select Elect or Update Beneficiary.

For more information

Details can be found on the Encompass Health intranet under the Benefits home page, or you may visit the Schwab website at workplace.schwab.com.

Schwab customer service center

Call Participant Services at 800 724-7526 to enroll, change your salary deferral percentage, change your investment allocations, obtain a loan, process a rollover from another qualified plan or to inquire about account balances. The mobile app is available on the App Store or Google Play.
The Encompass Health Employee Stock Purchase Plan (ESPP), administered by UBS Financial Services, allows employees to purchase Encompass Health common stock through payroll deduction. This is a voluntary plan. Encompass Health pays the brokerage fees associated with the purchase of the stock.

How the plan works
You decide how much you would like to contribute from your paycheck each pay period. Enroll into the plan by visiting the UBS One Source’s website (instructions are below), or by calling customer service at 844 402-1854. Your authorized deductions will be deducted after tax from your paycheck each pay period during the offering period (calendar month) and deposited into your UBS Financial Services brokerage account. At the close of each offering period, or calendar month, UBS Financial Services will deliver your Encompass Health shares to your brokerage account. You can view the number of shares purchased for you by accessing your account on the UBS OneSource website (www.ubs.com/onesource/hls), or by calling customer service. You may sell your shares at any time provided the company is not in a blackout period. Any fees associated with the sale of your stock are your responsibility.

Who is eligible?
- Full- and part-time employees
- Must be at least 21 years old

How to enroll
There is no eligibility waiting period to participate. Contributions must be a whole dollar amount and a minimum of $20 per pay period is required to participate (no maximum applies). To enroll, go to the UBS One Source website (below), or contact customer service at 844 402-1854.

Follow these instructions to enroll online:
- Go to the UBS One Source website (www.ubs.com/onesource/hls)
- Click the link, “Enroll in your ESPP Plan” to create an account
- Enter your six-digit Encompass Health’s employee ID number and click SUBMIT
- Click YES to confirm your employee ID number
- Enter your date of birth
- Create a password
- Enter your contribution elections
- Check the “Carry Forward Your Contribution Election” box, Click NEXT
- Print “Confirmation of Elections”
- Done

How to make changes to an existing election
Once you are enrolled, you can change your contribution amount anytime by logging into the UBS OneSource website with your Encompass Health employee ID number and password you created. On the OneSource website you will see a link titled “Alerts & Elections.” Click this link to go to the Contribution Election page. Enter your contribution change and check the “Carry Forward” box to continue your new election going forward. UBS will mail you a confirmation of your change.

UBS contact information
Customer Service:  844 402-1854
Website:  www.ubs.com/onesource/hls

Employee assistance program
Encompass Health offers all employees an Employee Assistance Program (EAP) administered by American Behavioral Benefits Managers. This program provides access to counselors, crisis intervention and community resource referrals at no cost to you.

The Employee Assistance Program (EAP) is an employer-sponsored program designed to provide problem identification, short-term counseling referrals and crisis
intervention for you and your family members who experience personal or behavioral problems that impact your work performance.

Employees may voluntarily choose to take advantage of this confidential service to resolve personal problems.

**Services offered**
- 24/7 access to EAP counselors
- Assessment and referrals
- Counseling
- Community resource referrals
- Employee education, training and seminars
- Crisis intervention
- Conflict resolution

**For more information**
Details of benefit coverage and frequency of use of benefits are located on the Encompass Health Intranet on the Benefits home page.

**Enrolling**
This plan is provided by Encompass Health at no cost to employees – there is no enrollment form. Coverage is automatic upon hire date for all employees.

American Behavioral Benefits Managers, Inc.
Contact Information
Phone: 800 925-5EAP (5327)

**Step Up To Excellence points program**

Encompass Health offers you more opportunities to be recognized and rewarded for exceeding performance and contributing to Encompass Health’s commitment to excellence within the healthcare industry. Encompass Health believes that employees who strengthen our reputation and goals for excellence deserve recognition. Some of these actions include - Patient Satisfaction, Training & Education, Wellness Participation, Safety, Community Involvement, Teamwork, and Outstanding Employee Achievement Awards. Some examples of points that may be rewarded to employees for Stepping Up might include providing our patients with an excellent experience and a positive outcome; fostering an environment of working together; giving back to the community; or participating in the company’s wellness programs.

Employees may let leadership know when co-workers go above and beyond by “Nominating a Colleague” at stepuptoexcellence.com. The website also allows employees to recognize fellow employees with non-points valued E-certificates to celebrate a birthday, wedding, new baby or professional accomplishments.

Points earned may be redeemed for merchandise, travel, event tickets and activities. Visit stepuptoexcellence.com to view the Rewards Gallery and learn how to earn points through the programs currently in place. Any points you earn roll over from year to year, allowing you to accumulate total points towards items on your wish list.

The IRS considers employee recognition awards as income. As such, you will be taxed on the recognition points as they are entered and once awarded, the taxes will be reflected on your paystub after the reporting period.

If you terminate employment with Encompass Health, you will be able to redeem your points within 90 days of your last day of employment. If you have not redeemed your points by that date, a gift card for the equivalent amount of the points will be mailed to your home address.
Employee service recognition awards program

Encompass Health recognizes employees celebrating milestone anniversaries through the Service Recognition Awards Program. Beginning with the fifth year anniversary, and again every five years of service, employees receive a gift catalog from which to make a selection. The gift selections increase in value with every five-year milestone. The Service Recognition Awards Program also includes a retirement award.

Tuition reimbursement

Reimbursement of tuition is available upon completion of pre-approved, job-related courses that are offered through an accredited institution and scheduled outside normal working hours. In addition, the employee must be working toward a degree. Tuition reimbursement is subject to budgeting considerations.

Eligible expenses

Reimbursement is limited to tuition and associated mandatory fees for up to two courses per academic term. The annual maximum amount that any individual may receive for tuition reimbursement in a single calendar year is $3,500 for full-time employees and $1,750 for part-time employees.

Eligible employees

Active full-time and part-time employees (working at least 24 hours/week) in good standing that have been employed six months in an eligible class may take advantage of this benefit.

Advising

As a Encompass Health employee, you are also eligible to participate in an Advising Session with one of EdAssist’s Education Experts. Expert advisors will help you find the right school, program, degree or course to meet your educational and career objectives. They can also compare different programs, majors or degrees to help save you time and money toward your degree and assist with admissions and college financing processes.

There is no cost to you to participate in Advising. To schedule an appointment, access the Advising page within the EdAssist website.

Continuing education

Payment reimbursements may be available to employees who participate in job-related courses, seminars and conferences etc. that enhance the employee’s professional development. Continuing education is subject to corporate departments and hospital budgeting considerations.

Eligible expenses

Subject to approval, necessary tuition, room, meals and transportation costs associated with enrollment and attendance may be included. The annual maximum is $2,500 for full-time employees and $1,250 for part-time employees.

Eligible employees

All active full-time and part-time employees (working at least 24 hours/week) in good standing that have been employed six months in an eligible class may take advantage of this benefit.

Work commitment time frames

Employees must sign a Continuing Education Reimbursement Form if they reach the cumulative maximum listed below.

<table>
<thead>
<tr>
<th>Cumulative Maximums for Full- &amp; Part-time Employees</th>
<th>Commitment Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time employees $2,500</td>
<td>1 year</td>
</tr>
<tr>
<td>Part-time employees $1,250</td>
<td>1 year</td>
</tr>
</tbody>
</table>

More Information

For detailed information on the approval process and necessary application process, please refer to the Benefits homepage on the Encompass Health Intranet.
Federally mandated notices

Women's health and cancer rights act

The Women’s Health and Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage 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; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the patient and the patient’s attending physician, and is subject to any applicable annual deductibles, coinsurance and/or co-payment provisions.

If you have any questions about your benefits, please contact Blue Cross and Blue Shield of Texas’s Customer Service.

Premium assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on eligibility.

**ALABAMA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447

**ALASKA – Medicaid**
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

**ARKANSAS – Medicaid**
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

**COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)**
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
State Relay 711
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.mainegov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/
healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531
To see if any more States have added a premium assistance program since February 16, 2010, or for more information on special enrollment rights, you can also contact either of the following agencies:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
877 267-2323, Ext. 61565
**Paperwork reduction act statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Federal law requires Plan Sponsors to send the above notices annually to participants concerning the legislative changes affecting benefits under the plan.

Mothers’ and Newborns’ Health Protection Act

Under federal law, the Encompass Health Medical Plan generally may not restrict benefits for any length of hospital stay in connection with childbirth for mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Medical Plan may pay for a shorter stay if your physician or other attending provider (such as a nurse, midwife, or physician’s assistant) discharges the mother or newborn earlier, after a medical consultation.

Also, under federal law, the Medical Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Medical Plan may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours. However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification under the Medical Plan’s required precertification procedures. Please contact Blue Cross Blue Shield of Texas or refer to the summary plan description and other documents applicable to your coverage under the Medical Plan, in order to determine the specific precertification requirements that may apply to your health benefit coverage. Under these requirements, you may be required to notify Blue Cross Blue Shield of Texas if your hospital confinement exceeds 48 hours or 96 hours. Failure to comply with the precertification and notification requirements applicable to the Encompass Health Medical Plan may result in the Plan refusing to pay all or a portion of the costs of your medical care.

**NOTICE OF PRIVACY PRACTICES FOR THE ENCOMPASS HEALTH CORPORATION GROUP LIFE, AD&D, DISABILITY AND MEDICAL PLAN PARTICIPANTS AND THEIR COVERED DEPENDENTS**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) protect the manner in which your protected health information (“PHI”) may be used and disclosed by the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan (the “Plan”). The purpose of this notice is to provide you with information regarding your PHI privacy rights.
GENERAL RULES REGARDING HEALTH INFORMATION

Information about you and your health is personal. The Plan is committed to protecting health information about you (i.e., PHI) which is obtained in connection with the operation and administration of the Plan. This notice will tell you about the ways in which the Plan and its Business Associates (e.g., the third party administrators, such as Blue Cross Blue Shield of Texas (referred to as the “Business Associate”)), may use and disclose PHI about you. It also describes your rights regarding and certain obligations the Plan has regarding the use and disclosure of PHI.

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan’s legal duties and privacy practices with respect to your PHI;
- notify you following a breach of unsecured PHI; and follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that the Plan may use and disclose PHI. Except as described below, authorization or an opportunity to object is not required for these uses or disclosures. In most cases, the Plan tries not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request. For each category of uses or request for each category of uses or disclosures this notice will give some examples. Not every use or disclosure in a category will be listed. In addition, many of the uses and disclosures may be performed on the Plan's behalf by a Business Associate. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories described below.

- **For Treatment.** The Plan may receive, use, and disclose PHI about you to provide you with or help you to obtain health treatment or services. For example, the Business Associate may request and receive from your doctor information about the health condition for which you are seeking treatment in order to determine if the treatment you are seeking is covered by the Plan. The Plan may also contact you to provide information about treatment alternatives or other health-related benefits that may be of interest to you.

- **For Payment.** The Plan may receive, use, and disclose PHI about you so that the bills for health treatment and services you have received may be paid by the Plan. For example, the Business Associate may need to have information about a surgery which you have received to determine payment for services. Similarly, the Plan may receive, use, and disclose PHI to the Encompass Health Corporation Benefits Administration Committee (the “Committee”) in order to provide them with information necessary to process an appeal that you file.

- **For Health Care Operations.** The Plan may receive, use and disclose PHI about you for purposes of the Plan’s operations such as underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, for legal or auditing functions, or for general management and administrative activities. For instance, the Business Associate or an outside auditing firm on behalf of the Plan may perform a claims audit. The Plan, except with respect to any long-term care insurance program, is prohibited from using or disclosing your genetic information for underwriting purposes.

- **Plan Sponsor Information Request.** The Plan may disclose to Encompass Health Corporation and the affiliates who participate in the Plan (collectively the “Company”) summary health information (i.e., de-identified statistical information that summarizes the claims history, claims expenses or type of claims experienced by covered persons under the Plan) for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or determining Plan design. The Plan may also disclose to the Company information on whether a person is participating in the Plan and his or her benefit elections. The Plan may also disclose PHI to the Company for specific plan administration purposes such as treatment, payment or health care operations, as described above. The Company can only be provided PHI regarding covered persons as provided in the Plan document and consistent with this notice.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you advise the Plan otherwise by completing the attached Disclosure Objection Form and returning a copy of such completed form to the Plan’s “Contact Person” (as defined at the end of this notice), the Plan will be entitled to disclose PHI to a close family member or other person you identify that is directly relevant to such individual’s involvement in your health care treatment or payment for your health care treatment as follows: (i) if you are married, to your spouse, (ii) if you are in a domestic partnership, to your domestic partner, and (iii) if you are covered by the Plan as a child (regardless of whether you have attained age 18),
to either of your parents (which may include a stepparent). The Plan will have the right to make such disclosures as long as you are covered by the Plan (including coverage following reenrollment should you discontinue coverage and reenroll in the Plan) or have claims pending under the Plan following your termination of coverage. However, if you are age 18 or older, you may file a Disclosure Objection Form at any time if you want the Plan to cease making family member disclosures as described above. Your Disclosure Objection Form should be returned to the Plan’s Contact Person.

In rare circumstances, the Plan may release a limited amount of PHI to aid your family members, close friends, or disaster relief personnel in locating you in an emergency or in case of your incapacity. Whenever possible, you will be given an opportunity to agree or object before the Plan makes such use or disclosure.

- Pursuant to Your Authorization. Other uses and disclosures of PHI not covered by this notice or the laws that apply to the Plan, such as uses and disclosures for marketing or the sale of your PHI, will be made only with your written permission. If you sign an authorization giving the Plan permission to use or disclose PHI about you, you may revoke that authorization, in writing, at any time effective with respect to future uses and disclosures of your PHI.

SPECIAL SITUATIONS

The Plan will use or disclose PHI about you in the following special situations as follows:

- As required by federal, state or local law.
- To avert a serious threat to the health or safety of you, someone else or the public.
- If you are a member of the military or a veteran, to military command authorities.
- In connection with national security or intelligence activities or protective services for government officials.
- For workers’ compensation or similar programs.
- To respond to a court or administrative order, a subpoena, discovery request or other lawful process.
- As requested by federal, state and local law enforcement officials or a correctional institution.
- For public health activities, such as disease control, child abuse, or neglect or the Federal Food and Drug Administration with respect to adverse events or product defects.
- To government authorities for victims of abuse, neglect or domestic violence.
- With respect to a decedent, to a coroner or medical examiner.
- To organ procurement organizations to facilitate organ, eye, or tissue donations or transplants.
- To facilitate medical research, subject to special rules and restrictions under HIPAA.
- For activities authorized by law for oversight of the health care system or government benefit programs.
- To the Department of Health and Human Services to investigate or determine the Plan’s compliance with the HIPAA privacy rules.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding PHI the Plan has about you:

- Right to Inspect and Copy. You have the right to inspect and obtain a copy of PHI that the Plan or the Business Associate has about you.1 Usually, this includes health and billing records. You must submit your request in writing to the Plan’s Contact Person or the Business Associate. To the extent that the Plan maintains your PHI electronically, you may elect to receive a copy of such information in an electronic format, and if you choose to have the copy directly transmitted to a person you designate. The Plan may charge a fee for the labor costs of responding to your request.
- Right to Amend. If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. Your request must be made in writing and submitted to the Plan’s Contact Person or Business Associate. If the Plan denies your request, you may file a written statement of disagreement.
- Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures the Plan made of PHI about you for reasons other than treatment, payment, or health care operations or pursuant to your authorization. Your request must be in writing to the Plan’s Contact Person or Business Associate. If you request such an accounting more than once in a 12-month period, the Plan may charge a reasonable fee.

1. If you are a participant in a fully insured health care component offered under the Plan, such as vision benefits or long-term care insurance, you need to contact the applicable insurer regarding your privacy rights. This applies to all of the individual rights described in this notice.
• Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI the Plan discloses about you to someone who is involved in the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. Generally, the Plan is not required to agree to your request for restrictions. To request restrictions, you must make your request in writing to the Plan’s Contact Person or Business Associate.

• Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. Your request must be made in writing to the Plan’s Contact Person or Business Associate. The Plan will accommodate all reasonable requests.

• Right to a Copy of This Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at the following website: http://insidenew.encompasshealth.com/corporate/benefits/Pages/welcome.aspx.

WHO WILL FOLLOW THIS NOTICE

The privacy practices described in this notice will be followed by (i) the Plan with respect to its health care components (i.e., the medical, dental plans, health care spending account, employee assistance and any long-term care programs)2 and its fiduciaries (such as the Committee), (ii) the Plan’s Business Associates, and (iii) to the extent they are involved in the operation and administration of the health care components of the Plan, by the Company and its employees.

The non-health care components of the Plan (i.e., life insurance and accidental death and dismemberment insurance, short-term and long-term disability insurance, and the dependent care spending account) are not subject to the HIPAA privacy rules and the terms of this notice.

CHANGES TO THIS NOTICE

The Plan reserves the right to change this notice, effective for PHI the Plan already has about you as well as any information it receives in the future.

PLAN CONTACTS AND ETHICS ACTION LINE

If you have questions regarding this notice or your privacy rights, you may contact the Plan’s Contact Person or Privacy Officer. The Plan’s Contact Person is Marca S. Pearson, Vice President, Employee Benefits, 205 970-8156. The Plan’s Privacy Officer is Cheryl B. Levy, Chief Human Resources Officer, 205 970-7849.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan’s Contact Person or Privacy Officer. All complaints must be submitted in writing and must comply with the Plan’s privacy right complaint procedures. A copy of such procedures can be obtained from the Plan’s Contact Person without charge upon written request. You also may file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be penalized for filing a complaint.

HEALTH PROVIDERS AND YOUR HEALTH INFORMATION

Health providers (such as doctors, medical clinics, health maintenance organizations, insurers, hospitals, etc.) may also use and disclose PHI about you. You also have rights regarding the PHI which health providers obtain and have about you. You should consult the notices of privacy practices which you receive from health care providers for information regarding how and under what circumstances they may use and release your PHI and what rights you have with respect to their practices regarding your PHI.

[Attachment: Disclosure Objection Form]

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2. This notice covers only the self-insured health care components under the Plan. If you are a participant in a fully insured health care component offered under the Plan, such as vision benefits or long-term care insurance, you should receive a separate privacy notice directly from the applicable insurer.
DISCLOSURE OBJECTION FORM FOR THE ENCOMPASS HEALTH CORPORATION GROUP LIFE, AD&D, DISABILITY AND MEDICAL PLAN

[To be completed only if you object to family member disclosures]

I have read the “Notice of Privacy Practices for the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan Participants and Their Covered Dependents” (the “Notice”) and I understand that with respect to the health care components (i.e., the medical and dental plans, health care spending account, and employee assistance program), the Encompass Health Corporation Group Life, AD&D, Disability and Medical Plan (the “Plan”) will be entitled to disclose my protected health information (“PHI”) as described in the Notice in the section titled “Individuals Involved in Your Care or Payment for Your Care” unless I object to such disclosures. I hereby object to such disclosures and direct the health care components of the Plan, identified below, to disclose only to me, at the following address, my PHI that is relevant to my health care under the Plan:

Name:

Address:

City, State, ZIP:

Social Security Number: Date of Birth:

Telephone Number:

Relation to Employee:

Employee Name: Employee's Social Security Number:

Encompass Health Corporation Facility Name:

Affected Health Care Components (check only the health care components in which you are enrolled, as applicable):

___ Medical
___ Dental
___ Health Care Spending Account
___ Employee Assistance Program

Signature: Date:

Return your completed and executed Disclosure Objection Form to:

Marca S. Pearson
Vice President, Employee Benefits
Encompass Health Corporation
3660 Encompass Health Parkway
Birmingham, AL 35243
Telephone No.: 205 970-8156

THIS OBJECTION DOES NOT RESTRICT THE PLAN’S USE OR DISCLOSURE OF PHI AS DESCRIBED IN THE NOTICE EXCEPT WITH RESPECT TO THE SECTION “INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE.”

3. If you are a participant in a fully insured health care component offered under the Plan, such as vision benefits or long-term care insurance, you will receive a separate notice with instructions regarding the filing of a disclosure objection directly from the applicable insurer.
This glossary has many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Blue text indicates a term defined in this Glossary.

See page 31 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

**Allowed amount**
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

**Appeal**
A request for your health insurer or plan to review a decision or a grievance again.

**Balance billing**
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

**Coinsurance**
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

**Complications of pregnancy**
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

**Copayment**
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Deductible**
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Durable medical equipment (DME)**
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency medical condition**
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency medical transportation**
Ambulance services for an emergency medical condition.

**Emergency room care**
Emergency services you get in an emergency room.

**Emergency Services**
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Excluded services**
Health care services that your health insurance or plan doesn’t pay for or cover.
**Grievance**
A complaint that you communicate to your health insurer or plan.

**Habilitation services**
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health insurance**
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**Home health care**
Health care services a person receives at home.

**Hospice services**
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

**Hospitalization**
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**Hospital outpatient care**
Care in a hospital that usually doesn’t require an overnight stay.

**In-network coinsurance**
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

**In-network copayment**
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network copayments.

**Medically necessary**
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

**Network**
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-preferred provider**
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

**Out-of-network coinsurance**
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

**Out-of-network copayment**
A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

**Out-of-pocket limit**
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

**Physician services**
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan**
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

**Preauthorization**
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.
Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

**Preferred provider**
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

**Premium**
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

**Prescription drug coverage**
Health insurance or plan that helps pay for prescription drugs and medications.

**Prescription drugs**
Drugs and medications that by law require a prescription.

**Primary care physician**
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

**Primary care provider**
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Provider**
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified or accredited as required by state law.

**Reconstructive surgery**
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

**Rehabilitation services**
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Skilled nursing care**
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

**Specialist**
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

**UCR (usual, customary and reasonable)**
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

**Urgent care**
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
How You and Your Insurer Share Costs
- Example

Jane’s Plan Deductible: $1,500

Coinsurance: 20%

Out-of-Pocket Limit: $5,000

Jane hasn’t reached her $1,500 deductible yet.
Her plan doesn’t pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible; coinsurance begins.
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.
Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

Jane reaches her $5,000 out-of-pocket limit.
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $200
Jane pays: $0
Her plan pays: $200
**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

**Encompass Health Corporation – Core**

**Coverage Period:** 01/01/2018 – 12/31/2018  
**Coverage for:** Individual + Family | **Plan Type:** PPO

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or visit www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-521-2227 to request a copy.

### Important Questions

| **What is the overall deductible?** | **HealthSouth providers:** $0 Individual / $0 Family  
**In-Network providers:** $1,500 Individual / $3,000 Family  
**Out-of-Network providers:** $2,000 Individual / $4,000 Family | **Why This Matters:** Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Services that charge a copay, prescription drugs, and In-Network preventive care are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [www.healthcare.gov/coverage/preventive-care-benefits/](http://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | Yes. $150 Individual / $300 Family prescription drugs. Per occurrence: $500 In-Network inpatient admission. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | HealthSouth providers: $0 Individual / $0 Family  
**In-Network providers:** $5,000 Individual / $10,000 Family  
**Out-of-Network providers:** $6,000 Individual / $12,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, preauthorization penalties, balanced-billed charges, and healthcare this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See [www.bcbstx.com](http://www.bcbstx.com) or call 1-800-810-2583 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>HealthSouth Provider (You will pay the least)</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you visit a health care provider’s office or clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Chiropractic services limited to 26 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>N/A</td>
<td>No Charge; deductible does not apply</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>No Charge after office visit copay. Coinsurance may vary if services rendered in an outpatient hospital setting.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com](http://www.bcbstx.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>HealthSouth Provider (You will pay the least)</td>
<td>In-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 retail / $30 mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$45 retail / $135 mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 retail / $180 mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>copay/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$100 copay/prescription</td>
<td>Not Covered</td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Emergency room $250 copay; deductible does not apply</td>
<td>Emergency room services 30% coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com](http://www.bcbstx.com).
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<th>Services You May Need</th>
<th>HealthSouth Provider (You will pay the least)</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Certain services must be preauthorized; refer to benefits booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com](http://www.bcbstx.com).
### Common Medical Event

#### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>HealthSouth Provider (You will pay the least)</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required. Limited to 90 days per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>N/A</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>HealthSouth Provider (You will pay the least)</th>
<th>In-Network Provider</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

### Excluded services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult, only for accidents)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment (assisted reproductive technology lifetime max: $5,000 medical / $5,000 pharmacy)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-892-2803, U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance’s Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

---

#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $1,500
- **Specialist copayments**: $30
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

**This EXAMPLE event includes services like:**
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60 |

**The total Peg would pay is**: $5,060

---

#### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,500
- **Specialist copayments**: $30
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

**This EXAMPLE event includes services like:**
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$1,650</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$100</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60 |

**The total Joe would pay is**: $3,010

---

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $1,500
- **Specialist copayments**: $30
- **Hospital (facility) coinsurance**: 30%
- **Other coinsurance**: 30%

**This EXAMPLE event includes services like:**
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $2,000

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $0 |

**The total Mia would pay is**: $1,400

---

*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or visit www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-521-2227 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>HealthSouth providers: $0 Individual / $0 Family In-Network providers: $500 Individual / $1,000 Family Out-of-Network providers: $2,000 Individual / $4,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Services that charge a copay, prescription drugs, and In-Network preventive care are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $100 Individual / $200 Family prescription drugs. Per occurrence: $300 In-Network inpatient admission. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>HealthSouth providers: $0 Individual / $0 Family In-Network providers: $4,000 Individual / $8,000 Family Out-of-Network providers: $6,000 Individual / $12,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, preauthorization penalties, balanced-billed charges, and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-810-2583 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>HealthSouth Provider (You will pay the least)</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Chiropractic services limited to 26 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>N/A</td>
<td>No Charge; deductible does not apply</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>No Charge after office visit copay. Coinsurance may vary if services rendered in an outpatient hospital setting.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com](http://www.bcbstx.com).
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</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>N/A</td>
<td>$10 retail / $30 mail order copay/prescription</td>
<td>Not Covered</td>
<td>Prescription drug deductible: $100 Individual / $200 Family&lt;br&gt;Retail covers a 30 day supply. With appropriate prescription, up to a 90 day supply is available. Mail order covers a 90 day supply&lt;br&gt;Specialty drugs must be obtained from Prime Specialty Pharmacy. Mail order is not covered.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>N/A</td>
<td>$45 retail / $135 mail order copay/prescription</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>N/A</td>
<td>$60 retail / $180 mail order copay/prescription</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>N/A</td>
<td>$100 copay/prescription</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>N/A</td>
<td>Emergency room $200 copay; deductible does not apply&lt;br&gt;Emergency room services 10% coinsurance.</td>
<td>Emergency room $200 copay; deductible does not apply&lt;br&gt;Emergency room services 10% coinsurance.</td>
<td>Copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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<tr>
<th>Common Medical Event</th>
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<th>HealthSouth Provider (You will pay the least)</th>
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<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Certain services must be preauthorized; refer to benefits booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>N/A</td>
<td>$30 copay/visit; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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<th>HealthSouth Provider (You will pay the least)</th>
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<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required. Limited to 90 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>N/A</td>
<td>10% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**Excluded services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Cosmetic surgery
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- Acupuncture
- Bariatric surgery
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<table>
<thead>
<tr>
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<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow-up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Specialist copayments</strong></td>
<td><strong>Specialist copayments</strong></td>
<td><strong>Specialist copayments</strong></td>
</tr>
<tr>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost | $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th>Deductibles*</th>
<th>Copayments</th>
<th>Coinsurance</th>
<th>Total Peg would pay is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td>$1,200</td>
<td></td>
</tr>
<tr>
<td>Total Peg would pay is</td>
<td></td>
<td></td>
<td>$1,200</td>
<td></td>
</tr>
</tbody>
</table>

| What isn’t covered | Limits or exclusions | |
| --- | --- | 
| Limits or exclusions | $60 | 
| Total Peg would pay is | $2,160 | 

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or visit [www.bcbstx.com](http://www.bcbstx.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf) or call 1-800-521-2227 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For In-Network: $3,000 Individual / $6,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. In-Network preventive care is covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For In-Network: $3,000 Individual / $6,000 Family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, preauthorization penalties, balanced-billed charges, and healthcare this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-810-2583 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
<td>Chiropractic services limited to 26 visits per calendar year.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge; deductible does not apply</td>
<td>Not Covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

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<table>
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</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>No Charge after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>No Charge after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>No Charge after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>No Charge after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>No Charge after deductible</td>
<td>No Charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge after deductible</td>
<td>No Charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
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<td>No Charge after deductible</td>
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</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>In-Network Provider (You will pay the least)</td>
<td><strong>Certain services must be preauthorized; refer to benefits booklet for details.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td><strong>Preauthorization is required; 50% penalty if not preauthorized Out-of-Network.</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td><strong>Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Charge after deductible</td>
<td><strong>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td><strong>Preauthorization required.</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
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<td></td>
<td></td>
<td>20% coinsurance</td>
<td><strong>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</strong></td>
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<td>Childbirth/delivery facility services</td>
<td>No Charge after deductible</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge after deductible</td>
<td><strong>Preauthorization required.</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge after deductible</td>
<td><strong>Preauthorization required.</strong> Limited to 90 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No Charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No Charge after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge after deductible</td>
<td><strong>Preauthorization required.</strong></td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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- Routine eye care (Adult)
- Weight loss programs

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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $3,000
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $3,060

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $3,000
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $3,060

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $3,000
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn't covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.
Health care coverage is important for everyone.
We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

<table>
<thead>
<tr>
<th>Office of Civil Rights Coordinator</th>
<th>Phone:</th>
<th>855-664-7270 (voicemail)</th>
</tr>
</thead>
<tbody>
<tr>
<td>300 E. Randolph St.</td>
<td>TTY/TDD:</td>
<td>855-661-6965</td>
</tr>
<tr>
<td>35th Floor</td>
<td>Fax:</td>
<td>855-661-6960</td>
</tr>
<tr>
<td>Chicago, Illinois 60601</td>
<td>Email:</td>
<td><a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></td>
</tr>
</tbody>
</table>

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

<table>
<thead>
<tr>
<th>U.S. Dept. of Health &amp; Human Services</th>
<th>Phone:</th>
<th>800-368-1019</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 Independence Avenue SW</td>
<td>TTY/TDD:</td>
<td>800-537-7697</td>
</tr>
<tr>
<td>Room 509F, HHH Building 1019</td>
<td>Complaint Portal:</td>
<td><a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a></td>
</tr>
</tbody>
</table>
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer--offered coverage. Also, this employer contribution --as well as your employee contribution to employer--offered coverage-- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Employee Benefits at employee.benefits@encompasshealth.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹An employer--sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
### PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encompass Health Corporation</td>
<td>63-0860407</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>3660 Grandview Parkway, Suite 200</td>
<td>1-800-500-3401 Option 7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>AL</td>
<td>35243</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Benefits Department</td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - All employees. Eligible employees are:
    - Some employees. Eligible employees are:
      - Full-time employees and part-time eligible employees including part time working 32 hours per week and part time working 24 hours per week.

- With respect to dependents:
  - We do offer coverage. Eligible dependents are:
    - Employee’s legal spouse, same or opposite sex domestic partner (if he or she meets the domestic partner requirements); child up to age 26; disabled/incapacitated child age 26 and over, if not able to support himself and relies on employee for support (incapacity must have occurred before age 26).
  - We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

- Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes (Go to question 15)</th>
<th>No (STOP and return form to employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?</td>
<td>□ Yes (Continue)</td>
<td>□ No (STOP and return this form to employee)</td>
</tr>
<tr>
<td>13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?</td>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
<tr>
<td>14. Does the employer offer a health plan that meets the minimum value standard*?</td>
<td>□ Yes</td>
<td>□ No (STOP and return form to employee)</td>
</tr>
<tr>
<td>15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>a. How much would the employee have to pay in premiums for this plan?</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. What change will the employer make for the new plan year?</td>
<td>□ Employer won’t offer health coverage</td>
<td>□ Employer will start offering health coverage or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)</td>
</tr>
<tr>
<td>a. How much would the employee have to pay in premiums for this plan?</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
<table>
<thead>
<tr>
<th>Carrier/Administrator</th>
<th>Website</th>
<th>Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS of Texas</td>
<td>.bcbstx.com</td>
<td></td>
</tr>
<tr>
<td>Medical Plan</td>
<td></td>
<td>800 521-2227</td>
</tr>
<tr>
<td>Blue Access for Members (BAM)</td>
<td>bcbstx.com/member</td>
<td></td>
</tr>
<tr>
<td>Well On Target</td>
<td>wellontarget.com</td>
<td>877 806-9380</td>
</tr>
<tr>
<td>FSA Spending Accounts</td>
<td>connectyourcare.com</td>
<td>866 808-1444</td>
</tr>
<tr>
<td>Mail Order</td>
<td>myprime.com</td>
<td>877 794-3574</td>
</tr>
<tr>
<td>MetLife Dental</td>
<td>mybenefits.metlife.com</td>
<td>800 942-0854</td>
</tr>
<tr>
<td>VSP</td>
<td>vsp.com/home.html</td>
<td>800 877-7195</td>
</tr>
<tr>
<td>Superior Vision</td>
<td>superiorvision.com</td>
<td>800 507-3800</td>
</tr>
<tr>
<td>Charles Schwab</td>
<td>workplace.schwab.com</td>
<td>800 724-7526</td>
</tr>
<tr>
<td>UBS Financial Services</td>
<td>ubs.com/onesource/hls</td>
<td>844 402-1854</td>
</tr>
<tr>
<td>Unum Life and Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD Claims (group #467565)</td>
<td></td>
<td>800 723-8500</td>
</tr>
<tr>
<td>LTD Claims (group #467564)</td>
<td></td>
<td>800 723-8500</td>
</tr>
<tr>
<td>Group Term Life/Personal Accident Insurance</td>
<td></td>
<td>800 421-0344</td>
</tr>
<tr>
<td>Life Claims</td>
<td></td>
<td>888 556-3727</td>
</tr>
<tr>
<td>American Behavioral</td>
<td>americanbehavioral.com</td>
<td>800 925-5327</td>
</tr>
<tr>
<td>Benefit Concepts (COBRA)</td>
<td>benefitconcepts.com</td>
<td>800 969-2009</td>
</tr>
</tbody>
</table>