CARING IN A BETTER WAY DAY BY DAY

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

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

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

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

You may receive a Partner Satisfaction Survey, annually, at your home address. Please take a few minutes to complete the survey. Your opinion is important to your employer.

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

CARE IS OUR BUSINESS

Mission Statement

NHC is committed to being the industry leader in customer and investor satisfaction.
All information and forms contained within this handbook are the property of National HealthCare Corporation.

Forms included in this handbook may be reproduced for internal use only. With the exception of forms, the contents of this handbook should not be reproduced without permission in writing from National HealthCare Corporation.

This handbook contains all applicable Summary Plan Descriptions.

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

Produced and Published by National HealthCare Corporation

Printed in the United States of America
Nondiscrimination Statement

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

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

NHC:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  o Qualified sign language interpreters
  o Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  o Qualified interpreters
  o Information written in other languages

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

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

Mailing Address: 100 East Vine St. 
Murfreesboro, TN 37130 
Telephone Number: (615) 890-2020

Email Address: klocke@nhccare.com 
Fax Number: (615) 278-1232

TDD or State Relay Number: 7-1-1

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-615-890-2020 (TTY: 7-1-1). (Spanish)

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

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

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

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

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

 Argentine: Aumento de señal en el número 1-615-890-2020. (Arabic)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement of Receipt ........................................................................................................................................</td>
</tr>
<tr>
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<td>1900</td>
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<tr>
<td>2100</td>
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<td>2300</td>
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</table>
Acknowledgment of Receipt
National Health Corporation
Benefits Handbook

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

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

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

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

__________________________________________   ______________________________
Partner’s Signature Date

___________________________   ______________________________
Partner’s Social Security Number (last 4 digits)

__________________________________________
Partner’s Name (Please Print)
Partner Benefits Package
NHC and Affiliated Companies

<table>
<thead>
<tr>
<th>Pay Related Incentives</th>
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<tr>
<td>▪ PEP</td>
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<tr>
<td>▪ PIE</td>
<td></td>
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<tr>
<td>▪ Safety Award</td>
<td></td>
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<th>Service Awards</th>
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<tbody>
<tr>
<td>▪ Service Pins</td>
<td></td>
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<th>PAID LEAVE</th>
<th>UNPAID LEAVE</th>
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<td>▪ FMLA</td>
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<td>▪ Sick</td>
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<td>▪ Medical</td>
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<tr>
<td>▪ Perfect Attendance</td>
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<td>▪ Personal</td>
</tr>
<tr>
<td>▪ Bereavement</td>
<td></td>
<td>▪ Military Duty</td>
</tr>
<tr>
<td>▪ Jury Duty</td>
<td></td>
<td>▪ Witness Duty</td>
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<td>▪ Health</td>
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<tr>
<td>▪ Dental</td>
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<tr>
<td>▪ Vision</td>
<td></td>
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<tr>
<td>▪ Life</td>
<td></td>
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<tr>
<td>▪   Partner</td>
<td></td>
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<tr>
<td>▪   Dependent</td>
<td></td>
</tr>
<tr>
<td>▪ Short Term Disability</td>
<td></td>
</tr>
<tr>
<td>▪ Long Term Care Insurance Discount Plan</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Flex Plans</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Nontaxable Benefit Plan</td>
<td></td>
</tr>
<tr>
<td>▪   Insurance Premium Reimbursement</td>
<td></td>
</tr>
<tr>
<td>▪   Medical Care Expense Reimbursement</td>
<td></td>
</tr>
<tr>
<td>▪   Health Savings Account</td>
<td></td>
</tr>
<tr>
<td>▪   Dependent Care Assistance Expense Reimbursement</td>
<td></td>
</tr>
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</thead>
<tbody>
<tr>
<td>▪ 401(k)</td>
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<tr>
<td>▪ ESOP (NHC owned companies only)</td>
<td></td>
</tr>
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<thead>
<tr>
<th>Stock Purchase Plan</th>
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<tbody>
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<td>▪ Partner Stock Purchase Plan</td>
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<table>
<thead>
<tr>
<th>Education Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Tuition Reimbursement</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Financial Services</th>
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</tr>
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<tbody>
<tr>
<td>▪ Direct Deposit of Paycheck</td>
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</tr>
<tr>
<td>▪ Local Credit Union Membership</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Discounts</th>
<th></th>
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<tbody>
<tr>
<td>▪ Vacation Discounts</td>
<td></td>
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</tbody>
</table>

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

## Based on Regularly Scheduled Hours

<table>
<thead>
<tr>
<th>STATUS</th>
<th>ELIGIBLE FOR</th>
</tr>
</thead>
</table>
| FULL     | • PEP  

Part-time, regularly scheduled 37.50 hours or more each week (75 hours or more each pay period). Eligible for full benefit package. |
|          | • PIE  

Short Term Disability  
Long Term Care Insurance Discount Plan  
Nontaxable Benefit Plan  
- Medical Care Expense Reimbursement Account  
- Health Savings Account***  
- Dependent Care Expense Reimbursement Account  
Paid Leave (ETO/Sick/PA)  
Unpaid Leave  
401(k)  
ESOP (NHC Owned Locations Only)*  
Stock Purchase Plan  
Tuition Reimbursement  
Credit Union  
Vacation Discounts |
|          | • Safety Award  

IPAR  
Part-time, regularly scheduled 30 hours or more but less than 37.50 each week (60 hours or more but less than 75 hours each pay period). |
|          | • Service Pins  

Health  
Dental  
Vision  
Life  
Short Term Disability  
Long Term Care Insurance Discount Plan  
Nontaxable Benefit Plan  
- Medical Care Expense Reimbursement Account  
- Health Savings Account***  
- Dependent Care Expense Reimbursement Account  
Unpaid Leave  
401(k)  
ESOP (NHC Owned Locations Only)*  
Stock Purchase Plan  
Tuition Reimbursement  
Credit Union  
Vacation Discounts |
|          | • Safety Award  

PART  
Part-time, regularly scheduled 29 hours or less each week (or 58 hours or less each pay period), for an indefinite period of time. |
|          | • Service Pins  

Health**  
Dental***  
Vision****  
Short Term Disability****  
Long Term Care Insurance Discount Plan  
Nontaxable Benefit Plan  
- Medical Care Expense Reimbursement Account**  
- Health Savings Account***  
- Dependent Care Expense Reimbursement Account  
Unpaid Leave  
401(k)  
ESOP (NHC Owned Locations Only)*  
Stock Purchase Plan  
Tuition Reimbursement  
Credit Union  
Vacation Discounts |
|          | • Safety Award  

PRN  
Part-Time, used only on an as needed basis regardless of number of hours worked per week. |
|          | • Service Pins  

Health**  
Long Term Care Insurance Discount Plan  
Nontaxable Benefit Plan  
- Medical Care Expense Reimbursement Account**  
- Health Savings Account***  
- Dependent Care Expense Reimbursement Account  
401(k)  
ESOP (NHC Owned Locations Only)*  
Stock Purchase Plan  
Tuition Reimbursement  
Credit Union  
Vacation Discounts |
|          | • Safety Award  

TEMPORARY  
Working Full or Part-time hours for a limited period of time and typically working on a short term basis. |
|          | • Long Term Care Insurance Discount Plan  

PEP  
Safety Award  
Long Term Care Insurance Discount Plan  
Tuition Reimbursement  
Vacation Discounts  
Credit Union  
Credit Union  
Vacation Discounts |

*Plan frozen 12/14/2009 - participation is closed to new participants.  
**Partners must be eligible to participate in the NHC Health Benefit Plan as determined by the Affordable Care Act (ACA).  
***Eligibility requires enrollment in the NHC - HSA Value Plan option.  
****Eligibility requires a regular schedule of 20 or more hours each week.
The intent of the NHC-sponsored benefit plans is to provide a complete benefits package in compliance with the provisions of all applicable benefit laws and regulations.
Excellence Programs

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

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

Partner Excellence Program (PEP)

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

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

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

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

Partners Incentive for Excellence (PIE)

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

Safety Awareness Cash Awards

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

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

Service Awards

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

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

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

**Partner Name:** ______________________________________________________

**Employer Name:** ____________________________________________________

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

<table>
<thead>
<tr>
<th>ABSENCE</th>
<th>Beginning Date</th>
<th>Ending Date</th>
<th>Total Days/Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
</table>

*Complete the following request for Benefit Payment:*

<table>
<thead>
<tr>
<th>Requested</th>
<th>Beginning Date</th>
<th>Ending Date</th>
<th>Total Days/Hours Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ ETO</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>□ Sick</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Outpatient Treatment or Hospital Admission (circle if applicable)</td>
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<tr>
<td>□ PA</td>
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<td></td>
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<td></td>
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<td></td>
<td>Personal Medical or Family Medical Purpose (circle one)</td>
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<tr>
<th>Requested</th>
<th>Beginning Date</th>
<th>Ending Date</th>
<th>Total Days/Hours Requested</th>
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<tbody>
<tr>
<td>□ Bereavement</td>
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<td></td>
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<tr>
<td>□ Jury/Witness Pay</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Amount Received from Court Attach Receipt</td>
</tr>
</tbody>
</table>

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

**Partner Signature:** ______________________________________  **Date:** ____________

**Approved By:** ______________________________________  **Date:** ____________

Initials    Title
Earned Time Off (ETO)

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

ETO Eligibility and How ETO Is Earned

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

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

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

### ETO Account Earning and Balances

<table>
<thead>
<tr>
<th>Length of Full-time Service</th>
<th>ETO Days Earned Each Year</th>
<th>ETO Days Earned Monthly</th>
<th>Maximum Account Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 12 Months</td>
<td>10</td>
<td>0.834</td>
<td>10</td>
</tr>
<tr>
<td>13 through 36 Months</td>
<td>15</td>
<td>1.250</td>
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<tr>
<td>37 through 60 Months</td>
<td>16</td>
<td>1.334</td>
<td>20</td>
</tr>
<tr>
<td>5 Years to 10 Years</td>
<td>17</td>
<td>1.417</td>
<td>20</td>
</tr>
<tr>
<td>10 Years to 15 Years</td>
<td>18</td>
<td>1.500</td>
<td>20</td>
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<tr>
<td>15 Years to 20 Years</td>
<td>19</td>
<td>1.584</td>
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<tr>
<td>20 Years and Over</td>
<td>20</td>
<td>1.667</td>
<td>21</td>
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</tbody>
</table>

ETO Scheduling

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

Requests for ETO near and during Thanksgiving and Christmas may be difficult to accommodate since there are high numbers of requests for time off during the holiday season. Only one ETO day should be requested during the seven days before Thanksgiving Day and seven days after Thanksgiving Day. Only two days should be requested during the period seven days prior to Christmas Day and seven days after New Year’s Day. This helps to honor many more requests for time off, while also meeting patient care needs during the traditional holiday season.
NHC Absence/Leave Form must be submitted to your supervisor for approval of the requested days. The form will also be used as a request for payment for all applicable paid leave days.

**ETO Pay**

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

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

**Holiday Premium**

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

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

**Status Changes**

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

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

1. Your introductory period has ended;
2. Six consecutive months of full-time employment have been completed;
3. A voluntary resignation has been given in writing with at least 14 calendar days’ notice.
4. You have not been terminated for gross misconduct, violation of workplace rules or gross neglect of duties.

Your supervisor must approve all terminal ETO pay.

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

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

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

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

Sick Leave Eligibility and How Sick Leave is Earned

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

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

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

<table>
<thead>
<tr>
<th>Length of Full-time Service</th>
<th>Sick Leave Days Earned Each Year</th>
<th>Sick Leave Days Earned Monthly</th>
<th>Maximum Account Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 through 12 Months</td>
<td>5</td>
<td>.417</td>
<td>5</td>
</tr>
<tr>
<td>13 through 24 Months</td>
<td>9</td>
<td>.750</td>
<td>9</td>
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<tr>
<td>25 through 36 Months</td>
<td>9</td>
<td>.750</td>
<td>12</td>
</tr>
<tr>
<td>37 through 48 Months</td>
<td>9</td>
<td>.750</td>
<td>13</td>
</tr>
<tr>
<td>49 through 60 Months</td>
<td>9</td>
<td>.750</td>
<td>14</td>
</tr>
<tr>
<td>61 months to 6 Years</td>
<td>9</td>
<td>.750</td>
<td>15</td>
</tr>
<tr>
<td>6 Years</td>
<td>9</td>
<td>.750</td>
<td>16</td>
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<tr>
<td>7 Years</td>
<td>9</td>
<td>.750</td>
<td>17</td>
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<td>8 Years</td>
<td>9</td>
<td>.750</td>
<td>18</td>
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<tr>
<td>9 Years</td>
<td>9</td>
<td>.750</td>
<td>19</td>
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<tr>
<td>10 Years to 15 Years</td>
<td>9</td>
<td>.750</td>
<td>20</td>
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<tr>
<td>15 Years</td>
<td>9</td>
<td>.750</td>
<td>25</td>
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<tr>
<td>16 Years</td>
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<td>.750</td>
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<td>17 Years</td>
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<td>18 Years</td>
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<td>.750</td>
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<tr>
<td>19 Years</td>
<td>9</td>
<td>.750</td>
<td>29</td>
</tr>
<tr>
<td>20 Years and Over</td>
<td>9</td>
<td>.750</td>
<td>30</td>
</tr>
</tbody>
</table>
If you are admitted to a hospital, excluding emergency room treatment, on your first day of absence, the balance in your sick leave account is available for the duration of the illness or until the balance is exhausted, whichever comes first. Hospital admission includes outpatient surgery, outpatient procedures and outpatient treatment, such as chemotherapy, rehabilitation, radiation, etc.

Except as required by state law, if you have an illness without a hospitalization, your Sick Leave can start on the 3rd consecutive scheduled work day of illness (after 2 days without sick pay) and continue until either your Sick Leave Account is exhausted or your illness ends, whichever comes first.

Perfect Attendance Days (PA Days) are designed to be available for days 1 and 2 of your illness or to pay after your Sick Days have been exhausted. If PA days are not available, you may use days from your ETO account.

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

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

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

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

If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination, and may result in the forfeiture of earned benefits.
Massachusetts Partners: Subject to Code of Massachusetts – Title 940, Chapter 33.00 Effective July 1, 2015

Sick Leave Benefits for Massachusetts Partners

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

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

Sick Leave Eligibility and How Sick Leave is Earned

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

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

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

Earnings occur on the last pay period of each month. Updated Sick Leave account balances appear on your check stub each pay period. Your Sick Leave Account includes a maximum account balance available to be taken off with pay for Qualifying Absences. Once your account reaches the maximum applicable to you, based on your length of employment service, the available Sick Leave will remain the same (with no increase in the balance).

<table>
<thead>
<tr>
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<td>.750/day</td>
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<td>.750/day</td>
<td>29</td>
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<tr>
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<td>9</td>
<td>.750/day</td>
<td>30</td>
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</tbody>
</table>
**SICK LEAVE ACCOUNT EARNINGS AND BALANCES**

(IPAR, Part-Time, PRN & Temporary Massachusetts Partners)

<table>
<thead>
<tr>
<th>Length of Employment Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1 Month and Over</td>
<td>5</td>
<td>1 hour for each 30 hours paid</td>
<td>5</td>
</tr>
</tbody>
</table>

**Sick Leave Usage**

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

**Massachusetts Sick Leave**

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

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

**NHC Sick Leave**

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

If you have a Qualifying Absence, your NHC Sick Leave will start on the 3rd consecutive scheduled work day of the absence (after 2 days without Sick pay) and continue until either your NHC Sick Leave Account is exhausted or the Qualifying Absence ends, whichever occurs first.

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

**Additional Guidelines Applicable to both Massachusetts & NHC Sick Leave**

If you are a Full-Time partner, NHC Perfect Attendance Days (PA Days) are designed to be available for days 1 and 2 of your illness or to pay after your Sick Leave has been exhausted. If PA days are not available, you may use days from your ETO account to supplement your Sick Leave Days.

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

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

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

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

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

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

**Massachusetts Break In Service Rules**

- Following a break in service of up to 4 months, unused Sick Leave earned before the break in service will be reinstated. The maximum that can be reinstated is 40 hours.

- Following a break in service between 4 and 12 months, unused Sick Leave earned before the break in service will be reinstated if the balance of unused sick time equals or exceeds 10 hours. The maximum that can be reinstated is 40 hours.

- Following a break in service of up to 12 months, you will not be required to restart the 90-day waiting period.
Perfect Attendance Days (PA Days)

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

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

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

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

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

Your PA account has a 5 day maximum balance. When your account reaches 5 days, all future earnings are added to your ETO balance. This movement from PA days to ETO days will continue as long as your PA balance remains at 5.

<table>
<thead>
<tr>
<th>Length of Full-time Service</th>
<th>PA Days Earned Each Year</th>
<th>PA Days Earned Monthly</th>
<th>Maximum Account Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2</td>
<td>.167</td>
<td>5</td>
</tr>
</tbody>
</table>

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

PA Days are designed to supplement your Sick Leave Account. They can be used to pay for either of the first 2 days of absence due to your illness or after all Sick Leave Days have been paid. They can also be used for all family medical needs.

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

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

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

Bereavement Leave (Paid Leave)

You must be full-time and have completed your introductory period to be eligible for Bereavement Leave. Partners on leave of absence, with the exception of intermittent leave, are excluded from bereavement leave eligibility. Partners on intermittent leave of absence may request bereavement leave for a scheduled work day.

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

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

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

Jury Duty Leave (Paid Leave)

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

Family and Medical Leave Act - FMLA (Unpaid Leave)

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

If you are eligible, you are entitled to:

**Twelve workweeks of leave in a 12-month period for:**

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with you of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for your spouse, child, or parent who has a serious health condition;
- a serious health condition that makes you unable to perform the essential functions of your job;
- any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered military member on "covered active duty;" or

**Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if you are the service member's spouse, child, parent, or next of kin (military caregiver leave).**
You may use more than one FMLA-qualifying reason during a 12-month period as long as it does not exceed 12 workweeks, with the exception of military caregiver leave. The regulations provide you to be entitled to a combined total of 26 workweeks of military caregiver leave and leave for any other FMLA-qualifying reason in this “single 12-month period,” provided that you may not take more than 12 workweeks of leave for any other FMLA-qualifying reason during this period. For example, in the single 12-month period you could take 12 weeks of FMLA leave to care for a newborn child and 14 weeks of military caregiver leave, but could not take 18 weeks of leave to care for a newborn child and 8 weeks of military caregiver leave.

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

**Notice of Need for FMLA Leave**

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

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

**Illness Related FMLA Leave Documentation**

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

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

**Pay and Benefits During FMLA Leave**

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

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

**Partner Reinstatement after FMLA Leave**

If you return to work as scheduled from an approved FMLA leave, you will be reinstated to the same or an equivalent position. If you do not return as scheduled from an approved FMLA leave, you will be considered to have voluntarily resigned your employment.
You should contact your supervisor as soon as possible if you are unable to return to work following your FMLA leave to discuss your options. You can submit a written request for a Personal Leave of Absence which can only be granted with supervisor approval. The other option is to terminate your employment and re-apply when your situation is suitable for the position for which you are qualified.

**Medical Leave of Absence (Unpaid Leave)**

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

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

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

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

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

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

**Personal Leave of Absence (Unpaid Leave)**

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

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

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

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

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

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

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

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

**Military Leave (Unpaid Leave)**

The company recognizes that some partners may be called upon to serve in the military. Your employer grants military leaves of absence provided you submit written verification of a call to duty from the appropriate military authority, and the cumulative period of military service with your employer does not exceed five years.
The company also grants you unpaid time off to meet your training obligations in the Active Reserves. If you are involved in periodic reserve training, you are not required to use ETO, but may choose to do so if you desire pay for hours on military duty.

**Witness Duty Leave (Unpaid Leave)**

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

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

**Witness Duty Leave (Paid Leave)**

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

**Workers’ Compensation Leave**

For information related to Workers’ Compensation Leave, please refer to your NHC Partner Handbook.
Insurance Plans

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

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

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

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

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

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

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

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

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

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

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

## 700 – Enrollment Form • PAGE 1

### Before-Tax Benefit Options

#### HEALTH BENEFIT PLAN
- **Medical**
- **Dental**
- **Vision**

#### MONTAGEABLE BENEFIT PLAN
- **Medical Care Deduction**
- **Dependent Care Deduction**

### After-Tax Benefit Options
- **Short Term Disability**

### BASIC TERM LIFE AND ADDITIONAL INSURANCE

### PARTNER AND DEPENDENT LIFE INSURANCE

### Dependent Information

In order to be an Eligible Dependent, a person must be enrolled by the Partner and meet at least ONE of the following criteria:
1. Be the Eligible Partner’s current spouse who is not divorced or legally separated from the Eligible Partner as of the Eligible Partner’s eligibility; or
2. Be the Eligible Partner’s (a) natural child; (b) legally adopted child (including children placed for the purposes of adoption); (c) step-child; or (d) children for whom the Eligible Partner is the legal guardian who are less than 26 years old, regardless of financial or marital status.

The Plan Administrator reserves the right to require proof of eligibility including, but not limited to, medical records, legal adoption or legal custody guardianship documents, and a certified copy of any Qualified Medical Child Support Order.

For Dependent Term Life Insurance, unmarried child, step-child, or legally adopted child up to age 26 is eligible for coverage provided they are dependent on you for 50% or more of their support and are living with you in a regular parent-child relationship. If any unmarried child over age 26 is in need of support from you, you may apply for coverage for that dependent child.
Partner Information – PLEASE READ CAREFULLY

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

Notice of Limited Special Enrollment Rights – PLEASE READ CAREFULLY

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

Other Special Enrollment Notice

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

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

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

LIST OTHER NON-MEDICARE GROUP HEALTH COVERAGE INFORMATION BELOW:

Coverage Type: Sponsor’s Name, Address & Phone # other coverage is through:
- Medical Insurance
- Other Medical Coverage (name)

Policy # (If coverage is through insurance):
- Medical Insurance
- Other Medical Coverage (name)

Other Medicare Coverage Information:

Coverage Date of person covered:
- Name of person covered:
- DOB for person:
- Names and relationships of family members covered by other Non-Medicare coverage:

LIST MEDICARE COVERAGE INFORMATION BELOW:

Names of family members covered by Medicare:
- Medicare Part A Effective Date:
- Medicare Part B Effective Date:
- Is Medicare eligibility due to:
- Kidney failure (ESRD)
- Disability
- Retired

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

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

Name of Health Plan:
- Sponsor of Plan:
- From:
- To:

Authorization I Signature (REQUIRED)

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

- I hereby authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above.
- I authorize the collection and/or filing of a lawsuit for recovery of monies paid for benefits when a third party is responsible for the injuries or illnesses.
- I understand the benefits elections I have made may only be altered due to a special enrollment right or change in status as defined and permitted under the plan. I understand that I only decline any coverage — other than health coverage — and apply at a later date, I may be required to show evidence of insurability.
- I understand that inaccurate information provided to me could result in the denial of benefits.
- I understand that any dishonesty, misrepresentation or false statements related to enrolling dependents in any insurance plan may result in disciplinary action, up to and including termination of employment.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals the purpose of misstating information concerning any fact material there commits a fraudulent insurance act which is a crime and subjects such person to criminal prosecution.
- I hereby enroll, apply for additional coverage, or request exchange to all insurance benefits only during a scheduled enrollment period.
- I understand that for STD coverage:
  - If I am not Active at Work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of Active at Work.
  - If I am eligible for state mandated temporary disability benefits, or any employer sponsored income replacement plan the combination of my state mandated benefit or other income benefit and my STD weekly benefit may not exceed 70% of my basic weekly income.
  - New plans and benefit increases are subject to a 12/12 pre-existing condition limitation (5/12 in PA). If my earnings are based in whole or in part on commissions, earnings must be averaged over the 12-month period prior to the date disability begins.
- By signing this Enrollment Form I hereby state, certify and represent that the information provided is true, accurate, complete and not misleading. I acknowledge, understand and agree that any omissions, or false, inaccurate, or misleading statements made by me may invalidate my coverage and, if applicable, the coverage of my Dependent(s). I understand that any person who knowingly and with intent to defraud, deface or deceive files a statement of claim or an application containing false, inaccurate, incomplete or misleading information may be guilty of a punishable crime. I understand that coverage will become effective only on the date specified after enrollment has been approved and after I have paid my share of the first full Premium due.

Partner Information

Partner Name:
- Social Security #: 

Signature Required:
- Date Required:

10/2017 (EA)
# NHC BENEFITS HANDBOOK

## Health Savings Account (HSA) Individual Enrollment Form

### Eligibility

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

- ☐ YES  ☐ NO  Are you covered by any other non-qualified health plan, including Medicare?
- ☐ YES  ☐ NO  Are you claimed as a dependent on another individual's tax return?
- ☐ YES  ☐ NO  Do you have access to dollars in a flexible spending account (FSA), such as NHC's Nontaxable Benefit Plan, that can pay for any medical expenses before the required deductible is met, including a spouse's FSA?

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

### Account Holder Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI.</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
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<table>
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<tr>
<th>SSN</th>
<th>Gender</th>
<th>Date of Birth (mm/dd/yyyy)</th>
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<tr>
<td></td>
<td>☐ Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Female</td>
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<table>
<thead>
<tr>
<th>E-mail Address</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Street Address</th>
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<th>State</th>
<th>ZIP</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (if different)</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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<tr>
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<td></td>
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<td></td>
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</tbody>
</table>

### Health Benefit Plan Coverage – NHC HSA Value Option

<table>
<thead>
<tr>
<th>Coverage Effective Date</th>
<th>Coverage Type</th>
<th>☐ Partner Only</th>
<th>☐ Partner Plus One</th>
<th>☐ Partner &amp; Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contribution Amount

An HSA allows you to make pre-tax contributions to an FDIC-insured savings account. The best way to make contributions into your account is through payroll contributions so that you avoid payroll taxes on those dollars. As long as you use the money to pay for medical expenses, you never pay taxes or penalties on those dollars. If you are actively employed and eligible to contribute to a HSA account, your employer will cover the monthly administration fee ($2.50) and will contribute the annual amount listed in the table below into your HSA. The employer contribution will be deposited into your HSA account in $25 increments, based on the 26 pay periods that correspond with the medical premium deductions. For newly hired partners, the amount will be pro-rated based on the month in which your coverage is effective.

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

<table>
<thead>
<tr>
<th>Coverage Tier</th>
<th>2018 Tax Year Annual Maximum Contribution Amount</th>
<th>Annual amount you wish to contribute:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employer</td>
<td>Partner Only</td>
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<tr>
<td>Partner Only</td>
<td>$6,000</td>
<td>$2,850</td>
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<tr>
<td>Partner Plus One</td>
<td>$8,000</td>
<td>$6,800</td>
</tr>
<tr>
<td>Partner Plus Family</td>
<td>$6,000</td>
<td>$6,300</td>
</tr>
</tbody>
</table>

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

### Authorization and Certification

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

Print Name: __________________________  Signature: __________________________  Date: __________________________

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

866.346.5800  January 10/17

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**FDIC**

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The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), subject to applicable deposit limits.
# NHC Health Benefit Plan Premiums

**Effective 1/1/2018**

<table>
<thead>
<tr>
<th>PLAN OPTION</th>
<th>Coverage Level</th>
<th>Deduction Taken Twice Monthly</th>
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<tbody>
<tr>
<td>Value</td>
<td>Partner Only</td>
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</tr>
<tr>
<td></td>
<td>Partner Plus One</td>
<td>$175.50</td>
</tr>
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<td></td>
<td>Partner and Family</td>
<td>$190.00</td>
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<tr>
<td>HSA Value</td>
<td>Partner Only</td>
<td>$42.00</td>
</tr>
<tr>
<td></td>
<td>Partner Plus One</td>
<td>$164.00</td>
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<tr>
<td></td>
<td>Partner and Family</td>
<td>$176.50</td>
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Dental and Vision Premiums  
Monthly, Effective 1/1/2018

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>High Plan</th>
<th>Low Plan</th>
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<tbody>
<tr>
<td><strong>DENTAL</strong></td>
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<td></td>
</tr>
<tr>
<td>Partner Only</td>
<td>$28.54</td>
<td>$16.44</td>
</tr>
<tr>
<td>Partner Plus One</td>
<td>$55.44</td>
<td>$33.52</td>
</tr>
<tr>
<td>Partner and Family</td>
<td>$96.64</td>
<td>$53.88</td>
</tr>
<tr>
<td><strong>VISION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner Only</td>
<td></td>
<td>$7.95</td>
</tr>
<tr>
<td>Partner Plus One</td>
<td></td>
<td>$16.84</td>
</tr>
<tr>
<td>Partner and Family</td>
<td></td>
<td>$24.25</td>
</tr>
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</table>
Partner & Dependent Term Life
Insurance w/AD&D Premiums
Bi-Weekly, Effective 1/1/2018

Rates illustrated below are the bi-weekly payroll deduction amount for each applicable Benefit Option. Premiums are deducted two times each month.

<table>
<thead>
<tr>
<th>PARTNER</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
<th>Option 5</th>
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<tr>
<td>&lt;25</td>
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<td>$0.81</td>
<td>$1.62</td>
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<tr>
<td>25-29</td>
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<td>$0.92</td>
<td>$1.85</td>
<td>$2.77</td>
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<tr>
<td>30-34</td>
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<td>35-39</td>
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<td>45-49</td>
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<td>55-59</td>
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<td>60-64</td>
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<td>$1.85</td>
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<th>CHILD(REN)</th>
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<tr>
<td>Premium includes coverage for all current &amp; future eligible children</td>
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<td>$2.31</td>
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<td>$4.62</td>
</tr>
</tbody>
</table>

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

Complete coverage information is in the Certificate of Insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.
## Short Term Disability Premiums
### Monthly, Effective 1/1/2018

<table>
<thead>
<tr>
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*Your weekly benefit may not exceed 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions).*
Health Benefit Plan

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

1. If you are a full-time Partner or an IPAR (generally scheduled between 30.00 and 37.50 hours each week) and you have completed your waiting period, you are eligible to enroll in the Plan during your initial and/or during the Plan’s annual enrollment period. If you enroll, you will be required to pay a portion of the cost of the coverage that you elect (the “premium”). The monthly premiums are shared between the Partner and their Employer. Information regarding your premiums for coverage under the Plan will be provided during the applicable enrollment periods.

2. If you enroll, you may also enroll your Eligible Dependents. In order to enroll your Eligible Dependents, you will be required to provide certain information regarding your dependents that verifies their eligibility for the Plan (including but not limited to their taxpayer identification number). You will be required to pay a premium for your Eligible Dependent’s coverage as well.

3. You must request enrollment during your initial enrollment period or during the annual enrollment period. The SPD provides more detail on the initial and annual enrollment periods. The election that you make during the applicable enrollment periods (including an election to waive coverage) cannot be changed for the remainder of the plan year unless you experience one of the specific events described in the SPD and you submit your request to change your election timely. For example, if you choose no coverage during the initial enrollment period but you have a child during the plan year, you may enroll yourself and your child if you request enrollment timely. The SPD provides more detailed information regarding permissible changes to your election, including a list of permissible events.

4. The Plan is self-insured, which means that NHC has not paid an insurance carrier to take the risk. NHC has, however, engaged Blue Cross Blue Shield of Tennessee ("BCBST") to administer the claims.

5. If you enroll, BCBST will issue an identification card to each Covered Person the month that coverage begins. Identification cards must be presented to all of your providers at the time services are received. If you do not receive an ID card, you should contact BCBST. The contact information for BCBST is provided in the Summary Plan Description.

6. The plan uses Preferred Provider Networks (PPOs) for most services including pharmaceuticals. The Plan’s benefits for services provided by a network provider are greater than services or treatments provided by a non-network provider. The Summary Plan Description includes phone numbers and web sites to help you determine if your provider is a member of the network.

7. Premiums are payable through payroll deduction (if you are receiving a paycheck) and are withheld/paid in advance for the following month’s coverage. Your portion of the premium is deducted from your check monthly. Half is deducted on the 1st pay period of the month with the balance (1/2) deducted on the second pay period of the month. The premiums are automatically excluded from income.

8. Coverage will generally end at the end of the month in which you or your dependent’s cease to be eligible; however, if coverage is lost due to a “qualifying event” you or your dependents may elect to continue that coverage pursuant to a federal law called “COBRA” for up to 18, 29, or 36 months (depending on the type of qualifying event) so long you make a timely election and pay the COBRA premium, which is 102% of the total cost of the coverage that is typically shared by you and NHC.

9. If you have any questions about your rights and obligations under the Plan and are unable to find the answers in the SPD, please contact the plan administrator or the claims administrator. The contact information for both can be found in the SPD.
Please pay particular attention to the limitations on and exclusions for services or treatments.

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Throughout this document, BCBST or BCBS is used and refers to Blue Cross Blue Shield of Tennessee or the Blue Cross Blue Shield Association throughout the United States. BCBST and BCBS may be used interchangeably.
NATIONAL
HEALTH CORPORATION
Health Benefit Plan Summary Plan Description

Effective January 1, 2018
Table of Contents

Introduction .................................................................................................................................................. 7
Nondiscrimination Statement .................................................................................................................... 8
Eligibility ..................................................................................................................................................... 10
Enrollment ................................................................................................................................................ 12
Termination of Coverage ........................................................................................................................... 17
Extended Medical Plan ............................................................................................................................... 18
General Notice of COBRA Continuation Coverage Rights ................................................................. 20
Relationship with Network Providers ........................................................................................................ 24
BlueCard/BlueCard PPO Program ............................................................................................................. 25
Claims and Payment .................................................................................................................................. 27
Prior Authorization, Care Management, Medical Policy and Patient Safety ........................................... 29
Coordination of Benefits ............................................................................................................................ 32
Subrogation and Right of Reimbursement ............................................................................................... 37
Decisions About Benefit Eligibility and Amounts .................................................................................... 39
ERISA Benefit Claim Grievance Procedures ............................................................................................. 40
Limitations on Covered Services ................................................................................................................ 46
Covered Services ....................................................................................................................................... 47
Additional Exclusions from Coverage .................................................................................................... 67
Schedule of Benefits — Value Option ........................................................................................................ 69
Schedule of Benefits — HSA Value Option ............................................................................................... 72
Organ Transplant Services ....................................................................................................................... 75
Miscellaneous Limits ................................................................................................................................. 76
Prescription Drug Program – Value Option ............................................................................................... 77
Prescription Drug Program – HSA Value Option ....................................................................................... 78
Definitions .................................................................................................................................................. 79
Statement of ERISA Rights ....................................................................................................................... 91
Newborns’ and Mothers’ Health Protection Act ....................................................................................... 92
Women’s Health and Cancer Rights Act of 1998 ....................................................................................... 92
Mental Health Parity Act ............................................................................................................................. 92
Uniformed Services Employment and Reemployment Rights Act of 1994 ............................................. 92
Health Benefit Plan General Information ............................................................................................... 93
Statute of Limitations ............................................................................................................................... 94
Forum for Disputes ................................................................................................................................. 94
Amendment / Termination ....................................................................................................................... 94
No Assignment ......................................................................................................................................... 94
No Representations Contrary to the Plan ................................................................................................. 94
No Employment Rights .......................................................................................................................... 94
Plan Funding ............................................................................................................................................. 94
Applicable Law ........................................................................................................................................ 94
Introduction

National Health Corporation ("NHC") has established the Health Benefits Plan ("Plan") to make certain health care benefits available to eligible employees and their eligible dependents. The terms of the Plan are set forth in this Summary Plan Description. NHC is the Plan sponsor and the Plan administrator of the Plan.

NHC has engaged BlueCross BlueShield of Tennessee ("BCBST") to provide day-to-day administration of the claims payments and reimbursement under the terms of this Plan, and to provide other services as contracted with NHC. BCBST does not assume any financial risk or obligation with respect to Plan claims. BCBST is not the Sponsor, Plan administrator or a Fiduciary, as those terms are defined in the Federal law called the Employee Retirement Income Security Act ("ERISA").

This Summary Plan Description ("SPD") describes the terms and conditions of your Coverage through the Plan. It replaces and supersedes any SPD booklet or description of benefits with a prior effective date. If there is a conflict between this SPD and any other documents or materials related to the Plan (e.g. enrollment material booklets), this SPD will control.

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

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

If you have any questions when reading this SPD, You should contact BCBST or the Plan Administrator. You will find contact information for both in this SPD. You can also find BCBST contact information on Your ID card. The representatives are also available to discuss any other matters related to your Coverage under the Plan.

Independent Licensee of The BlueCross BlueShield Association

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

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

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

NHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, you may do so in person or by mail, fax, or email by contacting the Section 504/1557 Coordinator posted at the location in question or by contacting the Compliance Department at:

Mailing Address: 100 East Vine St. Telephone Number: (615) 890-2020
Murfreesboro, TN 37130

Email Address: klocke@nhccare.com Fax Number: (615) 278-1232

TDD or State Relay Number: 7-1-1

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).
Eligibility

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

NOTE: You will be required to pay a Premium for the coverage You elect.

A. Eligible Partner Defined:

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

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

B. Qualifying Part-Time Partner Defined:

A Partner becomes a Qualifying Part-Time Partner if the partner averages 30 Hours of Service per week during the partner’s New Hire Initial Measurement Period. If properly and timely elected during the initial enrollment period described in the Summary Plan Description, coverage for a Qualifying Part-time Partner will become effective on the first day of the Qualifying Part-Time Partner Stability Period (if still employed on that date). A Qualifying Part-time Partner remains eligible for the duration of the Qualifying Part-Time Partner Stability Period so long as the Partner remains employed during the Qualifying Part-Time Partner Stability Period. A Qualifying Part-time Partner who is permitted to take a leave of absence during a Qualifying Part-Time Partner Stability Period will be treated as a newly hired Partner upon return from any such leave that qualifies as a Break in Service.

C. Eligible Ongoing Partner Defined:

A Partner becomes an Ongoing Eligible Partner if the Partner averages 30 hours of service per week during the Plan’s Standard Measurement Period. If properly and timely elected during the annual enrollment period described in the Summary Plan Description, coverage for an Ongoing Eligible Partner will become effective on the first day of the Eligible Ongoing Partner Stability Period (if still employed on that date). An Ongoing Eligible Partner remains eligible for the duration of the Ongoing Eligible Partner Stability period so long as the Partner remains employed during the Ongoing Eligible Partner Stability Period. An Ongoing Eligible Partner who is permitted to take a leave of absence during an Ongoing Eligible Partner Stability Period will be treated as a newly hired Partner upon return from any such leave that qualifies as a Break in Service.

The Plan Administrator has adopted policies and procedures for determining whether a Partner averages 30 hours of service per week and whether the Partner has experienced a break in service.

D. Additional Terms of Eligibility

1. If a Partner experiences a Break in Service during a Measurement Period and then again resumes Hours of Service following a Break in Service, such Partner will be treated as a newly hired Partner upon the date that the Partner resumes Hours of Service for the Employer.
2. An Eligible Partner who resumes Hours of Service during a Stability Period following a period with no Hours of Service that does not qualify as a Break in Service will have his or her previous election of coverage reinstated upon return to employment as of the first day of the month following resumption of Hours of Service.
3. Impact of Special Unpaid Leaves of Absence: If a Partner takes a Special Unpaid Leave of Absence during a Measurement Period, the Employer will disregard all consecutive Weeks of such unpaid leave when determining the average Hours of Service during the applicable Measurement Period.
4. Each Partner’s Hours of Service will be determined in a manner consistent with Internal Revenue Code Section 4980H and the regulations issued thereunder.

E. Eligible Dependents Defined:

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

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

F. Incapacitated Children

1. If a Covered Dependent Child is incapacitated on the date the Child turns age 26, coverage for such Child will continue beyond the age of 26 so long as the following requirements are satisfied:
   2. You provide written notice to BCBST of the incapacity prior to the date the child turns age 26; and
   3. You provide sufficient documentation (as determined by BCBST) supporting the Child’s incapacity.
4. A child is considered “incapacitated” if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

G. Proof of Eligibility and Other Information; Appeals

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

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

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent’s enrollment in the Plan is conditional pending the Plan Administrator’s timely receipt of the requested information regarding your dependents.

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

A. Initial Enrollment Period

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

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

B. Annual Enrollment Period

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

C. Changes In Coverage

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

First, your election will automatically terminate if You terminate employment or lose eligibility under the Plan, except as otherwise described in the “Coverage Termination” section of this Booklet. NOTE: You are still required to provide timely notice of an event that results in loss of eligibility (e.g. divorce).

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

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

D. Status Changes

The following status changes will allow You to change Your enrollment election during the plan year:

1. Marital Status. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. Change in Number of Dependents. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with You for adoption, or death of a Dependent. See also “Special Enrollment” below.
3. **Change in Dependent Eligibility.** Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.

4. **Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan.** You, or Your Eligible Dependent experiences a change in employment status due to one of the following events:
   a. Termination or commencement of employment;
   b. A strike or lockout;
   c. Commencement or return from an unpaid leave of absence;
   d. A change in employment status, *e.g.* unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
   e. A change in worksite; and
   f. Any other change in employment status that affects benefits eligibility.

5. **Change in Residence that Affects Eligibility.** You or Your eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for medical coverage or becomes eligible for medical coverage.

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

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

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

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

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

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

3. **Gaining Coverage Under Another Plan Providing Minimum Essential Coverage.** You may also cancel your coverage if you change employment status during the year to a position that is expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Covered Partner ceasing to be eligible under the group health plan (*e.g.* you are enrolled...
E. Cost or Coverage Changes

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

1. **Change in Cost of Coverage.** If Your share of the premium for medical coverage You elected significantly increases, You may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another benefit plan option under the NHC Health Benefit Plan may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, Your premiums will automatically be adjusted to reflect the insignificant cost change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. **Entitlement to or Loss of Entitlement to Medicare or Medicaid.** You or Your eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. **Governmental Plan Coverage Change.** You or Your Eligible Dependent loses coverage under a group medical plan sponsored by a governmental or educational institution.

4. **New Benefit Option Added.** You are eligible for a new or improved medical coverage option.

5. **Court Ordered Coverage.** You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order (“QMCSO”) that requires medical coverage for Your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child You have enrolled in the Plan and such coverage is actually provided by the other plan.

6. **Reductions in Coverage.** If coverage under an option is significantly curtailed, You may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, You may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. **Change under another Employer Plan.** You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:
   a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or
   b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Health Benefit Plan.

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

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

1. New Dependent Special Enrollment

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

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

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

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

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

A “loss of eligibility” results if any of the following occurs:

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

b. Reaching a lifetime limit on all benefits.

c. Cessation of all employer contributions.

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

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

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

3. Loss of Eligibility for CHIP or MEDICAID

The eligible Partner and/or an eligible Dependent Child may be enrolled if either of the following conditions is satisfied:

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

b. You or Your Eligible Dependent Child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state Child health Plan.
NOTE: Unlike the other special enrollment events, You have 60 days to request enrollment for Loss of Eligibility for Medicaid or eligibility for premium assistance as described above.

G. Qualified Medical Child Support Order

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

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

H. Effective Date of Enrollment Changes

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

I. Denial of Requested Enrollment Changes

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

Coverage will terminate if the Covered Partner does not continue to meet the eligibility requirements described in this Plan. Coverage for a Covered Person who has lost his or her eligibility shall automatically terminate on the last day of the month following the date that eligibility is lost.

Coverage under the Plan will be terminated if any of the following events occur:

1. Coverage will terminate for all Covered Persons at the end of the month in which you terminate employment.
2. If You fail to timely pay the required premium, Coverage will terminate for all Covered Persons at the end of the last month for which a timely and complete premium payment is made. Premium payments made by a Covered Person other than by payroll deductions are considered made when received by the Plan Administrator.
3. Except as otherwise indicated in this Summary Plan Description, Coverage will terminate for all Covered Persons at the end of the month in which you cease to be an Eligible Partner.
4. Coverage will terminate for any Covered Persons at the end of the month following the Plan Administrator’s receipt of a request to cancel such Covered Person’s coverage pursuant to a Change in Status event as described herein.
5. Coverage for a Covered Dependent will end on the date the dependent ceases to be an Eligible Dependent except coverage for a child who is ceasing to be an Eligible Dependent because he or she is turning 26 will end at the end of the month in which the child turns age 26.
6. Coverage for a Covered Person(s) will terminate if the Plan Administrator reasonably determines that a Covered Person has failed to reasonably cooperate with the Employer or Plan, or the Covered Person has committed fraud or made a material misrepresentation with respect to eligibility or coverage under the Plan. Coverage may be terminated immediately or it may be retroactively terminated in the case of fraud or a material misrepresentation.
7. A Covered Dependent’s coverage will end as of the date that the information requested by the Plan Administrator with respect to such dependent is not provided timely.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the termination of Coverage for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys’ fees, expenses and court costs.

If you lose coverage due to a Qualifying Event, you may be eligible to continue coverage under the Plan in accordance with a federal law called “COBRA. See the COBRA Continuation of Coverage section in this booklet for more information.
Extended Medical Plan

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

A. Eligibility Requirements

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

B. Extended Medical Plan Provisions

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

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

C. Plan’s Right to Waive Eligibility

1. Eligibility for the Extended Medical Plan may be waived by the Plan Sponsor in cases of partner gross misconduct, violation of workplace rules or gross neglect of duties. Acts of gross misconduct include intentional, wanton, willful, deliberate, reckless or deliberate indifference to an employer’s interest.
2. The termination of a sponsoring Affiliated Employer relationship between the NHC Health Benefit Plan and any sponsoring Affiliated Employer voids eligibility to the Extended Medical Plan for all Partners of the sponsoring Affiliated Employer. If the sponsoring Affiliated Employer has former
Partners covered by the Extended Medical Plan on the date of the termination of the sponsoring Affiliated Employer relationship, the Extended Medical Plan coverage for the former Partners will end on the last day of the month following 60 days from the relationship termination or the last day of the calendar year following the relationship termination, whichever is longer in duration. COBRA will be offered to all Partners covered on the termination date and to former Partners who lose coverage under the Extended Medical Plan as a result of the termination of the relationship.
General Notice of COBRA
Continuation Coverage Rights

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Partner, commencement of a proceeding in bankruptcy with
respect to the Employer, or the Partner’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the qualifying event.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

Disability extension of 18-month period of continuation coverage

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

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

If a qualified beneficiary other than the Covered Partner experiences another qualifying event during the 18 (or, if applicable, the 29) month COBRA continuation coverage period, the qualified beneficiary (other than the Covered Partner) can get up to 36 months of COBRA continuation coverage measured from the date of the
original qualifying event, if notice of the second qualifying event is properly given to the Plan. This extension may be available to a qualified beneficiary Spouse and/or any qualified beneficiary Dependent children receiving continuation coverage if the Partner or former Partner dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

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

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

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

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

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

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay all or a part of the premium for your continuation coverage. You will have a grace period of 45 days to pay any retroactive premium for the period from the date continuation coverage starts until the date you choose continuation coverage. You will have a grace period of 30 days to pay any subsequent premiums.
If you have any questions about the law, please contact the COBRA Administrator identified in the General COBRA notice you received when you first became enrolled (or contact the Plan Administrator identified in this SPD).
Relationship with Network Providers

Independent Contractors

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

National Health Corporation, as Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of your Coverage. The Plan Administrator makes Coverage decisions based on the terms of this Plan, the ASA, BCBST’s participation agreements with Network Providers, BCBST’s internal guidelines, policies, procedures, and applicable State or Federal laws.

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

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

Termination of Providers’ Participation

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

Provider Directory

You may check to see if a Provider is in your Plan’s Provider Network by going online to www.bcbst.com.
BlueCard/BlueCard PPO Program

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

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

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

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

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

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

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

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

BLUECARD WORLDWIDE: Through the BlueCard Worldwide Program, you also have access to a participating Hospital network and referrals to doctors in major travel destinations throughout the world. When you need to locate a Hospital or doctor, you can call the BlueCard Worldwide Service Center at 1-800-810-BLUE, or call collect at 1-804-673-1177, 24 hours a day, 7 days a week.
You can also visit the website: https://www.bluecardworldwide.com/, or you can call BCBST. When you need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer you to a participating Hospital. You will only be responsible for the Plan’s usual out-of-pocket expense (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance Coverage). In an Emergency, you should go to the nearest Hospital and call the BlueCard Worldwide Service Center if you are admitted. You still have the choice of using non-BlueCard Worldwide Hospitals; however, you may have to pay the Hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but you will have to pay the Provider and then file the claim for reimbursement.
Claims and Payment

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

A. Claims

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

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.

2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to you. Only post-service claims can be billed to the Plan, or you.

3. Urgent Care is defined as medical care or Treatment for injury or condition, not so severe as to require Emergency Room Care, that, if delayed or denied, could seriously jeopardize (1) the life or health of the claimant, or (2) the claimant’s ability to regain maximum function. Urgent Care is also medical care or treatment that if delayed or denied, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or Treatment. A claim for denied Urgent Care is always a pre-service claim.

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Covered Person Payments. The Network Provider will submit the claim directly to the Plan.

2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If you use an Out-of-Network Provider, you are responsible for the difference between Billed Charges and the Allowed Amount for a Covered Service. You are also responsible for complying with any of the Plan’s medical management policies or procedures (including obtaining Prior Authorization of such Covered Services, when necessary).

If you are charged or receive a bill, in order to be reimbursed, you must submit the claim on a timely basis, but no later than July 1 following the year in which expenses were incurred. If you do not submit a claim within the above stated time period it will not be paid. If it is not reasonably possible to submit the claim within the stated time period the claim will not be invalidated or reduced.

3. Not all Covered Services are available from Network Providers. There may be some Provider types that BCBST does not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in section (2) directly above. You are also responsible for complying with any of the Plan’s medical management policies or procedures (including, obtaining Prior Authorization of such Covered Services, when necessary).

4. You may request a claim form from BCBST’s customer service department. BCBST will send you a claim form within 15 days. You must submit proof of your own payment to BCBST for the Covered Service. BCBST may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

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

6. You may request a claim form from BCBST’s customer service department. BCBST will send you a claim form within 15 days. BCBST may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

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

C. Payment

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

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

3. Non-Contracted Providers may or may not file your claims for you. Either way, the In-Network Benefit level shown in the Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers. However, you are responsible for the difference in the Billed Charge and the Allowed Amount for that Covered Service. The Plan’s payment fully discharges its obligation related to that claim.

4. BCBST will pay benefits according to the Plan’s terms within 30 days after it receives a claim form that is complete. Claims are processed in accordance with current industry standards, and based on BCBST’s information at the time it receives the claim form. Neither the Plan nor BCBST are responsible for over or under payment of claims if your claim information is not complete or is inaccurate. Reasonable efforts will be made to obtain and verify relevant facts when claim forms are submitted.

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

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

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

D. Complete Information

Whenever you need to file a claim yourself, it can be processed for you more efficiently if you complete a claim form. This will ensure that you provide all the information needed. Most Providers will have claim forms or you can request them by calling the customer service department at the number listed on the Health Plan ID Card.

Mail all claim forms to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002
Prior Authorization, Care Management, Medical Policy and Patient Safety

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

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

A. Prior Authorization

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

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

1. Inpatient Hospital stays (except maternity admissions),
2. skilled nursing facility and rehabilitation facility admissions,
3. certain outpatient surgeries and/or procedures,
4. Durable Medical Equipment (DME), Prosthetics and Orthotics greater than $500,
5. spinal surgeries,
6. spinal injections,
7. hip, knee and shoulder surgeries,
8. certain Specialty Drugs, and
9. certain Prescription Drugs (if Covered by a prescription drug card).

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

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

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers, or benefits will be reduced or denied.

For the most current list of services that require Prior Authorization, call customer service or visit BCBST website at www.bcbst.com.

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

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

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

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

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

B. Care Management

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

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

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

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

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

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

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

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

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

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

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

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

D. **Patient Safety**

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

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

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

A. Definitions

The following terms apply to this provision:

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

Each contract or other arrangement for coverage is a separate Health Care Arrangement. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Health Care Arrangement.

3. Primary Plan/Secondary Plan
   a. The order of benefit determination rules state whether this Plan is a “Primary Plan” or “Secondary Plan” as to another Health Care Arrangement covering you.
   b. When this Plan is a Primary Plan, its benefits are determined before those of the other Health Care Arrangement. This Plan does not consider the other Health Care Arrangement’s benefits.
c. When this Plan is a Secondary Plan, its benefits are determined after those of the other Health Care Arrangement and may be reduced because of the other Health Care Arrangement’s benefits.

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

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

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

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

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

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

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

B. Order of Benefit Determination Rules

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

1. Non-Dependent/Dependent

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

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

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

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

(ii) Medicare;

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

2. Dependent Child/Parents Not Separated or Divorced

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

a. The benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year.
b. If both parents have the same birthday, the benefits of the Health Care Arrangement that has covered one parent longer are determined before those of the Health Care Arrangement of the other parent.

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

3. Dependent Child/Separated, Divorced or Unmarried Parents

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

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

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

c. finally, the Health Care Arrangement of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangement of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. The Health Care Arrangement of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

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

4. Active/Inactive Partner

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

5. Longer/Shorter Length of Coverage

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

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

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

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

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

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

c. The claimant’s length of time covered under a Health Care Arrangement is measured from the claimant’s first date of coverage under that Health Care Arrangement. If that date is not readily available, the date the claimant first became a Covered Person of the Plan shall be used as the
date from which to determine the length of time the claimant’s coverage under the present
Health Care Arrangement has been in force.

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


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

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

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

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

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

d. If

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

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

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

C. Effect on the Benefits of this Plan

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

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

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

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

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

2. When the benefits of this Plan are reduced as described above, each benefit is reduced
proportionately and is then charged against any applicable benefit limit of this Plan.

3. The Plan Administrator will not, however, consider the benefits of the other Health Care
Arrangement or Arrangements in determining benefits under this Plan when
a. the other Health Care Arrangement has a rule coordinating its benefits with those of this Plan and such rule states that benefits of the other Health Care Arrangement will be determined after those of this Plan; and

b. the order of benefit determination rules requires this Plan to determine benefits before those of the other Health Care Arrangement.

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

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

G. Are You Also Covered by Medicare?

If you are also Covered by Medicare, the Plan Administrator follows the Medicare Secondary Payor (MSP) rules to determine your benefits.
Subrogation and Right of Reimbursement

A. Subrogation Rights

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

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

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

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

B. Priority Right of Reimbursement

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

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

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

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

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

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

C. Notice and Cooperation

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

The Covered Person shall not do anything to hinder, delay, impede or jeopardize the Plan’s subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall
entitle the Plan to withhold any and all benefits due the Covered Person under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan’s subrogation rights and/or priority right of reimbursement.

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

D. Legal Action and Costs

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

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

E. Settlement or Other Compromise

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

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

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

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

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

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

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

1. to take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Health Benefit Plan;

2. to formulate, interpret, and apply rules, regulations, and policies necessary to administer the Health Benefit Plan;

3. to decide questions, including legal or factual questions, relating to the eligibility for, and the calculation and payment of, benefits under the Health Benefit Plan; and

4. to resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Health Benefit Plan, or other Health Benefit Plan documents, instruments or communications;

5. except as specifically provided to the contrary elsewhere in the Health Benefit Plan, to process, and approve or deny, benefit claims and rule on any benefit exclusions, and determine the manner of benefit payments.

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

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

The term “claim” described herein means a request or claim for payment of medical care or Treatment made by you under the Health Benefit Plan as a benefit provided by that Plan. A Claim for benefit that is denied may be appealed under the Claim Grievance Procedures of this Plan which follow. Claims by other entities, such as a pharmacy, that are not covered by the Health Benefit Plan as a Covered Partner or a Covered Dependents are not claims to which these ERISA Benefit Claim Grievance Procedures apply.

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

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

Also, when the term “you” is used it means you or your authorized representative. For you see, these ERISA Benefit Claim Grievance Procedures also apply to your authorized representative. The Plan Administrator, however, will require proof, satisfactory to the Plan Administrator in its sole discretion, that an individual is your authorized representative.

Finally, the terms “adverse benefit claim determination” does not mean a medical management dispute with a health care Provider (such as your doctor or Hospital) until that health care Provider has exhausted applicable health care Provider claim procedures and the Plan Administrator has determined that you are financially responsible for all or some portion of a disputed claim that is denied. You cannot use these procedures to resolve a claim you have for a Provider’s negligence. These procedures are only to resolve a benefit claim that is subject to the Plan Administrator’s control.

If you make a request to the Health Benefit Plan for payment of medical care or Treatment in advance of such care or Treatment, or for payment for medical care or Treatment after you have received such care or Treatment, and you are turned down, you will be notified in writing or electronically of this initial adverse benefit claim determination. (This is called an “initial” adverse benefit claim determination because you have the right to appeal an initial adverse benefit claim determination for further review.) That notification should provide you the following:

1. The specific reason or reasons for the initial adverse benefit claim determination.
2. Reference to the specific Health Benefit Plan provision or provisions on which the initial adverse benefit claim determination was based.
3. A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary.
4. A description of the Health Benefit Plan’s review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) within 180 days following an adverse benefit claim determination on review of an appeal of an initial adverse benefit determination (unless a longer time to bring such a civil action is required by law).
5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making an initial adverse benefit claim determination, then the specific rule, guideline, protocol or other similar criterion (or, alternatively, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the initial adverse benefit claim determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon your request).

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

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

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

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

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

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

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

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

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

6. A review on appeal which provides the identity of medical or vocational experts whose advice was obtained by the Plan Administrator in connection with your initial adverse benefit claim determination, without regard to whether the advice was relied upon in making the initial adverse benefit claim determination.
If you appeal an initial adverse benefit claim determination and you are turned down on appeal, you will be notified in writing or electronically of the adverse benefit claim determination on review of your appeal. That notification will provide you the following:

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

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

However, before you can file a request for an external review on an initial internal adverse benefit claim determination, you must first appeal that initial adverse determination under the above Plan procedures. That is a second level of internal review.

If your claim is again denied on one or more of the five reasons, then this is a final denial of the internal claims procedure of the Plan. Only at this point where you have exhausted the Plan’s internal review procedures may you then proceed to file for external review. You may omit this exhaustion of the Plan’s final, internal appeal requirement if the Plan fails to comply with the above requirements of the internal appeals procedures, except if that failure is based on a minor violation that does not cause, and is not likely to cause, you harm or materially interferes with your right to file such a claim for external review.

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

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

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

The independent review organization must provide written notice to both you and the Plan of its decision to uphold or reverse the adverse benefit determination no later than 45 days after its receipt of the request for external review.
If your benefit claim is turned down in the final review for which you are eligible, you have a right to bring a civil action under ERISA Section 502(a) in State or Federal Court. **However, you must bring such a civil action within 180 days of that adverse benefit claim determination on review of your appeal (unless longer time to bring such a civil action is required by law).** If you do not bring a civil action under ERISA Section 502(a) in State or Federal Court within this period, then you will be time-barred from bringing such an action under the terms of the Health Benefit Plan. If the Plan Administrator fails to follow these ERISA Benefit Claim Grievance Procedures with respect to your benefit claim on review of your appeal, your benefit claim on review of your appeal will be deemed to be denied, and an adverse benefit claim determination made on review of your appeal as of the last day the Plan Administrator could have complied with these procedures.

The preceding description of ERISA Benefit Claim Grievance Procedures apply generally to all benefit claims under the Health Benefit Plan, except as specifically otherwise indicated. There are special timing rules, though, that apply to the Plan Administrator and to you with respect to such benefit claims. These special timing rules depend on the type of benefit claim you make.

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

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

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

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

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

### A. Urgent Care Requests

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

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

Likewise, provided your request is made at least 24 hours before the end of the previously approved Treatment, if you request an extension on a course of Treatment, the Plan Administrator should notify you of its decision (whether adverse or not) as soon as possible, but not later than 24 hours after the receipt of your request. A determination by the Plan Administrator not to extend the course of Treatment will also be the same as an initial adverse benefit claim determination of an Urgent Care request under these ERISA Benefit Claim Grievance Procedures.

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

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

B. Pre-Service Requests

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

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

C. Post-Service Claims

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

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

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

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

Other Exclusions

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

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

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

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

A. Practitioner/Preventive Office Services

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

1. Covered Services

   a. Diagnosis and treatment of illness or injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Rehabilitation therapies.

g. Allergy care including basic testing, evaluations, serum and injections.
h. Casts and dressings.
i. Foot care necessary to prevent the complications of an existing disease state.
j. Routine foot care for the treatment of (1) flat feet, (2) corns, (3) bunions, (4) calluses, (5) ingrown toenails and fungal infections, (6) fallen arches, (7) weak feet or chronic foot strain.
k. Foot orthotics, shoe inserts and custom made shoes.
l. Pre- and post-natal maternity care.
m. Services and Supplies for the diagnosis and treatment of illness or injury, including those relating to hearing, speech, voice or language.
n. Emergency conditions presented to the Practitioner’s Office.

2. Exclusions from Coverage
a. Office visits and physical exams for (1) school, (2) camp, (3) employment, (4) travel, (5) insurance, (6) marriage or legal proceedings, (7) pastoral or financial counseling and (8) related immunizations and tests.
b. Rehabilitation therapies are subject to the limitations of the Therapeutic/Rehabilitation benefit.

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

1. Covered Services
   a. Excisions (including mole removal), incisions
   b. Surgical repairs, including suturing lacerations
   c. Biopsies
   d. Endoscopies
   e. Casting and splinting
   f. Joint injection and drainage
   g. Cryosurgery
   h. Vasectomy

2. Exclusions from Coverage
   a. Dental procedures, except as otherwise indicated in this Plan

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

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

1. Covered Services
700 – Health Benefit Plan Summary Plan Description • PAGE 49

a. Room and board in a semi-private room; general nursing care; medications, injections, diagnostics and special care units.
b. Prescription Drugs that are prescribed, dispensed or intended for use while the Covered Person is confined in a Hospital, skilled nursing facility or other similar facility.
c. Attending Practitioner’s services for professional care.
d. Maternity and delivery services, including Complications of Pregnancy.
e. Observation stays.
f. Blood/plasma is a Covered Service unless free.

2. Assistant Surgeon

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

3. Exclusions from Coverage

a. Inpatient stays primarily for therapy (such as physical or occupational therapy).
b. Private duty nursing.
c. Services that could be provided in a less intensive setting.
d. Weekend Hospital admission only when surgical procedures are scheduled on the date of admission or in cases of documented emergency.
e. Prior Authorization for Covered Services must be obtained from BCBST or benefits will be denied or reduced.

D. Hospital Emergency Care Services

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

1. Covered Services

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

2. Exclusions from Coverage

a. Emergency Care does not include treatment of a chronic, non-Emergency Medical Condition where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.
b. Once the Covered Person’s medical condition has stabilized, Prior Authorization must be obtained from BCBST for inpatient care or transfer to another facility. Benefits will be denied or reduced if such Authorization is not obtained within 24 hours or the next working day.

E. Ambulance Services/Emergency Medical Transportation

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

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

2. Exclusions from Coverage
   a. Transportation for the convenience of the Covered Person.
   b. Transportation that is not essential to reduce the probability of harm to the patient.
   c. Services when you are not transported to a facility.

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

1. Covered Services
   a. Practitioner services.
   b. Outpatient diagnostics (such as x-rays and laboratory services).
   c. Outpatient Treatments (such as medications and injections.)
   d. Outpatient surgery and supplies.
   e. Observation stays.

2. Exclusions from Coverage
   a. Therapeutic Services are subject to the terms of the Therapeutic/Rehabilitation Services benefit.
   b. Services that could be provided in a less intensive setting.

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

G. Family Planning and Reproductive Services
Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility.

1. Covered Services
   a. Benefits for family planning, history, physical examination and diagnostic testing.
   b. Sterilization procedures.
   c. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion.

2. Exclusions from Coverage
   a. Benefits for any services or supplies that are designed to medically enhance a Covered Person’s level of fertility in the absence of a disease state.
   b. Assisted Reproductive Technology (ART), such as GIFT, ZIFT, in vitro fertilization and fertility drugs.
   c. Sperm preservation.
   d. Services or supplies for the reversals of sterilizations.
   e. Elective abortions.
   f. Induced abortion unless (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, (2) the fetus is not viable, (3) the pregnancy is a result of
rape or incest, or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

H. **Reconstructive Surgery**

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

1. Covered Services
   a. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state.
   b. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy). Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions from Coverage
   a. Services, supplies or prosthetics primarily to improve appearance.
   b. Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance.

I. **Skilled Nursing/Rehabilitation Facility Services**

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

1. Covered Services
   a. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units.
   b. The attending Practitioner’s services for professional care.
   c. Coverage is limited as indicated in the Schedule of Benefits.

2. Exclusions from Coverage
   a. Custodial, domiciliary or private duty nursing services.
   b. Skilled nursing services not received in a Medicare certified skilled nursing facility.

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

J. **Therapeutic/Rehabilitation Services**

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

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

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

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

2. Exclusions to Coverage

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

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

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

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

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

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

K. Organ Transplants

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

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

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

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

1. Prior Authorization Procedures

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

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

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

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

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

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

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

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

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

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

d. Donor Organ Procurement. If the donor is not a Covered Person, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself (1) testing for the donor’s compatibility; (2) removal of the organ from donor’s body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of your organ Transplant Service.

3. Conditions/Limitations

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

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

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

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

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

e. Once you have notified Transplant Case Management and received Prior Authorization, you may decide to have the transplant performed outside the Transplant Network. However, your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the service provided will be Covered.

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

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

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

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

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

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

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

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

4. Exclusions from Coverage

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

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

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

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

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

e. Non-Covered Services.

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

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

h. Payment to an organ donor or the donor’s family as compensation for an organ, or payment required to obtain written consent to donate an organ.
i. Donor services including screening and assessment procedures that have not received Prior Authorization.

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

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

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

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

L. Dental Services, TMJ, and Oral Surgical Treatment

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

1. Covered Services

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

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

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

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

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

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

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

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

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

   e. Removal of impacted teeth, including wisdom teeth.

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

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

   a. Non-surgical TMJ includes: (1) history exam, (2) office visit, (3) x-rays, (4) diagnostic study casts, (5) medications, and (6) appliances to stabilize jaw joint and medications.
b. Dental Covered Services should be filed with the dental carrier first if dental insurance is in effect.

3. Exclusions from Coverage
   a. Services as a result of an injury to the jaw, natural teeth, mouth, or face started after one year from the date of the injury.
   b. The facility charges for surgery will be Covered under the conditions of the inpatient or outpatient facility benefit.
   c. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of non-impacted wisdom teeth; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.
   d. Treatment for correction of underbite, overbite, and misalignment of the teeth, including but not limited to, braces for dental indications, orthognathic surgery, occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.
   e. Professional charges except as indicated above.

M. Diagnostic Services
   Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.
   1. Covered Services
      a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging.
      b. Diagnostic laboratory services ordered by a Practitioner.
   2. Exclusions from Coverage
      a. Diagnostic services that are not Medically Necessary and Appropriate.
      b. Diagnostic services not ordered by a Practitioner.

N. Durable Medical Equipment
   Medically Necessary and Appropriate medical equipment or items that, in the absence of illness or injury (1) are of no medical or other value to you; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not for your convenience.
   1. Covered Services
      a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase.
      b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
      c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
      d. The replacement of items needed as the result of normal wear and tear, defects or aging.
   2. Exclusions from Coverage
      a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.
b. Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical Equipment.

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

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

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

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

g. Portable ramp for wheelchair.

O. Prosthetics/Orthotics

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

1. Covered Services

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

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

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

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

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

2. Exclusions from Coverage

   a. Hearing aids.

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

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

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

P. Supplies

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

1. Covered Services

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

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

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

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

Q. Home Health Care Services

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

1. Covered Services
   a. Part-Time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.
   b. Home infusion therapy.
   c. Rehabilitation therapies such as physical therapy, occupational therapy, speech therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitation benefit).
   d. Medical social services.
   e. Dietary guidance.
   f. Coverage is limited as indicated in the Schedule of Benefits.

2. Exclusions from Coverage
   a. Items such as non-treatment services or (1) routine transportation, (2) homemaker or housekeeping services, (3) behavioral counseling, (4) supportive environmental equipment, (5) maintenance or Custodial Care, (6) social casework, (7) meal delivery, (8) personal hygiene, and (9) convenience items.
   b. BCBST’s Medical Policy may limit the number of visits per hour per day.
   c. Prior authorization must be obtained from BCBST for such services.

R. Hospice

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

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

2. Exclusions from Coverage
   a. Prior Authorization must be obtained from BCBST for services.
   b. Inpatient hospice services, unless approved by Care Management.
   c. Services such as (1) homemaker or housekeeping services, (2) meals, (3) convenience or comfort items not related to the illness, (4) supportive environmental equipment, (5) private duty nursing, (6) routine transportation, and (7) funeral or financial counseling.
   d. Coverage is limited as indicated in the Schedule of Benefits.

S. Behavioral Health Services

1. Prior Authorization Requirements
   Prior Authorization is required for
a. All inpatient levels of care. Inpatient levels of care include Acute care, residential care, partial Hospital care, and intensive outpatient programs.

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

c. Applied Behavioral Analysis (ABA) therapy.

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

2. Covered Services

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

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

b. You may substitute other levels of care for inpatient days as follows:
   (i) Two residential treatment days for 1 inpatient day.
   (ii) Two partial Hospital days for 1 inpatient day.
   (iii) Three intensive outpatient program days for 1 inpatient day.

c. Other case management benefits may be available.

3. Exclusions from Coverage

a. Non-emergency behavioral health Acute care, residential care, partial Hospitalization, intensive outpatient programs stays or treatment in halfway houses or group homes, and electro-convulsive treatments that are not Prior Authorized during your treatment in a facility or program, whether the facility or program is a Network Provider or an Out-of-Network Provider. Emergency Services require a notification within 24 hours to receive Prior Authorization.

b. Pastoral counseling.

c. Marriage and family counseling.

d. Vocational and educational training and/or services.

e. Custodial or domiciliary care.

f. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.

g. Sleep disorders.

h. Services related to mental retardation or developmental disabilities.

i. Habilitative as opposed to Rehabilitation Services; services to achieve a level of functioning the individual has never attained.

j. Behavioral problems such as anti-social personality disorders, sexual deviation or dysfunction or social maladjustment.

k. Court ordered examinations and treatment, unless Medically Necessary and Appropriate.

l. Any care in lieu of legal involvement or incarceration.

m. Pain management.

n. Hypnosis or regressive hypnotic techniques.
o. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.

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

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

T. Vision

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

1. Covered Services
   a. Services and supplies for the diagnosis and Treatment of diseases and injuries to the eye.
   b. First set of eyeglasses or contact lens following cataract surgery.

2. Exclusions from Coverage
   Benefits will not be provided for the following services, supplies or charges:
   a. Services, surgeries and supplies to detect or correct refractive errors of the eyes.
   b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.
   c. Eye exercises and/or therapy.
   d. Visual training.

U. Diabetes Treatment

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

1. Covered Services
   a. Blood glucose monitors, including monitors designed for the legally blind.
   b. Test strips for blood glucose monitors.
   c. Visual reading and urine test strips.
   d. Insulin.
   e. Injection aids.
   f. Syringes.
   g. Lancets.
   h. Oral hypoglycemic agents.
   i. Glucagon emergency kits.
   j. Injectable incretin mimetics (such as Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes.
k. Insulin pumps, infusion devices, and appurtenances, not subject to the benefit limit for Durable Medical Equipment indicated in the Schedule of Benefits. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.

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

2. Exclusions from Coverage
   a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.
   b. Supplies not required by State statute.

V. Prescription Drug Program

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

1. Benefits for Prescription Drugs
   a. Value Option
      Prescriptions obtained from retail pharmacies have a limited calendar day supply. This limit is shown in the Schedule of Benefits.

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

      Your Copayments vary based on the days supply dispensed as shown in the Schedule of Benefits. Some products may be subject to additional Quantity Limitations as adopted by BCBST.

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

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

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

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

      Your payment may vary based on the days supply dispensed as shown in the Schedule of Benefits. Some products may be subject to additional Quantity Limitations as adopted by BCBST.

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

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

2. Benefits for Self-administered Specialty Drugs

You have a distinct Network for Specialty Drugs called the Specialty Pharmacy Network. Benefits are only available when you use a Specialty Pharmacy Network provider for your self-administered Specialty Drugs. Please refer to Provider-administered Specialty Drugs in Definitions for information on benefits for Provider-administered Specialty Drugs.
Specialty Drugs have a limited day supply per Prescription. (See the Schedule of Benefits).

3. Covered Services
   a. This Plan covers the following at 100%, in accordance with the Women’s Preventive Services provision of the Affordable Care Act:
      (i) Generic contraceptives,
      (ii) Vaginal ring,
      (iii) Hormonal patch, and
      (iv) Emergency contraception available with a prescription.
      Brand name Prescription Contraceptive Drugs are Covered as indicated in the Schedule of Benefits.
   b. Prescription Drugs prescribed when you are not confined in a Hospital or other facility. Prescription Drugs must be:
      (i) prescribed on or after the date your Coverage begins,
      (ii) approved for use by the Food and Drug Administration (FDA),
      (iii) dispensed by a licensed pharmacist or dispensing physician,
      (iv) listed on the Preferred Drug Formulary, and
      (v) not available for purchase without a Prescription.
   c. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
   d. Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.
   e. Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.
   f. Immunizations administered at a Network Pharmacy.

4. Limitations
   a. Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
   b. The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will Cover the refill.
   c. Certain drugs are not Covered except when prescribed under specific circumstances as determined by the P & T Committee.
   d. Prescription and non-Prescription medical supplies, devices and appliances are not covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma.
   e. Immunological agents, including but not limited to (1) biological sera; (2) blood; (3) blood plasma; or (4) other blood products are not Covered, except for blood products required by hemophiliacs.
   f. Injectable drugs, except when (1) intended for self-administration, or (2) defined by the BCBST.
   g. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain
quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA-approved dosage for four calendar weeks.

h. The Plan does not Cover Prescription Drugs prescribed for purposes other than for
   (i) indications approved by the FDA, or
   (ii) off-label indications recognized through peer-reviewed medical literature.

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

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

5. Exclusions from Coverage

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

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

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

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

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

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

f. Contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the Plan.

g. Medications intended to terminate a pregnancy.

h. Non-medical supplies or substances, including support garments, regardless of their intended use.

i. Artificial appliances.

j. Allergen extracts.

k. Any drugs or medicines dispensed more than one year following the date of the Prescription.

l. Prescription Drugs you are entitled to receive without charge in accordance with any worker’s compensation laws or any Municipal, State, or Federal program.

m. Replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law).

n. Drugs dispensed by a Provider other than a Pharmacy or dispensing physician.

o. Prescription Drugs used for the Treatment of infertility.


q. Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression).
r. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches, except as required by the Affordable Care Act.

s. All newly FDA approved drugs prior to review by the Plan’s P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval.

t. Prescription Drugs used for cosmetic purposes including, but not limited to (1) drugs used to reduce wrinkles, (2) drugs to promote hair-growth, (3) drugs used to control perspiration, (4) drugs to remove hair, and (5) fade cream products.

u. FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

v. Prescription Drugs used during the maintenance phase of chemical dependence treatment, unless Authorized by BCBST.

w. Compound drugs, unless Medically Necessary and Medically Appropriate.

x. Drugs used to enhance athletic performance.

y. Specialty Drugs filled or refilled at an Out-of-Network Pharmacy.

z. Experimental and/or Investigational Drugs.

aa. Provider-administered Specialty Drugs, as indicated on the Specialty Drugs list.

bb. Prescription Drugs or refills dispensed
   
   (i) in quantities in excess of amounts specified in the Benefit payment section;

   (ii) without Prior Authorization when required; or

   (iii) that exceed any applicable Allowed Amount, or any other maximum benefit amounts stated in the Plan.

These exclusions only apply to Prescription Drug Benefits. Items that are excluded under Prescription Drug Benefits may be Covered as medical supplies under the Plan. Please review your Plan carefully.

6. DEFINITIONS

a. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.

b. **Brand Name Drug** – A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.

c. **Compound Drug** – An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and that contains at least one ingredient classified as a Legend Prescription Drug.

d. **Drug Copayment** – The dollar amount specified in the Schedule of Benefits that you must pay directly to the Network Pharmacy when the covered Prescription Drug is dispensed. The Drug Copayment is determined by the type of drug purchased and must be paid for each Prescription Drug.

e. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: “Caution – limited by Federal law to Investigational use.”
f. **Generic Drug** – A Prescription Drug, as described herein, that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug.

g. **HDHP Preventive Drug List** – The Preventive Drug List applies to HSA Value option only. You pay a copay for preventive care medications instead of having to meet your plan’s deductible for certain prescription drugs. Prescription drugs on the Preventive Drug List will be covered as if you already met your deductible, so you are only responsible for paying the appropriate copay.

The list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. The list does not guarantee coverage for preventive care drugs that are not listed. The list is subject to change throughout the year. Check bcbst.com for the current list. To ensure coverage, check your Schedule of Benefits or call the toll-free number shown on your ID card.

h. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, “Caution: Federal law prohibits dispensing without a Prescription.”

i. **Non-Preferred Brand Drug or Elective Drug** – A Brand Name Drug that is not considered a Preferred Drug by the Pharmacy Benefit Manager. Usually there are lower cost alternatives to some Brand Name Drugs.

j. **Out-of-Network Pharmacy** – A Pharmacy that has not entered into a service agreement with the Pharmacy Benefit Manager or its agent to provide benefits at specified rates to you.

k. **Pharmacy** – A State or Federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the State in which he or she practices.

l. **Pharmacy Benefit Manager (PBM)** – A company that administers, or handles, the drug benefit program for the health Plan.

m. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of participating pharmacists, Network Providers, the Medical Director and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the (1) Drug Formulary, (2) Preferred Brand Drug list, (3) Prior Authorization Drug list, and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

n. **Preferred Brand Drug** – Brand Name Drugs that have been reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.

o. **Preferred Drug Formulary** – A list of specific generic and brand name Prescription Drugs Covered by the Plan subject to Quantity Limitations, Prior Authorization and Step Therapy. The Drug Formulary is subject to periodic review and modification at least annually by the Pharmacy and Therapeutics Committee. The Drug Formulary is available for review at www.bcbst.com, or by calling the toll-free number shown on the back of Your Covered Person ID card.

p. **Preferred Provider Pharmacy or In-Network Pharmacy** – A Pharmacy that has entered into a Network Pharmacy Agreement with the Pharmacy Benefit Manager or its agent to legally dispense Prescription Drugs to you.

q. **Prescription** – A written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure and authorized by law to a pharmacist or dispensing Physician for a drug, or drug product to be dispensed.

r. **Prescription Drug** – A medication containing at least one Legend Drug that may not be dispensed under applicable State or Federal law without a Prescription, and/or insulin.
s. **Preventive Drug** – Drugs that are prescribed (1) for a Covered Person who has developed risk factors for a disease that has not yet become a health issue; (2) to prevent the reoccurrence of a disease from which the Covered Person has recovered; or (3) as part of preventive care procedures. Preventive Drug applies to HSA Value Option only. See [www.bcbst.com](http://www.bcbst.com) for complete list of Preventive Drugs. The Preventive Drug list is reviewed at least periodically by the P&T Committee.

t. **Prior Authorization Drugs** – Prescription Drugs that are only eligible for reimbursement after Prior Authorization as determined by the P&T Committee. These are subject to change at any time. The current list can be found at [www.bcbst.com](http://www.bcbst.com).

u. **Provider-Administered Specialty Drugs** – Medically Necessary and Appropriate Specialty Drugs for the treatment of disease, administered by a Practitioner or home health care agency and listed as a Provider-administered drug on the Specialty Drug List. Certain Specialty Drugs require Prior Authorization from BCBST, or benefits will be reduced or denied. Call customer service at the number listed on Your Covered Person ID card or check the web site ([www.bcbst.com](http://www.bcbst.com)) to find out which Specialty Drugs require Prior Authorization.

(i) **Covered Services** – Provider-administered Specialty Drugs as identified on the Specialty Drugs list (includes administration by a qualified provider). Check [www.bcbst.com](http://www.bcbst.com) to view the Specialty Drug list or call customer service at the number listed on Your Covered Person ID card with questions about a specific drug’s classification. Only those drugs listed as Provider-administered Specialty Drugs are Covered under this benefit.

(ii) **Exclusions** – Self-administered Specialty Drugs as identified on the Specialty Drug list, except as may be Covered in the Prescription Drug section.

(iii) FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

v. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee. These are subject to change at any time. The current list can be found at [www.bcbst.com](http://www.bcbst.com).

w. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Administrator’s Specialty Drugs list. Specialty Drugs are categorized as provider-administered or self-administered.

x. **Specialty Pharmacy** – A pharmacy that is designated as a Specialty Pharmacy by the Plan for Specialty Drug Prescription Orders or Refills.

y. **Step Therapy** – A form of Prior Authorization that begins drug therapy for a medical condition with the most cost-effective and safest drug therapy and progresses to alternate drugs only if necessary. Prescription Drugs subject to Step Therapy guidelines are; (1) used only for patients with certain conditions; (2) Covered only for patients who have failed to respond to, or have demonstrated an intolerance to, alternate Prescription Drugs, as supported by appropriate medical documentation; and (3) when used in conjunction with selected Prescription Drugs for the Treatment of your condition.

**Generic Drugs** – Prescription Drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If you have any questions, please contact your customer service representative by calling the toll-free number shown on the Covered Person ID Card.

**Important Note:** The Preferred, Prior Authorization, Specialty, Quantity Limitations, Generic, Limited Formulary, and HDHP Preventive Drug lists are subject to change. Current lists can be found at [www.bcbst.com](http://www.bcbst.com).
Additional Exclusions from Coverage

This Plan does not provide benefits for the following services, supplies or charges:

1. Services or supplies not listed under Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by BCBST.
3. Services or supplies that are Investigational in nature including, but not limited to (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) Treatments.
4. When more than one Treatment alternative exists, all are Medically Appropriate and Medically Necessary, and either would meet your needs, the Plan Administrator reserves the right to provide payment for the least expensive Covered Service alternative.
5. Illness or injury resulting from war and covered by (1) veteran’s benefit, or (2) other coverage for which you are legally entitled and that occurred before your Coverage began under this Plan.
6. Self-treatment or training.
7. Staff consultations required by Hospital or other facility rules.
8. Services that are free.
9. Services or supplies for the Treatment of work related illness or injury, regardless of the presence or absence of workers’ compensation coverage. This exclusion does not apply to injuries or illnesses resulting from self-employment by a sole-proprietor.
10. Personal, physical fitness, recreational and convenience items and services such as (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
11. Services that are not ordered, provided, or authorized by your Physician.
12. Services or supplies received before your effective date for Coverage with this Plan.
13. Services or supplies related to a Hospital confinement, received before your effective date for Coverage with this Plan.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
15. Telephone or email consultations, or charges for failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records.
16. Services for providing requested medical information or completing forms. The Plan will not charge you or your legal representative for statutorily required copying charges.
17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
20. Any service stated as a non-Covered Service exclusion, condition or limitation.
21. Charges for services performed by you or your spouse, or you or your spouse’s parent, sister, brother or child.
22. Any charges for handling fees.
23. Unless Covered under the Prescription Drug program, in this Plan, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.

24. Safety items or items to affect performance primarily in sports-related activities.

25. Services or supplies related to obesity, including gastric stapling, stomach by-pass surgery, lap ban, reversible surgical or other treatment of morbid obesity except when determined to be Medically Necessary and Appropriate. Consultation of dieting, exercise & drugs are excluded.

26. Cosmetic Services, except as appropriate per Medical Policy. This exclusion also applies to surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Cosmetic Services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins, and varicose veins, except as appropriate per Medical Policy; (12) piercing ears or other body parts; (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculectomy/abdominoplasty; (16) thighplasty; (17) brachioplasty; (18) Blepharoplasty and browplasty.

27. Genetic testing.

28. Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under this Plan.

29. Sperm preservation.

30. Treatment of sexual dysfunction, including but not limited to erectile dysfunction (such as Viagra), delayed ejaculation, anorgasmia and decreased libido unless determined by medical records to be organic in nature.

31. Services or supplies related to Treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Covered Person’s refusal to accept Treatment, medicines, or a course of Treatment that a Provider has recommended or has been determined to be Medically Necessary and Appropriate, including leaving an inpatient medical facility against the advice of the treating physician.

32. Services for planned maternity delivery in a home setting or location other than a licensed Hospital or birthing center.

33. Services or supplies related to complications of non-covered services.

34. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic Surgery is not Surgery to treat cleft palate.

35. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.

36. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
Schedule of Benefits — Value Option

To receive the maximum benefit from the Plan, make sure to use a Provider that is a member of the BlueCross BlueShield Provider Network.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN’S PAYMENT FOR COVERED SERVICES</th>
<th>Received from Network Providers</th>
<th>Received from Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Exams and Consultations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and treatment of injury or illness</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Maternity office visits</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Preventive – Children under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Well Woman Exam &amp; Wellcare Exam – Ages 6 and up&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Injections and Immunizations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections and allergy serum</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Immunizations, under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Immunizations, age 6 and above</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>All other injections</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Non-Routine Advanced Radiological Imaging Services&lt;sup&gt;4&lt;/sup&gt;</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>All Other Diagnostic Services for illness or injury</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Maternity care diagnostic services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Preventive Screenings, under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Preventive Mammogram, Bone Density, Cervical Cancer Screening, Prostate Screening and Colorectal Cancer Screening&lt;sup&gt;5&lt;/sup&gt;</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Other Wellcare Screenings, age 6 and above</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Preventive/Well Care Services</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Manual Breast Pump, limited to one per pregnancy</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Other office procedures, services or supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Surgery, including anesthesia&lt;sup&gt;6, 7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Services: Physical, speech, and occupational, therapy</td>
<td>100%</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Chiropractic and manipulative therapy</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Cardiac and pulmonary rehab</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>All Other Office services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>PLAN’S PAYMENT FOR COVERED SERVICES</td>
<td>Received from NHC or NHC Affiliate</td>
<td>Received from Network Providers</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Stays, including maternity stays</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Facility charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing or Rehab Facility stays</strong>&lt;sup&gt;8&lt;/sup&gt; (limited to 365 days per incident)</td>
<td>Facility charges</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Hospital Emergency Care Services</strong></td>
<td>Emergency Room Charges</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Non-Acute/Non-Emergency Use of Emergency Room</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Non-Routine Advanced Radiological Imaging Services&lt;sup&gt;4&lt;/sup&gt;</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>All Other Hospital Charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Practitioner Charges (Emergency)</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Practitioner Charges (Non-Acute/Non-Emergency)</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services / Outpatient Surgery</strong>&lt;sup&gt;6,7&lt;/sup&gt;</td>
<td>Facility charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Services and Outpatient Preventive Screenings</strong></td>
<td>Non-Routine Advanced Radiological Imaging Services&lt;sup&gt;4&lt;/sup&gt;</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>All other Diagnostic Services for illness/injury</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Maternity care diagnostic services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive Screenings, under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive Mammogram, Bone Density, Cervical Cancer, Prostate Screening and Colorectal Cancer Screening&lt;sup&gt;5&lt;/sup&gt;</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Wellcare Screenings, age 6 and above</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Manual Breast Pump, limited to one per pregnancy</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Other Outpatient Procedures, Services or Supplies</strong></td>
<td>Therapy Services: Physical, speech, and occupational therapy</td>
<td>100%</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Chiropractic and Manipulative Therapy</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Cardiac and Pulmonary Rehab</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment (DME)</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Orthotics and Prosthetics</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Supplies</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td>All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
### OTHER SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN'S PAYMENT FOR COVERED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Received from Network Providers¹</td>
</tr>
<tr>
<td>Received from NHC or an NHC Affiliate</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Home Health Care Services⁸</td>
<td>100%</td>
</tr>
<tr>
<td>Home Infusion Therapy⁸</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Care⁸</td>
<td>100%</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Supplies</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Telemedicine (PhysicianNow)</td>
<td>You pay a $38 charge per consultation</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN'S PAYMENT FOR COVERED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Received from Network Providers¹</td>
</tr>
<tr>
<td>Inpatient⁸</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after Deductible</td>
</tr>
</tbody>
</table>
Schedule of Benefits — HSA Value Option

A High Deductible Health Plan (HDHP) has a higher calendar year deductible than a typical health plan. Most services are covered only after you meet your Deductible. Some preventive care benefits may be paid before the Deductible is satisfied. When you are covered under a HDHP, you may qualify for tax savings by contributing to a Health Savings Account (HSA). An HSA is a custodial account used to pay for qualified medical expenses. HSAs are regulated by the Internal Revenue Service. An HSA is not part of your employer-sponsored and maintained benefits program.

To receive the maximum benefit from the Plan, make sure to use a Provider that is a member of the BlueCross BlueShield P Provider Network.

<table>
<thead>
<tr>
<th>SERVICES RECEIVED AT THE PRACTITIONER’S OFFICE</th>
<th>PLAN’S PAYMENT FOR COVERED SERVICES</th>
<th>Received from NHC or an NHC Affiliate</th>
<th>Received from Network Providers</th>
<th>Received from Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OFFICE EXAMS AND CONSULTATIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis and treatment of injury or illness</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity office visits</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive — Children under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Woman Exam &amp; Wellcare Exam – Ages 6 and up</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INJECTIONS AND IMMUNIZATIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections and allergy serum</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations, under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations, age 6 and above</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other injections</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES AND PREVENTIVE SCREENINGS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Routine Advanced Radiological Imaging Services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care diagnostic services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Screenings, under age 6</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Mammogram, Bone Density, Cervical Cancer Screening, Prostate Screening and Colorectal Cancer Screening</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Wellcare Screenings, age 6 and above</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive/Well Care Services</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually. Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy. Manual Breast Pump, limited to one per pregnancy. FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.</td>
<td>100% No Copayment</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER OFFICE PROCEDURES, SERVICES OR SUPPLIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Surgery, including anesthesia</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Services: Physical, speech, and occupational, therapy</td>
<td>100% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic and manipulative therapy</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac and pulmonary rehab</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DME</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Office services</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SERVICES RECEIVED AT A FACILITY

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN’S PAYMENT FOR COVERED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Received from NHC or an NHC Affiliate</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Stays, including maternity stays</strong>⁸</td>
<td>Facility charges</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
</tr>
<tr>
<td><strong>Skilled Nursing or Rehab Facility stays</strong> (limited to 365 days per incident)⁸</td>
<td>Facility charges</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
</tr>
<tr>
<td><strong>Hospital Emergency Care Services</strong></td>
<td>Emergency Room Charges</td>
</tr>
<tr>
<td></td>
<td>Non-Acute/Non-Emergency Use of Emergency Room</td>
</tr>
<tr>
<td></td>
<td>Non-Routine Advanced Radiological Imaging Services⁴</td>
</tr>
<tr>
<td></td>
<td>All Other Hospital Charges</td>
</tr>
<tr>
<td></td>
<td>Practitioner Charges (Emergency)</td>
</tr>
<tr>
<td></td>
<td>Practitioner Charges (Non-Acute/Non-Emergency)</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services / Outpatient Surgery</strong>⁶,⁷</td>
<td>Facility charges</td>
</tr>
<tr>
<td></td>
<td>Practitioner charges</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Services and Outpatient Preventive Screenings</strong></td>
<td>Non-Routine Advanced Radiological Imaging Services⁴</td>
</tr>
<tr>
<td></td>
<td>All other Diagnostic Services for illness/injury</td>
</tr>
<tr>
<td></td>
<td>Maternity care diagnostic services</td>
</tr>
<tr>
<td></td>
<td>Preventive Screenings, under age 6</td>
</tr>
<tr>
<td></td>
<td>Preventive Mammogram, Bone Density, Cervical Cancer, Prostate Screening and Colorectal Cancer Screening⁵</td>
</tr>
<tr>
<td></td>
<td>Other Wellcare Screenings, age 6 and above</td>
</tr>
<tr>
<td></td>
<td>Preventive/Well Care Services</td>
</tr>
<tr>
<td></td>
<td>Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.</td>
</tr>
<tr>
<td></td>
<td>Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.</td>
</tr>
<tr>
<td></td>
<td>Manual Breast Pump, limited to one per pregnancy</td>
</tr>
<tr>
<td></td>
<td>FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.</td>
</tr>
<tr>
<td><strong>Other Outpatient Procedures, Services or Supplies</strong></td>
<td>Therapy Services: Physical, speech, and occupational therapy</td>
</tr>
<tr>
<td></td>
<td>Chiropractic and Manipulative Therapy</td>
</tr>
<tr>
<td></td>
<td>Cardiac and Pulmonary Rehab</td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td></td>
<td>Orthotics and Prosthetics</td>
</tr>
<tr>
<td></td>
<td>Supplies</td>
</tr>
<tr>
<td></td>
<td>All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis</td>
</tr>
</tbody>
</table>
### OTHER SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN'S PAYMENT FOR COVERED SERVICES</th>
<th>Received from Network Providers ¹</th>
<th>Received from Out-of-Network Providers ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td></td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Home Health Care Services ³</td>
<td>100% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Home Infusion Therapy ³</td>
<td>100% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Hospice Care ³</td>
<td>100% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Supplies</td>
<td></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Telemedicine (PhysicianNow)</td>
<td></td>
<td>You pay a $38 charge per consultation</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### BEHAVIORAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN'S PAYMENT FOR COVERED SERVICES</th>
<th>Received from Network Providers ³</th>
<th>Received from Out-of-Network Providers ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient ³</td>
<td></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
# Organ Transplant Services

## Value & HSA Value Options

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>PLAN’S PAYMENT FOR COVERED SERVICES</th>
<th>Network Providers not in the Transplant Network&lt;sup&gt;9&lt;/sup&gt;</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Transplants Except Kidney&lt;sup&gt;9&lt;/sup&gt;</strong></td>
<td>In-Transplant Network Benefits</td>
<td>80% after Deductible, Out-of-Pocket Maximum applies</td>
<td>60% of Transplant Maximum Allowable Charge (TMAC), after Deductible, Out-of-Pocket Maximum applies; amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered</td>
</tr>
<tr>
<td><strong>Kidney Transplants&lt;sup&gt;9&lt;/sup&gt;</strong></td>
<td></td>
<td>80% after Deductible; Out-of-Pocket Maximum applies.</td>
<td>60% of Maximum Allowable Charge (MAC), after Deductible, Out-of-Pocket Maximum does not apply; amounts over MAC do not apply to the Out-of-Pocket and are not covered.</td>
</tr>
</tbody>
</table>
## Miscellaneous Limits

<table>
<thead>
<tr>
<th>Miscellaneous Limits</th>
<th>Value Option</th>
<th>HSA Value Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>In-Network Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Out-of-Network Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
<tr>
<td>Family</td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
</tbody>
</table>

1. Benefit percentages apply to BCBST Allowed Charge. In-Network level applies to services received from In-Network Providers and Non-Contracted Providers. The Covered Person is responsible for any amount exceeding the Allowed Amount for services received from Non-Contracted Providers.

2. Out-of-Network Provider benefit percentages apply to BCBST Allowed Amounts. The Covered Person is responsible for any amount exceeding the Allowed Amount for services received from Out-of-Network Providers.

3. Limited to one physical exam/annually exam per Calendar Year.

4. CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.

5. Age appropriate.

6. Some procedures may require Prior Authorization. Call the customer service number on your Health Plan ID Card to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced as described in #8.

7. Surgeries include invasive diagnostic services.

8. Prior Authorization required. Benefits will be reduced to 60% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 60% for In-Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. In-Network Providers in Tennessee are responsible for obtaining Prior Authorization; the Covered Person is not responsible for penalty when Tennessee In-Network Providers do not obtain Prior Authorization.

9. All organ Transplant Services require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call BCBST customer service before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may Balance Bill the Covered Person for amounts over the Transplant Maximum Allowable Charge (TMAC) not Covered by the Plan.
# Prescription Drug Program - Value Option

## PHARMACY PRESCRIPTION DRUG BENEFITS

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy</strong> (30 Day Supply)</td>
<td></td>
</tr>
<tr>
<td>Generic: $20.00 Co-Pay</td>
<td>You pay all costs, then file claim for reimbursement; Plan pays 60% after Deductible</td>
</tr>
<tr>
<td>Formulary: $35.00 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Brand: $55.00 Co-Pay</td>
<td></td>
</tr>
<tr>
<td><strong>Home Delivery¹ (90 Day Supply)</strong></td>
<td></td>
</tr>
<tr>
<td>Generic: $50.00 Co-Pay</td>
<td>N/A</td>
</tr>
<tr>
<td>Formulary: $87.50 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Brand: $137.50 Co-Pay</td>
<td></td>
</tr>
<tr>
<td><strong>Plus 90 Network¹ (90 Day Supply)</strong></td>
<td></td>
</tr>
<tr>
<td>Generic: $50.00 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Formulary: $87.50 Co-Pay</td>
<td></td>
</tr>
<tr>
<td>Brand: $137.50 Co-Pay</td>
<td></td>
</tr>
</tbody>
</table>

## SPECIALTY PHARMACY PRESCRIPTION DRUG BENEFITS

*Specialty Pharmacy Products are limited to a 30-day supply per Prescription*

<table>
<thead>
<tr>
<th>SPECIALTY PHARMACY NETWORK</th>
<th>OTHER NETWORK PHARMACIES</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Administered² (30 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic: $20.00 Co-Pay</td>
<td>You pay 100%</td>
<td></td>
</tr>
<tr>
<td>Formulary: $35.00 Co-Pay</td>
<td>(You pay all costs,</td>
<td></td>
</tr>
<tr>
<td>Brand: $55.00 Co-Pay</td>
<td>no out of network benefits)</td>
<td></td>
</tr>
<tr>
<td><strong>Provider-Administered³ (30 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Prescription Drug Program – HSA Value Option

### PHARMACY PRESCRIPTION DRUG BENEFITS

<table>
<thead>
<tr>
<th>Pharmacy (30 Day Supply)</th>
<th>Pharmacy Prescription Drug Benefits</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Drugs Except Preventive and Specialty Drugs</td>
<td>You pay the full discounted retail price at the time of purchase until deductible has been met, then: Plan pays 80% Coinsurance You pay 20% Coinsurance until out-of-pocket maximum is met</td>
<td></td>
<td>You pay all costs, then file claim for reimbursement; Plan pays 60% after Deductible</td>
</tr>
<tr>
<td>Home Delivery(^1) (90 Day Supply)</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Plus 90 Network(^1) (90 Day Supply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Drugs(^4) (30 Day Supply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Drugs(^4) Home Delivery(^1) &amp; Plus 90 Network(^1) (90 Day Supply)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SPECIALTY PHARMACY PRESCRIPTION DRUG BENEFITS

Specialty Pharmacy Products are limited to a 30-day supply per Prescription

<table>
<thead>
<tr>
<th>SPECIALTY PHARMACY</th>
<th>SPECIALTY PHARMACY NETWORK</th>
<th>OTHER NETWORK PHARMACIES</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Drugs Self-Administered(^4) (30 Day Supply)</td>
<td>Generic: $ 20.00 Co-Pay Formulary: $ 35.00 Co-Pay Brand: $ 55.00 Co-Pay</td>
<td></td>
<td>You pay 100% (You pay all costs, no out of network benefits)</td>
</tr>
<tr>
<td>Self-Administered(^2) (30 Day Supply)</td>
<td>You pay Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider-Administered(^3) (30 Day Supply)</td>
<td>You pay Deductible and Coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

\(^1\) Go to BCBST.com for further information.

\(^2\) As indicated on the BCBST Self-Administered Specialty Pharmacy Products list.

\(^3\) As indicated on the BCBST Provider-Administered Specialty Pharmacy Products list. These specialty medications are ordered by your doctor and administered in an office or outpatient setting.

\(^4\) As indicated on the BCBST Preventive Drug List.
Definitions

Defined terms are capitalized. When defined words are used in this Plan, they have the meaning set forth in this section.

1. **Actively At Work** – The performance of all of an Eligible Partner’s regular duties for the Employer on a regularly scheduled work day at the location where such duties are normally performed. Eligible Partners will be considered to be Actively at Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Eligible Partner was Actively at Work on the last regularly scheduled work day.

2. **Acute** – An illness or injury that is both severe and of short duration.

3. **Administrative Services Agreement or ASA** – The arrangements between National Health Corporation and BCBST, including any amendments, and any attachments to the ASA.

4. **Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

5. **Affiliated Employer** – This term refers to a business organization contracted with National Health Corporation or National Healthcare Corporation (“NHC”) or their agents for management services which is authorized to use this instrument to establish, reflect and continue the Health Benefit Plan documented hereby. That authorization is terminated immediately at the earlier of (1) National Health Corporation’s termination of this Plan or (2) at the conclusion of the management services agreement for which business purpose the business organization is affiliated with National Health Corporation or NHC. An Affiliated Employer shall be deemed to have irrevocably authorized National Health Corporation to adopt, amend and terminate the Plan with respect to that Affiliated Employer. All such actions on behalf of an Affiliated Employer shall be automatically deemed to have been made in writing by the Affiliated Employer which this instrument is adopted, amended or terminated, such documentation of adoption, amendment or terminated being itself represented by the management services contract. In this regard, National Health Corporation will be an agent for the Affiliated Employer. The Affiliated Employer shall have no power, right or authority to amend the Plan unilaterally.

6. **Allowed Amount/Maximum Allowable Charge** – The amount that BCBST or BCBS, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan’s contract with a Network Provider for Covered Services rendered by that Provider or the amount payable based on the Plan’s fee schedule for the Covered Services for Services rendered by Out-of-Network Providers.

7. **Annual Enrollment Date** – This term is defined in the section on Enrollment.

8. **Annual Enrollment Period** – This term is defined in the section on Enrollment.

9. **Annual Enrollment Period** – Annual opportunity for Eligible Partners or otherwise eligible person, as designated by the Plan Administrator, to enroll or change Plan options in the Health Benefit Plan during the month of October or November each year. The Coverage begins immediately on the following January 1.

10. **Balance Billing** – This means when a Provider bills the Covered Person for the difference between the Provider’s charge and the Allowed Amount. For example, if a Provider’s charge is $100 and the Allowed Amount is $70, the Provider may bill the Covered Person (and not the Plan) for the remaining $30.

11. **Behavioral Health Services** – Any services or supplies that are Medically Necessary and Appropriate to treat a mental or nervous condition, alcoholism, chemical dependence, drug abuse or drug addiction.
12. **Beneficiary** – A Beneficiary is an individual who has Coverage under the Health Benefit Plan through a Covered Person.

13. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Allowed Amount for services.

14. **BlueCard PPO Participating Provider** – A physician, Hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Association (BlueCard PPO) Plans and/or Authorized by the Plan to provide Covered Services to Covered Persons.

15. **Break in Service** – A period of at least 13 full consecutive Weeks during which the Partner has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Partner has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).

16. **Calendar Year** – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st of that same year.

17. **Care Management** – A program that promotes quality and cost effective coordination of care for Covered Persons with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.

18. **Child** – An individual who is any of the following: (i) a natural or adopted child of an Eligible Partner (ii) a child for whom the Eligible Partner is the legal guardian (iii) a step child of an Eligible Partner. A step-child is a child of the Partner’s current Spouse.


20. **Covered Dependent** – An Eligible Dependent enrolled in the Plan by a Covered Partner in accordance with the Plan’s enrollment procedures.

21. **Covered Partner** – An Eligible Partner that has enrolled for coverage in the Plan in accordance with the Plan’s enrollment procedures.

22. **Covered Person** – collectively, a Covered Dependent and Covered Partner.

23. **Claim Determination** – This term is defined in the Coordination of Benefits section of this Plan. It is that period of time in which a benefit claim must be submitted in order to be paid.

24. **Clinical Trials** – Studies performed with human subjects to test new drugs or combinations of drugs, new approaches to surgery or radiotherapy or procedures to improve the diagnosis of disease and the quality of life of the patient. A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious and effective. Routine patient care associated with an approved Clinical Trial will be Covered under the Plan’s benefits in accordance with the Plan’s medical policies and procedures.

25. **Coinsurance** – The amount, stated as a percentage of the Allowed Amount for a Covered Service that is the Covered Person’s responsibility during the Calendar Year after any Deductible is satisfied by you. The Coinsurance percentage is calculated as 100%, minus the percentage payment of the Allowed Amount as specified in the Schedule of Benefits.

In addition to the Coinsurance percentage, you are responsible for the difference between the Billed Charges and the Allowed Amount for Covered Services if the Billed Charges of an Out-of-Network Provider are more than the Allowed Amount for such Services. This difference is also called Balance Billing.
26. **Complications of Pregnancy** – Conditions due to pregnancy, labor or delivery requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; non-emergency caesarian sections; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

27. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.

28. **Coordination of Benefits or COB** – This term describes whether this Plan or another Health Care Arrangement is primarily or secondarily liable for the payment of Medically Necessary and Medically Appropriate Services of a Covered Person.

29. **Copayment** – The fixed dollar amount specified in the Schedule of Benefits, that you are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time you receive those Covered Services. Copayments paid during a Calendar Year do not accumulate toward meeting the annual Deductible. Copayments paid during a Calendar Year do accumulate toward meeting the annual Out-of-Pocket Maximum.

30. **Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. The Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.

31. **Coverage** – This term refers to the rights to benefits described herein of Eligible Partners and Eligible Dependents after proper enrollment and arrangement for payment of premiums therefore as of the effective date of the commencement of those benefit rights and for the duration of such rights.

32. **Covered Dependent** – A Partner’s Eligible Covered Family Member who (1) meets the eligibility requirements of this Plan, (2) has been enrolled for Coverage, and (3) for whom arrangement has been made for the Plan to receive the applicable payment of the premium for Coverage by payroll deduction.

33. **Covered Family Members** – A Partner and his or her Covered Dependents.

34. **Covered Health Services, Coverage or Covered** – Those Medically Necessary and Appropriate services and supplies that are set forth in this Plan. Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan.

35. **Covered Partner** – An eligible Employee who is covered by this Plan.

36. **Covered Person** – A Covered Person is a Full-Time Partner or IPAR Partner and their Eligible Dependents and Beneficiaries while Covered by the Health Benefit Plan. If you are a Covered Person, this Plan may also use the lowercase term “you” to refer to you as a Covered Person in this Plan and only Covered Persons are included in the terms “you” or “your.”

37. **Covered Person Payment** – The dollar amounts for Covered Services that you are responsible for as set forth in the Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The Plan Administrator may require proof that you have made any required Premium.

38. **Custodial Care** – Any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.
39. **Deductible** – The dollar amount, specified in the Schedule of Benefits, that you must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for services. There is one Deductible amount for In-Network Providers and Out-of-Network Providers combined. The Deductible will apply to the Individual Out-of-Pocket and Family Out-of-Pocket Maximum(s). Copayments and any Balance Billing (that is, the difference between Billed Charges and the Allowed Amount) are not considered when determining if you have satisfied a Deductible.

40. **Durable Medical Equipment** – Equipment and supplies ordered by a Health Care Provider for everyday or extended use.

41. **Eligibility Period** – The initial period of time following the date of employment during which a Partner may apply for Coverage. If the Partner does not apply for Coverage during this Initial Eligibility Period, the Partner and any applicable Dependents will be considered a Late Enrollee.

42. **Eligible Dependent** – This term is defined in the section on Eligibility.

43. **Eligible Ongoing Partner Stability Period** – The 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan’s Standard Measurement Period.

44. **Eligible Partner** – This term is defined in the section on Eligibility.

45. **Emergency Medical Condition** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in
   a. serious impairment of bodily functions,
   b. serious dysfunction of any bodily organ or part, or
   c. placing a prudent layperson’s health in serious jeopardy.

Examples of Emergency conditions include: (1) severe chest pain, (2) uncontrollable bleeding, or (3) unconsciousness.

46. **Emergency Medical Transportation** – Ambulance services for an Emergency Medical Condition.

47. **Emergency Room Care** – Emergency Services received in an emergency room.

48. **Emergency Services** – Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency Medical Condition.

49. **Employee** – A common law employee working for National Health Corporation, NHC or an Affiliated Employer. The term “Employee” refers to a Partner of (1) National Health Corporation, (2) National Healthcare Corporation ("NHC"), or (3) an Affiliated Employer.

50. **Employer** – The term “Employer” refers to any of the following: (1) National Health Corporation, (2) National Healthcare Corporation ("NHC"), or (3) an Affiliated Employer.

51. **Enrollment Form** – A form or application that must be completed in full by the Eligible Partner before he or she will be considered for Coverage under the Plan. The form or application may be in paper form, or electronic, as determined by the Plan Administrator.


53. **Excluded Services** – Health care services that this Plan does not pay for or services which are not covered.

54. **Full-Time Partner** – An employment status which requires the Partner to be regularly scheduled for at least 37½ hours of work each week.

55. **Grievance** – This term refers to a complaint a Covered Person communicates to the Plan Administrator regarding a denied benefit claim.
56. **Health Benefit Plan** – This term refers to this Health Benefit Plan sponsored by National Health Corporation and any Affiliated Employer authorized or contracted with National Health Corporation to document its own health care plan under this instrument.

57. **Health Care Arrangement** – This term refers to health coverage under another health care arrangement as defined in the *Coordination of Benefits* section of this Plan.

58. **High Deductible Health Plan** – A qualified High Deductible Health Plan (HDHP) is a type of health insurance plan with lower premiums and higher deductibles than traditional health insurance plans. Most services are covered only after you meet your deductible. Some preventive care benefits may be paid before the deductible is satisfied.

59. **HIPAA** – This term is an abbreviation for the Health Insurance Portability and Accountability Act of 1996.

60. **Home Health Care** – Health Care Services a person receives at home.

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

62. **Hospital** – An institution that engages in providing impatient diagnosis and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons. The facility must meet ALL the following requirements:
   a. Be licensed as a hospital to provide the above-described in the State in which it is located,
   b. Charge for the services and supplies it provides,
   c. Keep a medical record of each patient,
   d. Provide an ongoing quality assurance program with reviews by medical physicians or orthopedic physicians licensed by the State in which the facility is located,
   e. Be supervised 24 hours a day by a staff of either medical physicians or orthopedic physicians licensed by the State in which the facility is located, and
   f. Provide 24 hour a day skilled nursing services by registered nurses licensed by the State in which the facility is located.

63. **Hospital Outpatient Care** – Hospital services that usually do not require an overnight stay.

64. **Hospital Services** – Covered Services that are Medically Necessary and Appropriate to be provided by an Acute care Hospital.

65. **Hospitalization** – When you are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

66. **Hours of Service** – Any hour for which the Partner is paid or entitled to payment for performance of services for the Employer and any hour for which the Partner is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R 2530.200b-2(a)(i):
   a. Vacation
   b. Holiday
   c. Illness or incapacity to the extent such coverage is provided by the Employer
   d. Layoff
   e. Jury duty
   f. Military duty or leave of absence
67. **Identification Card (ID Card, Health Plan ID Card or Covered Person ID Card)** – Card provided to Covered Persons that identifies them as Covered by this Health Benefit Plan and provides basic information about their Coverage. Although such cards do not guarantee eligibility for medical care benefits at any given time, they outline procedures for Providers to allow verifying that a patient has health Coverage under this Plan.

68. **Incapacitated Child** – This term refers to an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excludes mental illness) or physical handicap; and (2) chiefly dependent upon the Covered Partner or Covered Partner’s spouse for economic support and maintenance.

   a. If the child reaches the age while Covered under this Plan on which date Coverage would otherwise cease, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.
   
   b. We may ask you to furnish proof of the incapacity and dependency upon enrollment. We may ask for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

69. **Initial Enrollment Date** – This term is defined in the section on **Enrollment**

70. **Initial Enrollment Period** – This term is defined in the section on **Enrollment**.

71. **Initial Measurement Period** – The twelve (12) Calendar Month period beginning on the first day of the Calendar Month coinciding with or next following the Employee’s Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

72. **In-Network Benefit** – The Plan’s payment level that applies to Covered Services received from an In-Network Provider. See the Schedule of Benefits for payment levels.

73. **In-Network Coinsurance** – The percentage you pay of the Allowed Amount for Covered Services to In-Network Providers who contract with BCBS or BCBST. In-Network Coinsurance usually costs less than Out-of-Network Coinsurance.

74. **In-Network Copayment** – The fixed amount you pay for Covered Services to In-Network Providers who contract with BCBS or BCBST. In-Network Copayments usually are less than Out-of-Network Copayments.

75. **In-Network Provider/Preferred Provider** – A Provider who has contracted with BCBS or BCBST to provide access to benefits to Covered Persons at specified rates. Such In-Network Providers may be referred to as BlueCard PPO Participating Providers, Preferred Provider, Network Hospitals, and Preferred Transplant Network Providers, or similar Network Providers. A Provider’s status as an In-Network Provider can and does change. BCBS or BCBST reserves the right to change a Provider’s status.

76. **In-Transplant Network Provider** – A facility or Hospital that has contracted with BCBS or BCBST to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this Plan. For example, some Hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network Provider is a Preferred Provider when performing BCBS or BCBST contracted transplant procedures in accordance with the requirements of this Plan.

77. **Investigational Services** – The definition of “investigational” is based on the BlueCross and BlueShield of Tennessee’s technology evaluation criteria. Any technology that fails to meet ALL of the following four criteria is considered to be investigational.

   a. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:
(i) This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.

(ii) Any approval that is granted as an interim step in the U.S. Food and Drug Administration’s or any other federal governmental body’s regulatory process is not sufficient.

b. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:

   (i) The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   (ii) The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

c. The technology must improve the net health outcome, as demonstrated by:

   (i) The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

d. The improvement must be attainable outside the investigational settings, as demonstrated by:

   (i) In reviewing the criteria above, the Medical Policy Panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

The Medical Director has the authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

a. your medical records;

b. the protocol(s) under which proposed service or supply is to be delivered;

c. any consent document that you have executed or will be asked to execute, in order to receive the proposed service or supply;

d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by you;

e. regulations and other official publications issued by the FDA and HHS;

f. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Covered Persons requiring non-Investigational Services; or

g. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

The Medical Director’s decision is a decision on a benefit claim subject to the ERISA Benefit Claim Grievance Procedures section of this Plan, and a denial of a claim by the Medical Director may be appealed under that section.

78. IPAR – A Part-Time employment status with a work schedule which requires the Partner to be regularly scheduled 30 hours or more, but less than 37½ hours, of work each week. IPAR status allows participation in the Health Benefit Plan.
79. **Late Enrollee** – An Eligible Partner or Eligible Dependent who fails to apply for Coverage within: (1) his or her Initial Enrollment Period, or (2) any subsequent Annual Enrollment Period.

80. **Maintenance Care** – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services (1) fail to contribute toward cure, (2) fail to improve unassisted clinical function, (3) fail to significantly improve health, and (4) are indefinite or long-term in nature.

81. **Measurement Period** – The Initial Measurement Period or the Standard Measurement Period, as applicable.

82. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq).

83. **Medical Director** – The Physician designated by BCBST, or that Physician’s designee, who is responsible for the establishment and maintenance of the Plan’s medical management programs, including its Prior Authorization programs.

84. **Medical Policy** – This term is defined in the Prior Authorization, Case Management, Medical Policy and Patient Safety section.

85. **Medically Appropriate** – Services that have been determined by the Medical Director to be of value in the care of a specific Covered Person. To be Medically Appropriate, a service must:
   a. be Medically Necessary;
   b. be used to diagnose or treat a Covered Person’s condition caused by disease, injury or congenital malformation;
   c. be consistent with current standards of good medical practice for the Covered Person’s medical condition;
   d. be provided in the most appropriate site and at the most appropriate level of service for the Covered Person’s medical condition;
   e. on an ongoing basis, have a reasonable probability of
      (ii) correcting a significant congenital malformation or disfigurement caused by disease or injury;
      (iii) preventing significant malformation or disease;
      (iv) substantially improving a life sustaining bodily function impaired by disease or injury;
   f. not be provided solely to improve a Covered Person’s condition beyond normal variations in individual development and aging including
      (i) comfort measures in the absence of disease or injury;
      (ii) Cosmetic Service; and
      (iii) not be for the sole convenience of the Provider, Covered Person or Covered Person’s family.

86. **Medically Necessary and Appropriate** – Services that are both Medically Necessary and Medically Appropriate.

87. **Medically Necessary or Medical Necessity** – “Medically Necessary” means procedures, Treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are
   a. in accordance with generally accepted standards of medical practice;
   b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease;
c. not primarily for the convenience of the patient, physician or other health care provider; and
d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

88. Medicare – Insurance as is provided in Title XVIII of the Social Security Act, as amended.

89. Network or In-Network – This term describes the group of medical care practitioners and facilities which have contracts with BCBS or BCBST to provide health care services.

90. Non-Contracted Provider – A Provider that renders Covered Services to a Covered Person, in the situation where BCBS or BCBST has not contracted with that Provider type to provide those Covered Services. A Provider’s status as a Non-Contracted Provider can and does change. BCBS or BCBST reserves the right to change a Provider’s status.

91. Non-Preferred Provider/Out-of-Network Provider – Any Provider who is an eligible Provider type but who does not hold a contract with BCBS or BCBST to provide Covered Services.

92. Non-Routine Advanced Radiological Imaging – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

93. Oral Appliance – This term refers to a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.


95. Out-of-Network Copayments – A fixed amount you pay for Covered Services to Out-of-Network Providers who do not contract with BCBS or BCBST. Out-of-Network Provider Copayments usually cost more than In-Network Providers.

96. Out-of-Network Provider/Non-Preferred Provider – Any Provider who is an eligible Provider type but who does not hold a contract with BCBS or BCBST to provide Covered Services.

97. Out-of-Pocket Maximum – The total dollar amount, as stated in the Schedule of Benefits, that a Covered Person must incur and pay for Covered Services during the Calendar Year, including Deductible and Coinsurance.

Penalties, Out-of-Network Provider Coinsurance and any balance of charges (the difference between Balanced Billing Charges and the Allowed Amount) are not considered when determining if the Out-of-Pocket Maximum has been satisfied.

When the Out-of-Pocket Maximum is satisfied, 100% of available benefits is payable for other Covered Services incurred by the Covered Person during the remainder of that Calendar Year, excluding Penalties, Out-of-Network Provider Coinsurance and any balance of charges (the difference between Balance Billing Charges and the Allowed Amount).

98. Partner – A Partner is an Employee.

99. Part-Time – An employment status indicating less than full time for an indefinite period of time and used in this Plan to describe regularly scheduled 29 hours or less of work each week.
100. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides, reimburses or pays for Covered Person’s Covered health care benefits.

101. **Penalty/Penalties** – Additional Covered Person Payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in the Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in payment for Covered Services.

102. **Periodic Health Screening** – An assessment of patient’s health status at intervals established by the Medical Director for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
   a. a complete history or interval update of the patient’s history and a review of the systems; and
   b. a physical examination of all major organ systems, and screening tests per the Medical Directory’s established Policy.

103. **Physician** – A licensed physician (M.D. – Medical Doctor or O.D. – Doctor of Osteopathic Medicine) who provides or coordinates health care services.

104. **Physician Services** – Health care services provided by a physician.

105. **Plan** – This health care benefit arrangement entitled *National Health Corporation Health Benefit Plan*.

106. **Plan Administrator** – The Plan Administrator of this Health Benefit Plan is National Health Corporation.

107. **Practitioner** – A person licensed by the State to provide medical services.

108. **Pre-Authorization/Prior Authorization** – A review conducted by BCBST prior to the delivery of certain services, to determine if such services will be considered Covered Services.

109. **Preferred Provider/In-Network Provider** – A Provider who has contracted with BCBS or BCBST to provide access to benefits to Covered Persons at specified rates. Such Preferred Providers may be referred to as BlueCard PPO Participating Providers, Network Hospitals, and Preferred Transplant Network Providers, or similar Network Providers. A Provider’s status as a Preferred Provider can and does change. BCBS or BCBST reserves the right to change a Provider’s status.

110. **Prescription Drug** – A medication containing at least one Legend Drug that may not be dispensed under applicable State or Federal law without a Prescription, and/or insulin.

111. **Primary Care Provider** – A physician, nurse practitioner, clinical nurse specialist or physician assistant allowed under State law who provides, coordinates or helps a patient access a range of health care services for that patient.

112. **Primary Plan** – Either this Plan or another Health Care Arrangement which, under the Coordination of Benefits (COB) rules of this Plan, is first liable to pay for covered health services before the other is liable.

113. **Prior Authorization/Pre-Authorization** – A review conducted by BCBST prior to the delivery of certain services, to determine if such services will be considered Covered Services.

114. **Provider** – A person or entity engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

115. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or State administrative agency that creates or recognizes the existence of a child’s right to receive Coverage benefits for which a Covered Partner is eligible under the Plan. Such order shall identify the Covered Partner and each such child by name and last known mailing address, give a description of the type and duration of Coverage to be provided to each child, and specifically identify this Plan as to which such order applies.
116. **Qualifying Events** – This term is defined in the *Continuation of Coverage Rights Under COBRA* section of this Plan.

117. **Qualifying Partner Stability Period** – The 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Partner’s anniversary date.

118. **Reasonable and Customary or Usual, Reasonable and Customary (UCR)** – The charge which is the usual charge made to persons in the same general locality for identical services or supplies. The UCR is sometimes used to determine the Allowed Amount.

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

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

121. **Secondary Plan** – Either this Plan or another Health Care Arrangement which is not the Primary Plan.

122. **Self-Insured** – A medical benefit plan established by an Employer that directly assumes the functions, responsibilities and liabilities of Plan Coverage.

123. **Skilled Nursing Care** – Covered services from licensed nurses in your own home or in a nursing home. Skilled Nursing Care services are from technicians and therapists in your own home or in a nursing home.

124. **Special Enrollment Period** – This term is defined, together with its causes, appears in the *Enrollment* section of this Plan.

125. **Special Unpaid Leave of Absence** – Any of the following types of unpaid leaves of absence that do not otherwise constitute a Break in Service:
   a. Leave protected by the Family and Medical Leave Act
   b. Leave protected by the Uniformed Services Employment and Reemployment Rights Act or
   c. Jury Duty (as reasonably defined by the Employer).

126. **Specialist** – A Physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or test certain types of symptoms and conditions. A Non-Physician Specialist is a Provider who has more training in a specific area of health care.

127. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Specialty Drugs list which you may find at www.bcbst.com. Specialty Drugs are categorized as provider-administered or self-administered.

128. **Sponsor** – The Sponsor of the Plan is National Health Corporation.

129. **Spouse** – A individual to whom the Partner is legally married in accordance with the Internal Revenue Code. A Spouse does not include a common law spouse.

130. **Standard Measurement Period** – The 12-month period that begins each November 1 and ends October 31; however, the first Standard Measurement Period begins January 1, 2014 and ends October 31, 2014. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Partners on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

131. **Surgery or Surgical Procedure** – Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body’s skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.
132. **Termination for Cause** – This term is defined in the Termination of Coverage section of this Plan.

133. **Totally Disabled or Total Disability** – this term applies to any of the following:
   a. A Covered Partner who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease.
   b. A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.
   c. A determination by the United States Social Security Administration that you are eligible for Social Security disability benefits.

134. **Transplant Case Management** – The Case Management department of BCBST that must Pre-Authorize your Organ Transplant Services.

135. **Transplant Maximum Allowable Charge (TMAC)** – The amount that BCBST or BCBS, in its sole discretion, has determined to be the maximum amount payable for Covered Services for Organ Transplants. Each type of organ Transplant has a separate TMAC.

136. **Transplant Network** – A network of Hospitals and facilities, each of which has agreed with BCBS or BCBST to perform specific organ Transplants. For example, some Hospitals might contract to perform heart Transplants, but not liver Transplants.

137. **Transplant Service or Services** – Medically Necessary and Appropriate services listed as Covered under the Organ Transplant Services section in this Plan.

138. **Treatment** – Any medically recognized service, procedure or medication used for the evaluation, the cure, the improvement or the maintenance of health care for an illness, disease, injury or pathological conditions.

139. **U.S. Preventive Services Task Force (USPSTF)** – The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine. The panel is composed of primary care providers such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists.

   The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of “Recommendation Statements.”

140. **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.

141. **Waiting Period** – The Waiting Period is the period following a person’s becoming an Eligible Partner before Coverage becomes effective.

142. **Week** – Any seven (7) consecutive calendar-day period.

143. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children to age 16.

144. **Well Woman Exam** – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.
Statement of ERISA Rights

The Employer Retirement Income Security Act of 1974 (ERISA) entitles you, as a Covered Person of this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator and at other specified locations, such as worksites, all Plan documents and copies of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Benefit Administration.

2. Obtain copies of all Plan documents and other Plan information upon written request to Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Receive a summary of the Plan’s annual financial report. The Plan is required by law to furnish each Covered Person with a copy of this summary annual report.

4. Continue your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You will have to pay for such Coverage. Review the COBRA Coverage section of this Plan for the rules governing your continuation Coverage rights.

In addition to creating rights for Eligible Partners and Eligible Dependents, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate the Plan are called “fiduciaries” of the Plan and have a duty to do so prudently and in the interest of Plan Covered Persons and Beneficiaries. No one, including the Employer, may fire Eligible Partners or otherwise discriminate against Eligible Partners in any way to prevent Eligible Partners from obtaining a benefit under this Plan or exercising rights under ERISA. If your claim or arrangement for benefits is denied, in whole or in part, you have a right to know why this was done and to obtain copies of documents relating to the decision without charge. You have the right to have the Plan Administrator review your claim and reconsider it.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a State or Federal court. Also, if you disagree with Plan Administrator’s decision (or lack thereof) concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If the Plan fiduciaries misuses money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, it may order you to pay these expenses if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Newborns’ and Mothers’ Health Protection Act

Your Plan provides maternity and newborn infant Coverage. This Plan does not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan does not prohibit the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours where applicable). In any case the Plan may not, under Federal law, require that a Provider obtain Prior Authorization to prescribe a length of stay not in excess of the above periods. Please refer to the Covered Services section of this Plan for further details.

Women’s Health and Cancer Rights Act of 1998

Covered Persons who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to Coverage for

1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the Covered Services section of this Plan for details.

Mental Health Parity Act

Under the Plan, the financial requirements and Treatment limitations imposed on mental health and substance abuse disorder benefits are not more restrictive than the predominate financial requirements and Treatment limitations that apply to substantially all medical and surgical benefits. The Plan’s criteria for Medical Necessity determination with respect to mental health or substance abuse disorder are available upon request free of charge.

Uniformed Services Employment and Reemployment Rights Act of 1994

If you leave your job here to perform military service, you have the right to elect to continue your existing Coverage under this Plan for you and your Eligible dependents for up to 24 months while you are in the military.

Even if you do not elect to continue your Coverage during your military service, you have the right to be reinstated in this Plan when you are reemployed. Benefits are not payable for military service connected illness or injury.
# Health Benefit Plan General Information

<table>
<thead>
<tr>
<th><strong>PLAN NAME &amp; IDENTIFICATION NUMBER</strong></th>
<th>Health Benefit Plan</th>
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</thead>
<tbody>
<tr>
<td><strong>EMPLOYER IDENTIFICATION NUMBER</strong></td>
<td>62-1294263</td>
</tr>
<tr>
<td><strong>PLAN NUMBER</strong></td>
<td>503</td>
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</table>
| **PLAN SPONSOR**                      | National Health Corporation  
100 Vine Street  
Murfreesboro, TN  37130  
(and affiliates) |
| **PLAN ADMINISTRATOR**                | National Health Corporation  
100 Vine Street  
Murfreesboro, TN  37130  
615-890-2020 |
| **TYPE PLAN**                         | Employee Welfare Benefit Plan |
| **PLAN YEAR**                         | January 1 through December 31 |
| **AGENT FOR SERVICE OF LEGAL PROCESS**| John K. Lines  
100 Vine Street  
Murfreesboro, TN  37130  
615-890-2020  
(and the Plan Administrator at this same address) |
Statute of Limitations

In no event will a claimant or any other person be entitled to challenge a decision of the Plan Administrator in court or in any other administrative proceeding unless and until the claim and appeal procedures described within this Summary Plan Description have been complied with and exhausted. In no event may a claimant challenge the Plan Administrator’s decision (including a deemed decision) upon appeal in any court or governmental proceeding after 12 months from the date of the Plan Administrator’s decision (including a deemed decision) of the appeal.

In no event may a Partner or any person bring any other claim for relief against the Plan Administrator, the Plan and/or NHC with respect to the Plan in court or in any other administrative proceeding more than 12 months after the claim arose.

Forum for Disputes

An employee shall only bring an action in connection with the Plan in the United States District Court for the Middle District of Tennessee.

Amendment / Termination

The Plan may be amended in any respect or terminated at any time, retroactively or otherwise, by NHC. The Plan may be amended by written amendment executed by an authorized officer of NHC or by any other process that clearly indicates the authorized officer has approved the amendment.

No Assignment

Your benefits under this Plan are not subject to anticipation, alienation, pledge, sale, transfer, assignment, garnishment, attachment, execution, or encumbrance of any kind and any attempt to do so will be void, except as required by law.

No Representations Contrary to the Plan

No verbal or written representations contrary to the terms of the Plan and its written amendments are binding upon the Plan, the Plan Administrator, NCH or an Affiliate.

No Employment Rights

The Plan does not confer employment rights upon any person. No person will be entitled, by virtue of the Plan, to remain in the NHC’s employment, and nothing in the Plan restricts NHC’s right to terminate any person’s employment at any time.

Plan Funding

Benefits are paid first with available plan assets, including but not limited to participant contributions then any deficiencies may be funded by NHC, in its sole discretion, from its general assets. The Plan is responsible for paying all plan administration expenses of the Plan.

Applicable Law

The laws of the State of Tennessee govern the Plan, except where ERISA preempts the application of such laws.
Dental Insurance Plan

If you are regularly scheduled 20 hours or more each week, you are eligible for the NHC Dental Insurance Plan.

You are eligible for Dental Insurance even if you are not enrolled in the company-sponsored health plan.

Dental coverage is available for your spouse and dependents; however, you must be enrolled for them to be eligible.

You are responsible for the total Dental Insurance premium. It is payroll deducted on the first pay period of every month. The premiums are automatically tax-sheltered unless the plan is instructed to do otherwise.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

Remember, that the only opportunity to make a change to the available coverage is on January 1 of each year, unless you experience a change in status as defined in this Handbook. Also, changes to your current dental plan option may only be made during annual enrollment (normally November with a January 1 effective date).

Your dental coverage will end on the last day of the month of your termination of employment, status change or ineligibility date. Your coverage may be continued at your personal expense through COBRA (continuation of coverage). Coverage may continue through COBRA for up to 18 months, 29 months or 36 months depending on the original reason for COBRA eligibility.
## Dental Insurance

### PLAN HIGHLIGHTS

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>You must be regularly working 20 hours or more per week to participate.</th>
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</thead>
<tbody>
<tr>
<td>Plan Benefit:</td>
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<tr>
<td>Type 1 Procedures</td>
<td>100%</td>
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<tr>
<td>Type 2 Procedures</td>
<td>80%</td>
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<tr>
<td>Type 3 Procedures</td>
<td>50%</td>
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<tr>
<td>Deductible</td>
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<tr>
<td>Type 2</td>
<td>$50/Calendar Year Type 2 &amp; 3, Waived Type 1, No Family Maximum</td>
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<tr>
<td>Type 3</td>
<td>$50/Calendar Year Type 2 &amp; 3, Waived Type 1, No Family Maximum</td>
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<tr>
<td>Maximum (per person)</td>
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<td>$1,200 per calendar year</td>
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<tr>
<td>Type 2</td>
<td>$1,200 per calendar year</td>
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<td>Type 3</td>
<td></td>
</tr>
<tr>
<td>Allowance</td>
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<tr>
<td>Type 2</td>
<td>75th Usual &amp; Customary</td>
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<tr>
<td>Type 3</td>
<td>Maximum Covered Expense</td>
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<td>Waiting Period</td>
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<td>Type 2</td>
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<tr>
<td>Type 3</td>
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<tr>
<td>Type 2</td>
<td>Included</td>
</tr>
<tr>
<td>Type 3</td>
<td>Included</td>
</tr>
</tbody>
</table>

### LOW PLAN SAMPLE SCHEDULE

| Type 1 Procedures | Periodic Oral Exam | Prophylaxis (cleanings) age 14 and over | $21 | $47 |
| Type 2 Procedures | Amalgam – One Surface, permanent | Resin – One Surface, anterior | Single tooth extraction | $37 | $40 | $37 |
| Type 3 Procedures | Crown – full cast, predominately base metal | Crown – Porcelain fused to precious metal | Root Canal, Molar | $242 | $332 | $408 |

To locate a provider in your area, go to [www.ameritas.com](http://www.ameritas.com) or call 1-800-487-5553
Eligibility

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

NOTE: You will be required to pay a Premium for the coverage you elect.

A. Eligible Partner Defined

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

1. You are an Employee who is eligible to work in the United States legally as confirmed by the USCIS (United States Citizenship Immigration Services) I-9;
2. You are designated by your Employer as a Full-Time, IPAR or Part-Time Partner regularly scheduled 20 hours or more each week.

B. Eligible Dependents Defined

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

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

C. Incapacitated Children

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

1. You provide written notice of the incapacity prior to the date the child turns age 26; and
2. You provide sufficient documentation supporting the Child’s incapacity.
3. A child is considered “incapacitated” if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

D. Proof of Eligibility and Other Information

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

E. Appeals

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

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent’s enrollment in the Plan is conditional pending the Plan Administrator’s timely receipt of the requested information regarding your dependents.

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

A. Initial Enrollment Period

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

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

B. Annual Enrollment Period

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

C. Changes In Coverage

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

First, your election will automatically terminate if you terminate employment or lose eligibility under the Plan, except as otherwise described in the “Coverage Termination” section.

NOTE: You are still required to provide timely notice of an event that result in loss of eligibility (e.g. divorce).

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

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

D. Status Changes

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

1. Marital Status. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. Change in Number of Dependents. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with you for adoption, or death of a Dependent. See also “Special Enrollment” below.
3. **Change in Dependent Eligibility.** Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.

4. **Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan.** You, or your Eligible Dependent experiences a change in employment status due to one of the following events:
   a. Termination or commencement of employment;
   b. A strike or lockout;
   c. Commencement or return from an unpaid leave of absence;
   d. A change in employment status, e.g., unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
   e. A change in worksite; and
   f. Any other change in employment status that affects benefits eligibility.

5. **Change in Residence that Affects Eligibility.** You or your eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for dental coverage or becomes eligible for dental coverage.

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

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

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

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

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

E. **Cost or Coverage Changes**

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

1. **Change in Cost of Coverage.** If Your share of the premium for dental coverage you elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another plan option may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your premiums will automatically be adjusted to reflect the insignificant cost.
change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. **Entitlement to or Loss of Entitlement to Medicare or Medicaid.** You or your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. **Governmental Plan Coverage Change.** You or your Eligible Dependent loses coverage under a group dental plan sponsored by a governmental or educational institution.

4. **New Benefit Option Added.** You are eligible for a new or improved dental coverage option.

5. **Court Ordered Coverage.** You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order ("QMCSO") that requires dental coverage for Your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child you have enrolled in the Plan and such coverage is actually provided by the other plan.

6. **Reductions in Coverage.** If coverage under an option is significantly curtailed, you may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. **Change under another Employer Plan.** You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:
   a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or
   b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Dental Plan.

F. **HIPAA Special Enrollment**

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

1. **New Dependent Special Enrollment**

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

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

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

2. **Loss Of Other Coverage Special Enrollment**

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

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

b. Reaching a lifetime limit on all benefits.

c. Cessation of all employer contributions.

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

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

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

3. Loss Of Eligibility for CHIP or Medicaid

The eligible Employee and/or an eligible Dependent Child may be enrolled if either of the following conditions is satisfied:

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

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

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

G. Qualified Medical Child Support Order

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

1. The name and last known mailing address of the Covered Person;

2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

3. A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and

4. The period to which the order applies.

H. Effective Date of Enrollment Changes

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

I. Denial of Requested Enrollment Changes

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

Coverage will terminate if the Covered Partner does not continue to meet the eligibility requirements described in this Plan. Coverage for a Covered Person who has lost his or her eligibility shall automatically terminate on the last day of the month following the date that eligibility is lost.

Coverage under the Plan will be terminated if any of the following events occur:

1. Coverage will terminate for all Covered Persons at the end of the month in which You terminate employment (last day employed).

2. If You fail to timely pay the required premium, Coverage will terminate for all Covered Persons at the end of the last month for which a timely and complete premium payment is made. Premium payments made by a Covered Person other than by payroll deductions are considered made when received by the Plan Administrator.

3. Except as otherwise indicated in this section, Coverage will terminate for all Covered Persons at the end of the month in which you cease to be an Eligible Partner.

4. Coverage will terminate for any Covered Persons at the end of the month following the Plan Administrator’s receipt of a request to cancel such Covered Persons’s coverage pursuant to a Change in Status event as described herein.

5. Coverage for a Covered Dependent will end on the date the dependent ceases to be an Eligible Dependent except that coverage for a child who is ceasing to be an Eligible Dependent because he or she is turning 26 will end at the end of the month in which the child turns age 26.

6. Coverage for a Covered Persons(s) will terminate if the Plan Administrator determines that a Covered Persons has failed to reasonably cooperate with the Employer or Plan, or the Covered Persons has committed fraud or made a material misrepresentation with respect to eligibility or coverage under the Plan. Coverage may be terminated immediately or it may be retroactively terminated in the case of fraud or a material misrepresentation.

7. A Covered Dependent’s coverage will end as of the date that the information requested by the Plan Administrator with respect to such dependent is not timely provided.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the termination of Coverage for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys’ fees, expenses and court costs.

If you lose coverage due to a Qualifying Event, you may be eligible to continue coverage under the Plan in accordance with a federal law called “COBRA.”
# Dental Insurance Plan General Information

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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<td>NHC Dental Insurance Plan</td>
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<td><strong>Employer Identification Number</strong></td>
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<tr>
<td><strong>Plan Number</strong></td>
<td>506</td>
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</tbody>
</table>
| **Plan Sponsor**                               | National Health Corporation  
100 Vine Street  
Murfreesboro, TN  37130  
615-890-2020                                |
| **Plan Administrator**                         | National Health Corporation  
100 Vine Street  
Murfreesboro, TN  37130  
615-890-2020                                |
| **Type Plan**                                  | Dental Coverage                                                         |
| **Plan Year**                                  | January 1 through December 31                                           |
| **Cost of Coverage**                           | Partner Paid                                                            |
| **Agent for Service of Legal Process**         | John K. Lines  
100 Vine Street  
Murfreesboro, TN  37130  
(and the Plan Administrator at this same address) |
| **Claims Administrator**                       | Ameritas Life Insurance Corporation  
P.O. Box 81889  
Lincoln, NE  68501            |
Vision Insurance Plan

If you are regularly scheduled 20 hours or more each week, you are eligible for the NHC Vision Plan.

You are eligible for Vision Insurance even if you are not enrolled in the company-sponsored health plan.

Vision coverage is available for your spouse and dependents; however, you must be enrolled for them to be eligible.

Vision Services Plan (VSP) network is used. However, limited benefits are available for services received outside of the network.

The Vision Plan covers eye exams, lens and frames. The frequency allowable for each service or product is defined in the following information.

You are responsible for the entire Vision Insurance premium. It is payroll deducted on the second pay period of every month. The premiums are automatically tax-sheltered unless the Plan is instructed to do otherwise.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.

Remember, the only opportunity to make a change to the available coverage is during annual enrollment (normally November with a January 1 effective date), unless you experience a change in status as defined in this Handbook.

Your vision coverage will end on the last day of the month of your termination of employment, status change or ineligibility date. Your coverage may be continued at your personal expense through COBRA (continuation of coverage). Coverage may continue through COBRA for up to 18 months, 29 months or 36 months depending on the original reason for COBRA eligibility.
# Vision Insurance

## Partners, Spouses & Dependent Children

<table>
<thead>
<tr>
<th>PLAN HIGHLIGHTS</th>
<th>VSP NETWORK</th>
<th>OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>You must be regularly working 20 or more hours per week to participate.</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$10 Exam $25 Eye Glass Lenses or Frames*</td>
<td>$10 Exam $25 Eye Glass Lenses or Frames*</td>
</tr>
<tr>
<td>Annual Eye Exam</td>
<td>Covered in full</td>
<td>Up to $52</td>
</tr>
<tr>
<td>Lenses (per pair)</td>
<td>[Single Vision] Covered in full</td>
<td>Up to $55</td>
</tr>
<tr>
<td></td>
<td>[Bifocal] Covered in full</td>
<td>Up to $75</td>
</tr>
<tr>
<td></td>
<td>[Trifocal] Covered in full</td>
<td>Up to $95</td>
</tr>
<tr>
<td></td>
<td>[Lenticular] Covered in full</td>
<td>Up to $125</td>
</tr>
<tr>
<td></td>
<td>[Progressive] See lens options</td>
<td>NA</td>
</tr>
<tr>
<td>Contacts</td>
<td>15% discount [See Additional Focus Features.]</td>
<td>No benefit</td>
</tr>
<tr>
<td>Fit &amp; Follow Up Exams</td>
<td>Up to $105</td>
<td>Up to $105</td>
</tr>
<tr>
<td>Elective</td>
<td>Covered in full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Covered in full</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>$120</td>
<td>Up to $45</td>
</tr>
<tr>
<td>Frequencies (months)</td>
<td>12/12/24 Based on date of service</td>
<td>12/12/24 Based on date of service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LENS OPTIONS (member cost)**</th>
<th>VSP NETWORK</th>
<th>OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progressive Lenses</td>
<td>Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.</td>
<td>Up to Lined Trifocal allowance.</td>
</tr>
<tr>
<td>Std. Polycarbonate</td>
<td>Covered in full for dependent children; $25 adults</td>
<td>No benefit</td>
</tr>
<tr>
<td>Solid Plastic Dye</td>
<td>$13 (except Pink I &amp; II)</td>
<td>No benefit</td>
</tr>
<tr>
<td>Plastic Gradient Dye</td>
<td>$15</td>
<td>No benefit</td>
</tr>
<tr>
<td>Photochromatic Lenses (Glass &amp; Plastic)</td>
<td>$27-$76</td>
<td>No benefit</td>
</tr>
<tr>
<td>Scratch Resistant Coating</td>
<td>$15-$29</td>
<td>No benefit</td>
</tr>
<tr>
<td>Anti-Reflective Coating</td>
<td>$39-$75</td>
<td>No benefit</td>
</tr>
<tr>
<td>Ultraviolet Coating</td>
<td>$14</td>
<td>No benefit</td>
</tr>
</tbody>
</table>

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

**Lens Option member costs vary by prescription, option chosen and retail locations.

To locate a provider in your area, go to [www.VSP.com](http://www.VSP.com) or call 1-800-877-7195
Eligibility

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

NOTE: You will be required to pay a Premium for the coverage You elect.

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

1. You are an Employee who is eligible to work in the United States legally as confirmed by the USCIS (United States Citizenship Immigration Services) I-9;
2. You are designated by your Employer as a Full-Time, IPAR or Part-Time Partner regularly scheduled 20 hours or more each week.

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

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

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

1. You provide written notice of the incapacity prior to the date the child turns age 26; and
2. You provide sufficient documentation supporting the Child’s incapacity.
3. A child is considered “incapacitated” if the child has a mental or physical incapacity that renders the child unable to care for him- or herself, as determined by the claims administrator.

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

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

Eligible Partners may request enrollment in the Plan for themselves and their Eligible Dependents at https://nhcpartnerbenefits.com as set forth in this section. Your Eligible Dependent’s enrollment in the Plan is conditional pending the Plan Administrator’s timely receipt of the requested information regarding your dependents.

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

A. Initial Enrollment Period

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

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

B. Annual Enrollment Period

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

C. Changes In Coverage

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

First, your election will automatically terminate if You terminate employment or lose eligibility under the Plan, except as otherwise described in the “Coverage Termination” section.

NOTE: You are still required to provide timely notice of an event that result in loss of eligibility (e.g. divorce).

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

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

D. Status Changes

The following status changes will allow You to change Your enrollment election during the plan year:

1. Marital Status. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a spouse. See also HIPAA Special Enrollment below.
2. Change in Number of Dependents. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with You for adoption, or death of a Dependent. See also “Special Enrollment” below.
3. **Change in Dependent Eligibility.** Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage under an employer plan.

4. **Change in Employment Status that Affects Eligibility under an Employer Sponsored Health Plan.** You, or Your Eligible Dependent experiences a change in employment status due to one of the following events:
   a. Termination or commencement of employment;
   b. A strike or lockout;
   c. Commencement or return from an unpaid leave of absence;
   d. A change in employment status, e.g., unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;
   e. A change in worksite; and
   f. Any other change in employment status that affects benefits eligibility.

5. **Change in Residence that Affects Eligibility.** You or your Eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for vision coverage or becomes eligible for vision coverage.

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

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

1. **Loss of Dependent Eligibility.** If the event is divorce, legal separation, annulment, death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements and You are enrolled in vision coverage, you may not cancel the coverage for any other covered Person.
   
   **Example.** Pat is unmarried and has one married child. Pat elects family vision coverage. Pat’s Child turns 26 and therefore loses eligibility for coverage under the Plan. Pat’s coverage will automatically change to single coverage. Pat cannot, however, cancel coverage for herself.

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

**E. Cost or Coverage Changes**

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

1. **Change in Cost of Coverage.** If Your share of the premium for vision coverage You elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Partner who elected to participate in another plan option may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise eligible Partners who elected not to participate in the Plan may elect to participate in the option that decreased in cost. For insignificant increases or decreases in the cost of options, however, Your premiums will automatically be adjusted to reflect the insignificant cost.
change. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. *Entitlement to or Loss of Entitlement to Medicare or Medicaid.* You or your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. *Governmental Plan Coverage Change.* You or Your Eligible Dependent loses coverage under a group vision plan sponsored by a governmental or educational institution.

4. *New Benefit Option Added.* You are eligible for a new or improved vision coverage option.

5. *Court Ordered Coverage.* You are an Eligible Partner and the Plan receives a Qualified Medical Child Support Order ("QMCSO") that requires vision coverage for Your Eligible Dependent Child; or another employer plan is required by a QMCSO to provide coverage to an Eligible Dependent Child You have enrolled in the Plan and such coverage is actually provided by the other plan.

6. *Reductions in Coverage.* If coverage under an option is significantly curtailed, you may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. *Change under another Employer Plan.* You may make an election change that is on account of and corresponds with a change made by another employer plan, so long as:
   a. The other employer plan permits employees to make an election change permitted by Internal Revenue Code Section 125; or
   b. The Plan Year for the other employer Plan is different from the Plan Year of the NHC Vision Plan.

**F. HIPAA Special Enrollment**

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

1. *New Dependent Special Enrollment*

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

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

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

2. *Loss Of Other Coverage Special Enrollment*

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

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

b. Reaching a lifetime limit on all benefits.

c. Cessation of all employer contributions.

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

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

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

3. Loss Of Eligibility for CHIP or Medicaid

The eligible Employee and/or an eligible Dependent Child may be enrolled if either of the following conditions is satisfied:

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

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

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

G. Qualified Medical Child Support Order

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

1. The name and last known mailing address of the Covered Person;

2. The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

3. A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and

4. The period to which the order applies.

H. Effective Date of Enrollment Changes

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

I. Denial of Requested Enrollment Changes

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

Coverage will terminate if the Covered Partner does not continue to meet the eligibility requirements described in this Plan. Coverage for a Covered Person who has lost his or her eligibility shall automatically terminate on the last day of the month following the date that eligibility is lost.

Coverage under the Plan will be terminated if any of the following events occur:

1. Coverage will terminate for all Covered Persons at the end of the month in which You terminate employment (last day employed).

2. If You fail to timely pay the required premium, Coverage will terminate for all Covered Persons at the end of the last month for which a timely and complete premium payment is made. Premium payments made by a Covered Person other than by payroll deductions are considered made when received by the Plan Administrator.

3. Except as otherwise indicated in this section, Coverage will terminate for all Covered Persons at the end of the month in which you cease to be an Eligible Partner.

4. Coverage will terminate for any Covered Persons at the end of the month following the Plan Administrator’s receipt of a request to cancel such Covered Person’s coverage pursuant to a Change in Status event as described herein.

5. Coverage for a Covered Dependent will end on the date the dependent ceases to be an Eligible Dependent except that coverage for a child who is ceasing to be an Eligible Dependent because he or she is turning 26 will end at the end of the month in which the child turns age 26.

6. Coverage for a Covered Persons(s) will terminate if the Plan Administrator determines that a Covered Persons has failed to reasonably cooperate with the Employer or Plan, or the Covered Persons has committed fraud or made a material misrepresentation with respect to eligibility or coverage under the Plan. Coverage may be terminated immediately or it may be retroactively terminated in the case of fraud or a material misrepresentation.

7. A Covered Dependent’s coverage will end as of the date that the information requested by the Plan Administrator with respect to such dependent is not timely provided.

Payment For Services Rendered After Termination of Coverage

If a Covered Person receives Covered Services after the termination of Coverage for any reason described above or if the coverage is retroactively terminated due to fraud or intentional misrepresentation, the Plan Administrator may recover the amount paid for such Covered Services from the Covered Person, plus any costs of recovering such amounts, including its attorneys’ fees, expenses and court costs.

If you lose coverage due to a Qualifying Event, you may be eligible to continue coverage under the Plan in accordance with a federal law called “COBRA.”
# Vision Insurance Plan General Information

<table>
<thead>
<tr>
<th><strong>Plan Name &amp; Identification Number</strong></th>
<th>NHC Vision Insurance Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employer Identification Number</strong></td>
<td>62-1294263</td>
</tr>
<tr>
<td><strong>Plan Number</strong></td>
<td>517</td>
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</tbody>
</table>
| **Plan Sponsor**                     | National Health Corporation  
100 Vine Street  
Murfreesboro, TN 37130  
(and affiliates) |
| **Plan Administrator**               | National Health Corporation  
100 Vine Street  
Murfreesboro, TN 37130  
615-890-2020 |
| **Type Plan**                        | Vision Coverage           |
| **Plan Year**                        | January 1 through December 31 |
| **Cost of Coverage**                 | Partner Paid              |
| **Agent for Service of Legal Process** | John K. Lines  
100 Vine Street  
Murfreesboro, TN 37130  
(and the Plan Administrator at this same address) |
| **Claims Administrator**             | Vision Service Plans  
3333 Quality Drive  
Rancho Cordova, CA 95670 |
Partner Basic Term Life Insurance Plan

The NHC Partner Basic Term Life Insurance Plan provides Term Life and Accidental Death and Dismemberment (AD&D) insurance to all partners who are regularly scheduled 30 or more hours each week.

The monthly premium for this Term Life Plan is fully paid by your employer.

You, as a covered partner, designate the beneficiary for this term life plan. A beneficiary is the person or persons who will actually receive the proceeds from the term life plan if you die while the policy is in effect. There are no requirements as to who you can name as beneficiary.

Remember to update the beneficiary as changes occur in your life, i.e. marriage, divorce, birth, adoption, etc. You may update your life insurance beneficiary at any time at https://nhcpartnerbenefits.com.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.
# Partner Basic Term Life Insurance Beneficiary Designation

Partner basic term life insurance is insurance on your life with the premium fully paid by your employer. The amount of coverage is based on consecutive years of Full-Time or IPAR service.

<table>
<thead>
<tr>
<th>Years of Full Time or IPAR Service</th>
<th>Basic Life</th>
<th>Additional AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years or less</td>
<td>$5,000</td>
<td>Up to $5,000</td>
</tr>
<tr>
<td>2 years but less than 5 years</td>
<td>$15,000</td>
<td>Up to $15,000</td>
</tr>
<tr>
<td>5 years or more</td>
<td>$20,000</td>
<td>Up to $20,000</td>
</tr>
</tbody>
</table>

*In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen.*

## Partner Information

<table>
<thead>
<tr>
<th>Insured's Partner's Name</th>
<th>Date</th>
<th>Social Security Number (Last 4 Digits)</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>XXX / XX /</td>
<td></td>
</tr>
</tbody>
</table>

## Basic Term Life Insurance Beneficiary Designation

(If you name more than one beneficiary, give percentages.)

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Relationship</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
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<td>3)</td>
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<tr>
<td>4)</td>
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</tr>
</tbody>
</table>

## Contingent Life Insurance Beneficiary Designation

(Used only if beneficiary named above predeceases you.)

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Relationship</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2)</td>
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<td>3)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured's Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Partner Basic Term Life Insurance

If you are a Full-Time or IPAR (regularly scheduled 30.00 or more hours each week) partner, you are covered by a company paid term life insurance and accidental death and dismemberment (AD&D) policy on the first of the month coinciding with your health benefit plan eligibility date.

The policy provisions are summarized below in question and answer form.

**What is Partner Basic Term Life Insurance?**

Partner basic term life insurance is insurance on your life. In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen.

**What is Accidental Death and Dismemberment Insurance?**

In the event of your death and if the death is an accident, excluding certain types of accidents, the benefit of life insurance is doubled. Dismemberment benefits are paid when one of the following losses occur: loss of a hand, foot or sight.

**Who is eligible for the Partner Basic Term Life and Accidental Death and Dismemberment Benefit?**

All full-time and IPAR partners.

**How do I enroll in the Partner Basic Term Life and Accidental Death and Dismemberment Benefit?**

You are automatically provided with partner term life and AD&D insurance with the full cost being paid by your employer. You must designate your beneficiary on the applicable Beneficiary Form.

**How much Partner Basic Term Life and Accidental Death and Dismemberment Insurance am I eligible for?**

The amount of your coverage is based on consecutive years of full-time service. The chart below explains:

<table>
<thead>
<tr>
<th>Years of Service</th>
<th>Basic Life</th>
<th>Additional AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years or less</td>
<td>$5,000</td>
<td>Up to $5,000</td>
</tr>
<tr>
<td>2 years but less than 5 years</td>
<td>$15,000</td>
<td>Up to $15,000</td>
</tr>
<tr>
<td>5 years or more</td>
<td>$20,000</td>
<td>Up to $20,000</td>
</tr>
</tbody>
</table>

If you are still employed when you attain age 70, your coverage will be reduced by 50% of your Amount of Life Insurance or Maximum Benefit in force on the day before you turn age 70. Your coverage at age 75 will be reduced to 30% of your Amount of Life or Maximum Benefit in force on the day before you turn age 75. Your coverage at age 80 will be reduced to 20% of your Amount of Life Insurance or Maximum Benefit in force on the day before you turn age 80.

**How do I designate a beneficiary?**

You should designate a beneficiary online at [https://nhcpartnerbenefits.com](https://nhcpartnerbenefits.com). The beneficiary designation should be kept updated and current to reflect any family status changes, i.e. birth, death, marriage, divorce, adoption.

**Do I pay any portion of the premium?**

No. Your employer pays the full cost.
If I leave my employer, or become ineligible for coverage, how do I convert my life insurance to an individual policy?

Instructions regarding how to convert your coverage will be mailed to your home address. In the event you desire to convert all or any part of your group life insurance coverage to an individual policy, you should follow the instructions timely. If you contact the life insurance company, the life insurance company will mail you the forms to allow you to convert all or any part of your group life insurance coverage to an individual policy. Once you have converted all or any part of your group life insurance coverage to an individual policy, you are responsible for the full premium and you will be billed directly by the life insurance company. The notice of conversion form must be received by the insurance company within 31 days of coverage termination.
Partner & Dependent Term Life Insurance Plan

Partners who are regularly scheduled 30 or more hours each week are eligible to enroll themselves and their dependents in the NHC Partner & Dependent Term Life Insurance Plan. The Plan provides Term Life Insurance, as well as an equal amount of Accidental Death and Dismemberment (AD&D).

You are eligible to enroll yourself and your dependents when you become eligible for other insurance benefits.

The monthly premium is fully partner paid for all coverages under this plan. You are responsible for the entire Partner & Dependent Term Life Insurance Premium. It is payroll deducted each pay period of every month.

You, as a covered partner, designate the beneficiary for this term life plan. A beneficiary is the person or persons that will actually receive the proceeds from the dependent life plan if you or your covered dependent(s) die while the policy is in effect.

There are no requirements as to who you can name as beneficiary. Remember to update the beneficiary as changes occur in your life, i.e. marriage, divorce, birth, adoption, etc. You may update your life insurance beneficiary at any time at https://nhcpartnerbenefits.com.

The plan is highlighted in the following pages of this Handbook. Please refer to your Certificate for details.
PARTNER & DEPENDENT TERM LIFE INSURANCE BENEFICIARY DESIGNATION

In the event of your death, the appropriate benefit is paid to the beneficiary you have chosen. If you have elected partner & dependent life coverage, the beneficiary for life insurance on the lives of your spouse or children will automatically be you, if surviving; otherwise your estate will be the beneficiary, subject to policy provisions.

<table>
<thead>
<tr>
<th>Partner Information</th>
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<tbody>
<tr>
<td>INSURED’S PARTNER’S NAME</td>
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<table>
<thead>
<tr>
<th>Term Life Insurance Beneficiary Designation</th>
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</thead>
<tbody>
<tr>
<td><em>(If you name more than one beneficiary, give percentages.)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>M.I.</th>
<th>LAST NAME</th>
<th>RELATIONSHIP</th>
<th>PERCENTAGE</th>
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<tbody>
<tr>
<td>1)</td>
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<tr>
<th>Contingent Life Insurance Beneficiary Designation</th>
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<tbody>
<tr>
<td><em>(Used only if beneficiary named above predeceases you.)</em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>M.I.</th>
<th>LAST NAME</th>
<th>RELATIONSHIP</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
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<td>4)</td>
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<td></td>
</tr>
</tbody>
</table>

INSURED’S SIGNATURE | DATE
Partner & Dependent Term Life Insurance

As an eligible Partner of NHC and its affiliated companies, you may purchase additional Partner, Spouse and Child(ren) Life Insurance benefits at a greatly reduced price. This Life Insurance is in addition to all other NHC Life Insurance benefits offered.

Eligibility
Active full-time or IPAR benefits eligible Partners of NHC and its affiliated companies.

Eligibility Waiting Period
The waiting period is the same as for your other insurance coverages.

Partner Benefit Amount
$10,000, $25,000, $50,000, $75,000, or $100,000

Guaranteed Issue Amount
The guaranteed issue amount is the amount of insurance that you may elect without providing evidence of good health. If you enroll during your initial enrollment period, the guaranteed issue amount is up to $100,000. If you decline coverage and later desire to enroll, you may enroll during the annual enrollment period in November of each year, and evidence of good health would be required. If approved, coverage would be effective the first of the month following approval.

Benefit Reductions
Reduces to 50% at age 70; further reduces to 30% at age 75; to 20% at age 80.

Dependent Coverage
You may also elect coverage on the lives of your spouse and/or dependent children. A dependent is defined as your:

– legally recognized spouse;

Your unmarried step-child, foster child or adopted child is included as a dependent if he/she depends on you for 50% or more of his/her support and is living with you in a regular parent-child relationship. A child is considered adopted if in your legal custody under an interim court order of adoption, whether or not a final adoption order is ever issued.

Dependent does not include:

– any person who is insured as a partner; or
– any person residing outside the United States, Canada or Mexico.

If an unmarried child is:

– incapable of self-sustaining employment because of mental retardation, developmental disability or physical handicap; and
– depends on you for 50% or more of his/her support;

that child will continue to be a dependent for as long as these two conditions exist.

No person may be considered to be a dependent of more than one partner.

If you do not currently have an eligible child, you will have 31 days to enroll following the addition of your first dependent child. All future children will be automatically enrolled at the same benefit level at no additional cost. A Personal Health Statement will not be required for your spouse or child if you enroll them during your initial eligibility period. (Dependent coverage is available only when you elect coverage for yourself.)
If your spouse or dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.

**Spouse Benefit Amount:** $5,000, $12,500, $25,000, $37,500, or $50,000, depending on the option that you selected for yourself. You may not elect coverage for your spouse if your spouse is covered as a Partner under this policy. A spouse is defined as a partner’s legally recognized wife or husband. **Spouse Guaranteed Issue Amount:** up to $50,000.

**Child Benefit Amount:** $2,500, $6,250, $12,500, $18,750, or $25,000 per child (children ages 14 days to 6 months are limited to a reduced benefit of $100). **Child Guaranteed Issue Amount:** up to $25,000.

If you decline dependent coverage for any of your current eligible dependents and later desire to enroll, you may enroll them during the annual enrollment period in November of each year and evidence of good health would be required. If approved, coverage would be effective the first of the month following approval.

**Portability or Conversion Option**

If you leave your employer, **Portability** is a continuation option that allows you to continue your coverage. This provision applies if your employment terminates prior to age 70 and you port a minimum of $5,000. The option allows you to continue all or a portion of your Partner Life Insurance under a separate Portability term policy. Portability is subject to a maximum of $100,000. Portability is also offered on spouse and child coverage. It is subject to a maximum of $50,000 spouse and $25,000 child, at economical group rates. To elect Portability, you must apply and pay the premium within 31 days of the termination of your Term Life Insurance. Proof of good health will not be required. Portability allows for continuation of coverage for a short period of time.

If your Term Life Insurance terminates, the plan’s **Conversion Privilege** allows you to convert all or a portion of your group coverage to an individual policy. You must request conversion and pay all the required premium within 31 days of the date of your Term Life insurance ends. No evidence of good health will be required. Conversion allows for permanent coverage continuation. **PORTABILITY OR CONVERSION MAY BE ELECTED UPON TERMINATION OF BENEFITS.**

**Living Benefits Option**

Should you be diagnosed as terminally ill with a 12-month life expectancy, the Living Benefits Option allows you to receive an accelerated payment of a portion of your life insurance proceeds. The option is available to individuals with at least $10,000 group coverage subject to any maximum age limit described in your certificate. You may request a minimum accelerated payment of $5,000 up to a maximum of 75% of your coverage. Funds are paid directly to you, with no policy restrictions on how you use them. The remaining benefit is then payable to the beneficiary.

**Waiver of Premium**

This provision applies if you become totally disabled before age 60 and your disability meets the definition of disability under the plan. You must provide proof of your condition within one year of your last day of work. Once approved, your coverage will continue without payment of premium up to age 65, as long as you remain totally disabled. The premium for your dependent’s coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates. Payment of premium is required until waiver is approved.

**Accidental Death & Dismemberment**

If accident or injury occurs, directly and independently of all other causes, and results in any of the following losses within 365 days of the accident, the plan will pay as follows: Accidental Death benefit matches life amount selected. AD&D benefits also available for loss of speech/hearing; loss of thumb/forefinger; seat belt/airbag; and paralysis. (See certificate for details.)
Universal Life Insurance Plan

The NHC Universal Life Insurance Plan provides Universal Life Insurance to partners and their dependents who were eligible and enrolled on December 31, 2005. The Plan closed to new enrollments on January 1, 2006 allowing partners who were enrolled on December 31, 2005 to maintain the coverage.

The monthly premium for the current coverage is fully partner paid and is deducted each pay period.

You, as a covered partner, designate the beneficiary for this life insurance plan. A beneficiary is the person or persons that will actually receive the proceeds from this life insurance plan if you or your covered dependents die while the policy is in effect. There are no requirements as to who you can name as beneficiary.

Remember to update the beneficiary information as changes occur in your life, i.e. marriage, divorce, birth, adoption, etc.

Coverage details are available in the Insurance Certificate received by each plan participant.
To update Beneficiary Designation Information, copy the blank Application for Payroll Deduction Life Insurance form and complete lines 1, 2, 3, 11, and sign and date on the bottom right side. Do not complete back of Form.

Return the updated Beneficiary information to:

Pancoast Benefits
PO Box 150905
Nashville, TN 37215

*Always keep a copy for your files.*
# Application for Payroll Deduction Life Insurance

**Transamerica Occidental Life Insurance Company**

**Administrative Office:** P.O. Box 506, Keene, NH 03431-0506

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## PLEASE COMPLETE INFORMATION ON EACH PERSON PROPOSED FOR COVERAGE - PART I

<table>
<thead>
<tr>
<th>Employer</th>
<th></th>
<th>Date of Hire:</th>
<th>Location/Dept:</th>
<th>ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee’s Address</th>
<th>Street</th>
<th>Apt No</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Home Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>First</td>
<td>Middle</td>
<td>Last</td>
<td>□ Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Social Security #</td>
<td>Annual Salary</td>
<td></td>
<td>2a. Social Security #</td>
<td>2b. Occupation:</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Birth Date:</td>
<td></td>
<td></td>
<td>3a. Birth Date:</td>
<td>Birth State</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Has the employee missed more than a total of 5 full days of active work due to an illness or injury in the past 3 months?</td>
<td></td>
<td></td>
<td>4a. Has the spouse/dependent been seen or treated by a licensed physician or other medical practitioner within the past 6 months?</td>
<td>4b. If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Has the employee been hospitalized in the past 6 months?</td>
<td></td>
<td></td>
<td>5a. Has the spouse/dependent been hospitalized in the past 6 months?</td>
<td>5b. If yes, explain.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has the employee ever been diagnosed by a physician as having a sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related illness or tested positive for the antibodies of the AIDS virus (HIV)?</td>
<td></td>
<td></td>
<td>6a. Has the spouse/dependent ever been diagnosed by a physician as having a sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related illness or tested positive for the antibodies of the AIDS virus (HIV)?</td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>Has the employee used tobacco in any form during the past 12 months?</td>
<td></td>
<td></td>
<td>7a. Has the spouse/dependent used tobacco in any form during the past 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan:</th>
<th>Face Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Contract type is Level unless Increase is checked. Increase</td>
</tr>
</tbody>
</table>

| 10. Basic Planned Premium Mode: | | 10a. Basic Planned Premium Mode: |
| Weekly | Other | Weekly | Other |
| Benefit: Basic Planned Premium | $ | Benefit: Basic Planned Premium | $ |
| Waiver of Monthly Deductions | $ | Waiver of Monthly Deductions | $ |
| Accidental Death Benefit | $ | Accidental Death Benefit | $ |
| Children’s Term Rider # | Units | Children’s Term Rider # | Units |
| Other | | Other | |
| Total Planned Premium: | $ | Total Planned Premium: | $ |

| Automatic Increase Option: | Yes | No | Spouse Automatic Increase Option: | Yes | No |

## Replacement question to be answered by Agent:

To the best of your knowledge, could any existing life insurance or annuities be replaced or changed if the insurance applied for is issued? □ Yes □ No If yes, provide name of insured, company and amount:

---

X Signature of Agent

X Signature of Employee

X Signature of Spouse/Dependent

Printed Name of Agent

Agent’s License #: 1GASO 11-198

Special Requests: Home Office Endorsements:

City/State Month/Day/Year

1/2017
PART II - Medical Questions (complete if required) Explain yes answers below in 17.

14. Employee ___________________ Spouse/Dependent__________________________
   Height: __________ Ft. ___________ In. ___________ Weight: __________ lbs.
   Height: __________ Ft. ___________ In. ___________ Weight: __________ lbs.

15. Has any person proposed for insurance ever been treated for or diagnosed as having:

   Employee  | Spouse/Dep | Employee  | Spouse/Dep |
   Yes  | No  | Yes  | No  |
   a. Diabetes? | □ | □ | □ | □ |
   b. Chest pain? | □ | □ | □ | □ |
   c. Heart disease? | □ | □ | □ | □ |
   d. Cancer or Tumor? | □ | □ | □ | □ |
   e. Mental or psychiatric disorder? | □ | □ | □ | □ |
   f. Stomach or intestinal disorder? | □ | □ | □ | □ |
   g. High blood pressure** | □ | □ | □ | □ |
   h. Ulcers? | □ | □ | □ | □ |
   i. Liver disease? | □ | □ | □ | □ |
   j. Hepatitis? | □ | □ | □ | □ |
   k. Reproductive organ disorder? | □ | □ | □ | □ |
   l. Lung or respiratory disease? | □ | □ | □ | □ |
   m. Blood disorder? | □ | □ | □ | □ |
   n. Stroke or paralysis? | □ | □ | □ | □ |
   o. Kidney disease? | □ | □ | □ | □ |
   p. Epilepsy? | □ | □ | □ | □ |

   *If yes, give most recent blood pressure reading and date:

16. Has any person proposed for insurance:

   Employee  | Spouse/Dep | Employee  | Spouse/Dep |
   Yes  | No  | Yes  | No  |
   a. Ever been declined or postponed for life insurance? | □ | □ | □ | □ |
   b. Within the past 5 years taken, or been advised to take, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?
   c. Currently taking any prescription medication? (If "YES", state name of medication, reason for taking, frequency, and dosage.) | □ | □ | □ | □ |
   d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study in the past 5 years? | □ | □ | □ | □ |
   e. Other than stated above, within the past 5 years had any other illness, operation or treatment? | □ | □ | □ | □ |

17. Describe details of any "Yes" answers to Question 4, 4a, 5a, 6a, 6u, 15 or 16. If needed, use a separate sheet of paper.

<table>
<thead>
<tr>
<th>Name</th>
<th>Quest #</th>
<th>Describe Injury, Illness or Disorder - Include Severity, Duration &amp; Outcome</th>
<th>Date Diagnosed</th>
<th>Length of Treatment</th>
<th>Current Status</th>
<th>Name &amp; Add of Doctor or Hospital</th>
</tr>
</thead>
<tbody>
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</table>

AGREEMENT: I agree and declare, (a) all statements, answers and representations contained in this application are full, complete and true to the best of my knowledge and belief, (b) this application shall constitute my application for insurance to Transamerica Occidental Life Insurance Company and with the contract to be issued to me.

DECLARATIONS AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: Transamerica Occidental Life Insurance Company or its reinsurers may obtain information about the proposed insured(s) from: any physician, medical practitioner, hospital, clinic or other medical facility, employer; other insurance companies or institutions; consumer reporting agency, or Medical Information Bureau, Inc. ("MIB, Inc."). The purpose is to evaluate my application for insurance or benefits. Transamerica Occidental Life Insurance Company may obtain an investigatory consumer report and any records or other information available as to diagnosis, treatment and prognosis of any physical or mental condition. Transamerica Occidental Life Insurance Company may make a brief report to MIB, Inc. about the Proposed Insured(s). Transamerica Occidental Life Insurance Company may obtain any drug, physical and mental health, and alcohol related information which may be protected by federal or state laws and regulations. As it pertains to alcohol and drug information covered by federal regulation, this may be revoked at any time by written notice to Transamerica Occidental Life Insurance Company. But, any action taken before my written revocation is received by Transamerica Occidental Life Insurance Company will not be affected.

This is valid for two and one-half years from the date of this application. An original or copy may be used by Transamerica Occidental Life Insurance Company or its authorized representative to obtain information. I have read and received a copy of the Notice of Information Procedures and am aware that I may have a copy of this authorization upon request. It includes the MIB, Inc. and Fair Credit Reporting Notices.

Signed at: ________________________ on: ________________________

   City/State: ________________ Month/Day/Year: ________________

   Signature of Agent

   Signature of Employee

   Signature of Owner if other than Employee

   Signature of Spouse/Dependent

1GA50 11-198 Transamerica Occidental Life Insurance Company, P.O. Box 8063, Little Rock, AR 72203-8063

1/2017
Short Term Disability Insurance Plan

If you are designated by your Employer as a Full-Time, IPAR or Part-Time partner regularly scheduled 20 hours or more each week, you are eligible for the NHC Short Term Disability Plan.

The Short Term Disability Plan is an income replacement plan that replaces up to 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions; if your earnings are based on commissions, commissions will be averaged over the 12-month period prior to the date disability begins) when you become disabled due to illness (to include pregnancy) or accident.

NOTE: If you choose an amount greater than 70% of your basic weekly income, the weekly benefit amount will be reduced at the time of claim. Premium adjustment in these situations will be limited to the 12 months immediately prior to the time of claim.

If you are eligible for state-mandated temporary disability benefits, or any employer-paid income replacement plan, the combination of your state-mandated benefit or other income and your Short Term Disability weekly benefit may not exceed 70% of your basic weekly earnings.

This plan has a 15 calendar day waiting period. Disability payments can continue up to 13 weeks, depending on the length of the disability.

The plan has a 12/12 pre-existing condition provision, meaning that if a condition was present anytime in the 12 months prior to coverage; a short term disability claim for that particular condition made any time in the 1st 12 months after coverage is effective would not be covered. However, coverage would still be available for any condition unrelated to the preexisting condition. The pre-existing limitation also applies to all weekly benefit increases.

You are responsible for the entire Short Term Disability Insurance premium. It is payroll deducted on the second pay period of every month.

Please refer to your Certificate for details.

Remember, that the opportunity to make a change to the available coverage is only during annual enrollment (normally November with a January 1 effective date).
Long Term Care Insurance Discount Plan

NHC’s Long Term Care Insurance Division offers LTC Insurance to our partners and their families (spouses, parents, grandparents and in-laws of partners). These insurance plans are available through several insurance companies and are tailored to meet each individual’s needs.

Premiums are based on age, health and benefits chosen. The premiums are fully paid by the partner or family member. Payroll deduction is not currently available. However, bank draft is an option.

All plans are fully portable and are, upon issue, guaranteed renewable for life.

The benefits included in each plan are designed to meet the individual needs of the person, but are individually underwritten meaning that the insured person’s current and past health history is a consideration in approval for coverage.

Plans will allow for your care to be received at home, in an adult day care center, assisted living center or in a nursing home.

Plan choices include:

**Daily or Monthly Benefit**

Amount the insurance company will pay for your care each day or month. It is best to start with a benefit close to the current cost of care in your area.

**Benefit Period**

(2, 3, 4, and 5 years): Length of time policy will pay for care once a claim has been made.

The total benefit or “pool of money” is determined by multiplying the daily or monthly benefit and the benefit period. For example: $200 per day for 3 years of benefits would provide a total benefit of $219,000.

**Elimination Period**

(30 and 90 days): The number of days before a policy will pay for your care. This is also referred to as a “deductible”.

**Inflation Protection**

Allows the benefit to increase automatically as cost of care increases. Inflation protection is highly recommended.

For information on the plans available and/or individual quotes, contact Stacia Vetter or Renee Adams at the NHC Long Term Care Insurance Division at **1-800-229-7141**.
Nontaxable Benefit Plan

NHC offers the Nontaxable Benefit Plan as a means for you to pay for certain expenses with earnings that will not be taxed for either Federal Income Tax or Social Security Taxes. This Plan is often referred to as a Cafeteria Plan, a Section 125 Plan, or a Flexible Spending Account.

The Plan offers the following options in which you may participate, tax sheltered. They include:

- **Insurance Premium Reimbursement**
  Eligibility – Participation in the health, dental or vision plans. This option allows you to pay your share of the premiums in the health, dental and/or vision plans with pre-tax dollars through payroll deduction.

- **Medical Care Expense Reimbursement**
  Eligibility – Partners who are eligible to participate in NHC Health Benefit Plan but who are not participating in the HSA Value Plan

- **Health Savings Account (HSA)**
  Eligibility – Participation in the HSA Value Plan

- **Dependent Care Assistance Expense Reimbursement**
  Eligibility – Full-time, IPAR, part-time partners or PRN

All participation decisions for the Insurance Premium Reimbursement, Medical Care Expense Reimbursement and the Dependent Care Assistance Expense Reimbursement must be made during Annual Enrollment of each year. Each year’s participation choices for active partners are a commitment for the full calendar year and cannot be changed unless a qualifying change in family status or other qualifying change event occurs.

Request for participation change because of a qualified family status change must be submitted within 30 days of the event. As required by Federal Regulations, requests made more than 30 days after the event cannot be honored. Health Savings Account contributions may be changed prospectively at any time during the Plan Year.

Annual contributions for active participants are deducted normally based on 24 pay periods each year, but the number of pay periods may vary year to year. Deduction amounts are determined by the participant’s annual election during online enrollment.

For new partners, you must make participation decisions prior to your commencement of participation in the Nontaxable Benefit Plan and in no event later than your NHC insurance eligibility date. Your commitment is through the end of the calendar year in which you begin to participate and cannot be changed unless a qualifying change in family status or other qualifying change event occurs. The number of contributions for the first year is based on two pay periods each month for the remainder of the calendar year starting with the first pay period following your eligibility date. Deduction amounts are determined by the participant’s election during online enrollment.

This plan carries with it some risk for both the partner and the employer.

The “Use it or Lose it” rule applies to the Medical Care Expense Reimbursement Account portion of the Plan. If you do not use all of the pre-tax earnings that you have contributed to your Medical Care Expense Reimbursement Account in the Plan, in the same calendar year they were contributed, you may lose them.

You have until March 31 of the following year to request reimbursement from the previous Plan Year. (See also page 2 - Carryover Provision).

The “Use it or Lose it” rule also applies to your Dependent Care Assistance Expense Reimbursement Account in this Plan. This means that if you do not use all of the pre-tax earnings that you have contributed to your Dependent Care Assistance Expense Reimbursement Account, in the same calendar year they were contributed, you will lose them; so you should be conservative in choosing your level of participation for each
Plan Year. All expenses reimbursed from your Dependent Care Assistance Expense Reimbursement Account in the Plan must be incurred January 1 through December 31. You have until March 31 of the following year to request reimbursement from the previous Plan Year. All account balances not claimed by March 31 for the previous Plan Year will be forfeited.

This is a benefit plan that actually allows you to take more money home in your pay check each pay period. However, you should use it wisely and conservatively.

**Carryover Provision (Effective Plan Year 2015)**

Beginning with Plan Year 2015, balances of up to $500 in your Medical Care Expense Reimbursement Account may be carried over to the next Plan Year to reimburse covered medical expenses incurred during the subsequent Plan Year. The carryover amount, if any, will be determined and available after the end of the runout period for the previous Plan Year. The runout period begins on January 1 and ends on March 31. After March 31, remaining balances from the previous Plan Year in excess of the $500 carryover will be forfeited.

Your right to carryover amounts under your Medical Care Expense Reimbursement Account will continue for so long as you remain eligible to participate in the NHC Health Benefit Plan (other than the HSA Value Plan). Accordingly, if you are transferred to a position that is ineligible to participate in the NHC Health Benefit Plan, or if you switch to coverage under the HSA Value Plan, you will forfeit whatever carryover balance you have in your Medical Care Expense Reimbursement Account upon your ceasing to be eligible to participate in the NHC Health Benefit Plan or switch to coverage under the HSA Value Plan.

If your employment terminates during a year in which you have carried over amounts under your Medical Care Expense Reimbursement Account from a prior year, you will continue to be able to claim covered medical expenses incurred during the year in which your employment terminated through the end of the runout period for that year. However, you will not be able to carryover any amounts to the year following the year in which you terminated employment. All account balances not claimed by March 31 in the year following the year in which your employment terminated will be forfeited.
CLAIMS FORM
Medical Care Expense Reimbursement Account
NHC Nontaxable Benefit Plan

Expenses which are submitted for payment must have been incurred by you, your spouse, or dependents during the applicable Plan Year (January 1 through December 31). To receive payment, complete and sign your Claims Form and submit to the Business Office along with the required documentation for the qualified medical expense (e.g., statements, receipts, invoices, or Explanation of Benefits [EOB] from your insurance company). See the reverse side of this form for instructions.

You have until March 31 of the following year to request reimbursement from the prior Plan Year. Balances of up to $500 may be carried over to the next Plan Year to reimburse covered medical expenses incurred in a subsequent Plan Year. The carryover amount will be determined and available after the end of the runout period for the previous Plan Year. The runout period for a Plan Year begins on January 1 of the next Plan Year and ends on March 31. All prior year account balances in excess of $500 that are not claimed by March 31 will be forfeited.

The carryover provision applies only if you are eligible to participate in the NHC Health Benefit Plan and are not enrolled in the HSA Value Plan.

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<tr>
<th>Partner Information (PLEASE PRINT)</th>
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<tbody>
<tr>
<td>LAST NAME</td>
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<td>SOCIAL SECURITY NUMBER (LAST 4 DIGITS)</td>
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<tr>
<th>Amount of Expenses for Which I am Requesting Payment From My Nontaxable Benefit Plan Account</th>
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<tr>
<td>MEDICAL CARE EXPENSES</td>
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<tr>
<th>Certification of Expenses</th>
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<tr>
<td>I represent and certify that I have incurred the expenses for which payment is sought under the Plan and that these expenses have been incurred during the Plan Year for which I make this claim. I further certify that said expenses are for qualified Medical Care Expenses and have not been covered or reimbursed from any other source. I understand that I cannot claim these expenses on my income tax return.</td>
</tr>
<tr>
<td>PARTNER SIGNATURE</td>
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</tbody>
</table>
How to File Your Medical Care Expense Claim

To receive payment, complete and sign your Claims Form and submit to the Business Office, the photocopied required documentation (e.g., statements, receipts, invoices, or Explanation of Benefits [EOB] from your insurance company) providing the detail of charges incurred. Keep a copy of this form and your original supporting documentation for your records.

Helpful Tips for Filing your Claims Form

REQUIRED

• Verify the expense is incurred during the plan year (January 1 through December 31) for which your claim is made.
• Submit charges for multiple years on separate claims forms.
• Orthodontia services are deemed to be incurred the date the payment is made. Submit the Claims Form as you pay for the services. Provide a receipt from the provider showing payment was made in the current plan year.
• Verify the expense is eligible for reimbursement. View the list of expenses covered and expenses not covered in the NHC Benefits Handbook (Section 1100 Nontaxable Benefit Plan) which can be found at https://nhcpartnerbenefits.com.
• Attach itemized detail of charges incurred (statements, receipts, invoices, Explanation of Benefits [EOB] from your insurance company) to the form. Valid receipts should include:
  - Provider Name & Address
  - Patient Name
  - Date of Service
  - Service Description
  - Amount Charged
• Read the Certification of Expenses carefully before signing.
• Provide the Business Office with your current mailing address if you have terminated employment.

NOT PERMITTED

• Submitting the Claims Form before services are actually provided.
• Copies of a payment schedules or cancelled checks, bank statements, or credit card receipts. These documents alone cannot be used to substantiate the claim.
• Submitting a Claims Form for expenses not covered.

Reimbursement Information

If you are an active partner, you will be reimbursed for your covered expenses from your Medical Care Expense Reimbursement Account up to the amount you have elected to contribute. If you are a terminated partner, the current account balance is available for reimbursement of eligible claims.

Following your submission of the Claims Form to the Business Office, your reimbursement will be included on your payroll check and processed according to the banking method we currently have on file, either direct deposit or negotiable check. If you want to make a change to your current direct deposit account information, submit a completed Payroll Selection Form, which can be found in the NHC Benefits Handbook at https://nhcpartnerbenefits.com. Your reimbursement method will remain in effect until an updated Payroll Selection Form has been received and processed, which may take up to 2-3 pay periods. To ensure your claim is paid correctly, it is advisable to submit changes to the Payroll Selection Form prior to submitting the Claims Form.

Please contact the Business Office if you have questions pertaining to your reimbursement.
CLAIMS FORM
Dependent Care Assistance Reimbursement Account
NHC Nontaxable Benefit Plan

Expenses which are submitted for payment must have been incurred by you, your spouse or your dependents during the applicable Plan Year (January 1 through December 31). To receive payment, complete and sign your Claims Form and submit to the Business Office along with either the required documentation for the qualified expense (e.g., statements, receipts, or invoices) or this form completed by the day care provider. See the reverse side of this form for instructions.

You have until March 31 of the following year to request reimbursement from the prior Plan Year. All prior year account balances not claimed by March 31 will be lost. Your employer or the Plan does not accept responsibility for direct payment to any individuals other than you, as a partner.

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<th>Partner Information (PLEASE PRINT)</th>
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<th>Dependent Name(s)</th>
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<tr>
<th>Day Care Provider Information</th>
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<tbody>
<tr>
<td>NAME</td>
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<tr>
<td>ADDRESS</td>
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<td>CITY</td>
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<td>DATES OF SERVICES</td>
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<td>DAY CARE PROVIDER SIGNATURE</td>
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Certification of Expenses
I represent and certify that all items requested to be reimbursed comply with the NHC Dependent Care Assistance Reimbursement Account and such items have not and will not be covered or reimbursed by any other plan or program of any employer or other person. I understand that I cannot claim these expenses on my income tax return.

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<tr>
<th>PARTNER SIGNATURE</th>
<th>DATE</th>
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How to File Your Dependent Care Expense Claim

To receive payment, complete and sign your Claims Form and submit to the Business Office the photocopied required documentation (e.g., statements, receipts or invoices) providing the detail of charges incurred or this form completed by the day care provider. Keep a copy of this form and your original supporting documentation for your records.

Helpful Tips for Filing your Claims Form

**REQUIRED**
- Verify the expense is *incurred* during the plan year (January 1 through December 31) for which your claim is made.
- Submit charges for multiple years on separate claims forms.
- Verify the expense is eligible for reimbursement. View the list of expenses covered and expenses not covered in the NHC Benefits Handbook (Section 1100 Nontaxable Benefit Plan) which can be found at https://nhcpartnerbenefits.com.
- Attach itemized detail of charges incurred (statements, receipts or invoices) to the form. Valid receipts should include:
  - Provider Name & Address
  - Dependent Name
  - Date of Service
  - Amount Charged
- Read the Certification of Expenses carefully before signing.
- Provide the Business Office with your current mailing address if you have terminated employment.

**NOT PERMITTED**
- Submitting the Claims Form before services are actually provided.
- Copies of cancelled checks, bank statements or credit card receipts. These documents alone cannot be used to substantiate the claim.
- Submitting a Claims Form for expenses not covered.

Reimbursement Information

You will be reimbursed for your covered expenses from your Dependent Care Assistance Expense Reimbursement Account up to the amount you have contributed.

Following your submission of the Claims Form to the Business Office, your reimbursement will be included on your payroll check and processed according to the banking method we currently have on file, either direct deposit or negotiable check. If you want to make a change to your current direct deposit account information, submit a completed Payroll Selection Form, which can be found in the NHC Benefits Handbook at Error! Hyperlink reference not valid. Your reimbursement method will remain in effect until an updated Payroll Selection Form has been received and processed, which may take up to 2-3 pay periods. To ensure your claim is paid correctly, it is advisable to submit changes to the Payroll Selection Form prior to submitting the Claims Form.

Please contact the Business Office if you have questions pertaining to your reimbursement.
REQUEST FOR CHANGE
NHC Nontaxable Benefit Plan

Partner Information (PLEASE PRINT)

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SOCIAL SECURITY NUMBER (LAST 4 DIGITS) EMPLOYER

ZZZ / ZZZ /

Change Details

I request to make a change in my NHC Nontaxable Benefit Plan and certify that my applicable change in family status occurred within the last 30 days.

1) The change is requested due to: (check one)

- Marriage
- Divorce/Legal Separation/Annulment
- Death of spouse or dependent child
- Birth, adoption of a child, or placement for adoption
- Strike or lockout of my spouse, my dependent, or myself
- Termination or commencement of employement of my spouse or my dependent
- Termination of my employment
- A change in employment from Part to Full-Time or Full to Part-Time by myself, my spouse or my dependent that affects my eligibility to participate in my or my spouse’s medical, dental or vision insurance coverage
- A change in worksite for myself, my spouse or my dependent
- Taking of an unpaid leave of absence by myself or my spouse or my dependent
- A significant change in my own or my spouse’s health or dental or vision insurance coverage attributable to my spouse’s employment
- A change in dependent’s eligibility requirements for coverage under the company sponsored health related plans.
- A change in residence.

2) The change in family status occurred within the last 30 days, on:

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3) Based on the above change in family status, my current request for participation in the Plan is:

- Increase in my Health Premium Benefit
- Increase in my Dental Premium Benefit
- Increase in my Vision Premium Benefit
- Increase in my Medical Care Expense Reimbursement Account Benefit to $__________ each pay period (Effective 1/1/2018, there is a $2,650 overall cap on contributions for each Plan Year.)
- Increase in my Dependent Care Assistance Expense Reimbursement Account Benefit to $__________ each pay period
- Decrease in my Health Premium Benefit
- Decrease in my Dental Premium Benefit
- Decrease in my Vision Premium Benefit
- Decrease in my Medical Care Expense Reimbursement Account Benefit to $__________ each pay period
- Decrease in my Dependent Care Assistance Expense Reimbursement Account Benefit to $__________ each pay period
- Stop my participation in my Health Premium Benefit
- Stop my participation in my Dental Premium Benefit
- Stop my participation in my Vision Premium Benefit
- Stop my participation in my Medical Care Expense Reimbursement Account Benefit
- Stop my participation in my Dependent Care Assistance Expense Reimbursement Account Benefit

I certify that the family status change marked above has occurred within the last 30 days and that the change I am making to my Nontaxable Benefit Plan is allowed solely because of my change of family status.

PARTNER SIGNATURE DATE

1/2018
NONTAXABLE BENEFIT PLAN

This section of this Handbook is the general explanation and description of benefits under the Nontaxable Benefit Plan. The Nontaxable Benefit Plan is a form of “cafeteria plan” or “flexible benefit plan”.

This is only a summary of the Nontaxable Benefit Plan. Discrepancies between this section of the Handbook and the actual Nontaxable Benefit Plan, as well as the resolution of any differences, are governed by the provisions of the actual Nontaxable Benefit Plan document itself and its related legal instruments. These documents are available from the Plan Administrator. The Employer reserves the right to modify, revoke, suspend, terminate or change any or all of the provisions of the Nontaxable Benefit Plan and the policies under which it is administered at any time. This right can be exercised with or without advance notice, consultation or reaching agreement with anyone, at any time.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Who can join the Nontaxable Benefit Plan and what type of coverages are available in the Plan?</td>
<td>13</td>
</tr>
<tr>
<td>2. How do I join the Nontaxable Benefit Plan?</td>
<td>14</td>
</tr>
<tr>
<td>3. How can my health, dental and/or vision expenses be paid on a before-tax basis?</td>
<td>14</td>
</tr>
<tr>
<td>4. How does the before-tax payment of health, dental and/or vision premiums work?</td>
<td>15</td>
</tr>
<tr>
<td>5. How does the before-tax payment of medical care expenses work?</td>
<td>15</td>
</tr>
<tr>
<td>6. What medical expenses are covered under my Medical Care Expense Reimbursement Account?</td>
<td>15</td>
</tr>
<tr>
<td>7. What is the carryover provision in my Medical Care Expense Reimbursement Account?</td>
<td>16</td>
</tr>
<tr>
<td>8. Are there any limits to covered expenses under, or contributions to, the Medical Care Expense Reimbursement Account?</td>
<td>16</td>
</tr>
<tr>
<td>9. Can I, as a plan participant, also deduct reimbursed medical expenses when I prepare my income tax return at year end?</td>
<td>16</td>
</tr>
<tr>
<td>10. How can my dependent care assistance expenses be paid on a before-tax basis?</td>
<td>16</td>
</tr>
<tr>
<td>11. How does the before-tax payment of dependent care assistance expenses work?</td>
<td>17</td>
</tr>
<tr>
<td>12. What expenses are covered under my Dependent Care Assistance Expense Reimbursement Account?</td>
<td>17</td>
</tr>
<tr>
<td>13. Are there any limits to my covered expenses under, or contributions to, my Dependent Care Assistance Expense Reimbursement Account?</td>
<td>17</td>
</tr>
<tr>
<td>14. Would I be better off taking the tax credit provided by tax law for household and dependent care services necessary for gainful employment instead of paying my dependent care expenses under the Nontaxable Benefit Plan?</td>
<td>18</td>
</tr>
<tr>
<td>15. Can I change my election under the Nontaxable Benefit Plan?</td>
<td>18</td>
</tr>
<tr>
<td>16. What happens if I am participating in the Nontaxable Benefit Plan and I take FMLA leave?</td>
<td>18</td>
</tr>
<tr>
<td>17. What happens if my employment terminates?</td>
<td>19</td>
</tr>
<tr>
<td>18. What happens if I become ineligible to participate in the NHC Health Benefit Plan, but my employment does not end?</td>
<td>19</td>
</tr>
<tr>
<td>20. Who provides recordkeeping services for the Nontaxable Benefit Plan?</td>
<td>20</td>
</tr>
<tr>
<td>21. Can the Nontaxable Benefit Plan be amended or terminated?</td>
<td>20</td>
</tr>
<tr>
<td>22. What are the Nontaxable Benefit Plan’s claims procedures?</td>
<td>20</td>
</tr>
<tr>
<td>23. What are my rights under ERISA?</td>
<td>21</td>
</tr>
</tbody>
</table>

GENERAL INFORMATION ABOUT THE NONTAXABLE BENEFIT PLAN                         23
The Nontaxable Benefit Plan works like this. Without the Nontaxable Benefit Plan, the dollars that you use to pay for your benefit coverage outside of the Nontaxable Benefit Plan would be taxed. In fact, they would be generally subject to at least two taxes: Federal Income Tax and FICA (“Social Security”) tax.

To save on these taxes, you simply direct us to pay your part of the cost of coverage (that is, your part of the premiums, etc.) out of your wages before you get it and before your wages are taxed. Without the Nontaxable Benefit Plan, you would pay such expenses out of your wages after your wages are taxed; after you have had Federal Income Tax and FICA tax withheld from your wages. The Nontaxable Benefit Plan turns this around and lets you pay your part of the cost of coverage before taxes are withheld. Therefore, the benefit that the Nontaxable Benefit Plan provides is a tax benefit.

It’s that simple! The result is that you save on taxes. And if you are new to the Nontaxable Benefit Plan, you will actually see the tax savings because your take-home pay increases.

The extra “take home” pay varies depending on your tax bracket. Most participants in the plan will increase their “take home” pay by at least 22.65% of the total dollars contributed to the plan. The 22.65% is 15% for Federal Income Taxes plus 7.65% for Social Security Taxes.

Beginning January 1, 2018 the Internal Revenue Service imposed a $2,650 maximum limit on your contributions to your Medical Care Expense Reimbursement Account. This limit may be adjusted for inflation each year.

1. Who can join the Nontaxable Benefit Plan and what type of coverages are available in the Plan?

The following are the types of benefit coverages you can pay for on a before-tax basis and when you will be eligible for such coverages:

- **Premiums for the NHC Health Benefit Plan coverage and any other health plan available through your employer.** For this benefit coverage you must first be eligible for coverage under the group Health Benefit Plan. See the section on the Health Benefit Plan in this Handbook regarding eligibility for that coverage.

- **Premiums for Dental Plan coverage.** You must be eligible for coverage under the Dental Plan first. See the section on the Dental Plan in this Handbook regarding eligibility for that coverage.

- **Premiums for Vision Plan coverage.** You must be eligible for coverage under the Vision Plan first. See the section on the Vision Plan in this Handbook regarding eligibility for that coverage.

- **Reimbursement of certain unreimbursed medical care expenses through a Medical Care Expense Reimbursement Account.** You must be eligible to participate in the NHC Health Benefit Plan and not enrolled in the HSA Value Plan (Health Savings Account) in order to contribute to a Medical Care Expense Reimbursement Account.

- **Contributions to the Health Savings Account (HSA).** You must be eligible and enrolled in the HSA Value Plan in order to make contributions to the Health Savings Account (HSA). Refer to Health Benefit Plan section in this Handbook regarding eligibility for that coverage.

- **Reimbursement of certain dependent care assistance expenses.** Once eligible, you can contribute to a Dependent Care Assistance Expense Reimbursement Account in order to be reimbursed for covered dependent care assistance expenses on a before-tax basis.

If you are a new hire, you may only join the Nontaxable Benefit Plan at the same time you become initially eligible to participate in the other NHC insurance plans.

However, if you are new and become eligible for coverage, and you do not elect to pay for coverage on a before-tax basis under the Nontaxable Benefit Plan when you are first eligible (i.e., you elect to waive the Nontaxable Benefit Plan's tax benefit), you will have to wait until a HIPAA Special Enrollment Period or the next Annual Enrollment period for the next Plan Year to begin participation in the Plan. The Plan Year is the 12 consecutive month period of January 1 through December 31. This is a requirement of federal tax law.

All elections for the Medical Care Expense Reimbursement Account and/or the Dependent Care Assistance Expense Reimbursement Account (and non-participation elections) are good for the entire Plan Year. You cannot change your election throughout the year (except as discussed later on in this section of the Handbook in the event you experience a “Change in Status”).

Coverage under the Health Benefit Plan, Dental Plan and Vision Plan is also a commitment for the entire Plan Year. However, Health Savings Account contributions may be changed at any time during the Plan Year.

Before the beginning of each following Plan Year on January 1, you will need to re-enroll during Online Annual Enrollment for the Medical Care Expense Reimbursement Account and/or the Dependent Care Assistance Expense Reimbursement Account. The insurance premium payments participation is different. Your participation in NHC’s medical, dental and vision insurance plan(s) continues indefinitely unless you decide you do not want to continue to make payments on a before-tax basis in a future
Plan Year. If you elect to waive the tax benefit of paying for covered benefits on a before-tax basis, you must do so during Online Annual Enrollment before the beginning of the Plan Year (i.e., before January 1) in which you wish to waive this tax benefit. If you wish to change back, that too must be done by new election before the beginning of the Plan Year on January 1.

If, however, you are eligible for a HIPAA Special Enrollment period (as defined by HIPAA), you can make an election regarding the payment of premiums under NHC’s medical, dental and vision insurance plans on a before-tax basis for coverage offered under the Nontaxable Benefit Plan during that special enrollment period. See the sections on the Health Benefit Plan, the Dental Plan and/or the Vision Plan, as appropriate, in this Handbook regarding HIPAA’s special enrollment periods.

If you terminate employment but return to work in the same Plan Year, you must wait until the next Plan Year to enroll, unless you return to work within 30 days. (Remember the Plan Year is the twelve consecutive month period of January 1 through December 31). If you return to work within 30 days in the same Plan Year, your participation in the Nontaxable Benefit Plan will automatically be reinstated. If you return to work after 30 days, but within the same Plan Year you left, under federal tax law you will have to wait until a HIPAA Special Enrollment prior or to the beginning of the next Plan Year on January 1 to join. If you are rehired after the Plan Year in which your employment ended, you will be treated as a new partner and may enroll once you have again met the Plan’s eligibility requirements.

If you lose your eligibility for all plans or programs for which you can make before-tax payments under the Nontaxable Benefit Plan or if your employment terminates (subject to the exceptions described in Questions 16 and 17 if they apply to you), or if the Nontaxable Benefit Plan terminates, your participation in the Nontaxable Benefit Plan will end.

2. How do I join the Nontaxable Benefit Plan?

**Health, Dental and Vision Premiums:** If you participate in the health, dental or vision plan, participation in the **Premium Conversion** part of the Plan is automatic. If you do not wish to participate in the **Premium Conversion** part, you must notify the Plan when you enroll for insurance coverage (and by doing so understand that your health, dental, and vision premiums will be taxed). Once a Notice of Nonparticipation is submitted, it will remain in effect until the Plan is notified of your desire to participate again.

**Medical Care Expense Reimbursement Account:** If you are a New Hire who is eligible to participate in the NHC Health Benefit Plan, you may participate in the Medical Care Expense Reimbursement Account when you enroll for health insurance coverage. However, partners that elect the HSA Value Plan are not eligible to participate in the Medical Care Expense Reimbursement Account Plan. Participation in the Medical Care Expense Reimbursement Account plan requires new enrollment each year. Once enrolled, your contributions to the account will begin the same pay period of your eligibility date for your health, dental, or vision coverage.

Refer to IRS Publication 502 at [http://www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf) for eligible medical, dental and/or vision expenses. Please note that IRS Publication 502 lists various medical, dental and vision expenses that may be deductible on your personal federal income tax return; however, additional limitations on which medical expenses may be reimbursed by your Medical Care Expense Reimbursement Account exist, which are not discussed in Publication 502. Some of these additional limitations are explained in IRS Publication 969 at [http://www.irs.gov/pub/irs-pdf/p969.pdf](http://www.irs.gov/pub/irs-pdf/p969.pdf). If you have a question about whether your Medical Care Expense Reimbursement Account can reimburse you for a particular medical, dental or vision expense, you should contact the Plan Administrator before incurring the expense.

**Health Savings Account Contributions:** You must be a participant in the HSA Value Plan and a health savings account must have been established for you at a financial institution in order to contribute to the Health Savings Account. Please refer to the Health Benefit Plan section of this Handbook for enrollment information. If you are participating in the HSA Value Plan, you may change your contributions to the Health Savings Account at any time during the Plan Year.


**Dependent Care Assistance Expense Reimbursement Account:** If you are a New Hire, you may participate in the Dependent Care Assistance Expense Reimbursement Account when you first become eligible. Participation in the Dependent Care Assistance Expense Reimbursement Account Plan requires a new enrollment each year. Once enrolled, your contributions to the account will begin the same pay period of your eligibility date for your health, dental, or vision coverage.

If you do not join the Nontaxable Benefit Plan when you are first eligible to join, you will have to wait until the first of the next Plan Year (January 1 of the following year) to join the Dependent Care Assistance Expense Reimbursement Account plan.

3. How can my health, dental and/or vision expenses be paid on a before-tax basis?

The Nontaxable Benefit Plan lets you convert your health, dental and/or vision insurance premiums from being paid on an after-tax basis to being paid on a before-tax basis. This is called a **Premium Conversion** and saves you tax dollars. If you are eligible to participate in the NHC Health Benefit Plan (and are not enrolled in the HSA Value Plan), the Nontaxable Benefit Plan also lets you save and pay for other unreimbursed health, dental and/or vision expenses on a before-tax basis out of a **Medical Care Expense Reimbursement Account** (also sometimes called a medical flexible spending account). Alternatively, if you have
During enrollment, you decide how much money you want to contribute to your Medical Care Expense Reimbursement Account. This amount will be deducted from your pay before any taxes are calculated and withheld, subject to limitations imposed by Section 125 of the Internal Revenue Code, which include a limitation on reimbursement for items having a useful life lasting beyond the end of the Plan Year in which they are purchased and other limitations. For instance, premiums for medical, dental or vision care insurance, or cancer or other specific disease insurance, hospital confinement or intensive care insurance, or contact lenses replacement insurance, or life insurance, or long-term care insurance, or wage continuation insurance are not covered expenses eligible for before-tax payment or reimbursement from your Medical Care Expense Reimbursement Account under the Nontaxable Benefit Plan. All questions concerning what are covered expenses will be decided by the Plan Administrator. You may appeal if you disagree with the Plan Administrator’s decision. However, if there is any question as to whether an expense is covered which you wish to pay for on a before-tax basis, you should ask about such coverage in advance.

4. How does the before-tax payment of health, dental and/or vision premiums work?

It works in two different ways, depending on whether premiums are being paid by “Premium Conversion” or whether a benefit is being paid from your Medical Care Expense Reimbursement Account. If you elect to convert the premium you pay for health insurance, the Dental Plan and/or Vision Plan to a payment on a before-tax basis, the Nontaxable Benefit Plan will decrease the taxable portion of your paycheck by the amount of your premium payment for that coverage. By your participation in the Nontaxable Benefit Plan, you direct your employer to make contributions to the Nontaxable Benefit Plan on your behalf to pay your premium for the health, dental or vision coverage you elected on a before-tax basis. Since your taxable pay is decreased, your taxes are lower. Since it lowers taxes, it creates tax savings - which you get to keep.

5. How does the before-tax payment of medical care expenses work?

During enrollment, you decide how much money you want to contribute to your Medical Care Expense Reimbursement Account for the Plan Year.

Your contributions are made to the Medical Care Expense Reimbursement Account before taxes are calculated and withheld from your pay. In order to be reimbursed for your covered medical expenses (even if you do not elect coverage under the Health Benefit Plan, the Dental Plan and/or the Vision Plan), you simply submit the required documentation (e.g., itemized statements, receipts, invoices, or Explanation of Benefits [EOB] from your insurance company) along with a claim form for your covered medical expenses to the Nontaxable Benefit Plan. The Nontaxable Benefit Plan will then reimburse you for your covered expenses from your Medical Care Expense Reimbursement Account up to the amount you have elected to contribute. The reimbursement will be included on your payroll check.

Your check stub shows how much money has gone into your Medical Care Expense Reimbursement Account and how much has been paid. You will also receive periodic account statements during the Plan Year. All medical expenses reimbursed from your Medical Care Expense Reimbursement Account must be incurred (date service provided) between January 1 through December 31, but you have 90 days after the end of the Plan Year to claim your money from the prior Plan Year. (See also - What is the carryover provision in my Medical Care Expense Reimbursement Account?). Again, the money that you claim is added to your net pay on your payroll check. It is never included in your taxable wages.

6. What medical expenses are covered under my Medical Care Expense Reimbursement Account?

You can receive reimbursement from your Medical Care Expense Reimbursement Account for almost all of your medical expenses and those of your spouse and legal dependents which are not reimbursed by any Health Benefit Plan, dental plan and/or vision plan. Expenses that are considered eligible for reimbursement may include amounts incurred for hospital bills, licensed doctor, dentist and orthodontist treatment, prescription drugs, eye care, hearing care, cost of transportation to and from treatment, deductibles, co-pays, coinsurance, amounts not paid or reimbursed because medical, dental or vision expenses are in excess of reasonable and customary. Only deductible expenses can be paid for on a before-tax basis under your Medical Care Expense Reimbursement Account.

Refer to IRS Publication 502 at [http://www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf) for eligible medical, dental and/or vision expenses and to IRS Publication 969 at [http://www.irs.gov/pub/irs-pdf/p969.pdf](http://www.irs.gov/pub/irs-pdf/p969.pdf) for some limitations on what eligible medical, dental and vision expenses may be reimbursed. Your reimbursements from your Medical Care Expense Reimbursement Account are also subject to limitations imposed by Section 125 of the Internal Revenue Code, which include a limitation on reimbursement for items having a useful life lasting beyond the end of the Plan Year in which they are purchased and other limitations. For instance, premiums for medical, dental or vision care insurance, or cancer or other specific disease insurance, hospital confinement or intensive care insurance, or contact lenses replacement insurance, or life insurance, or long-term care insurance, or wage continuation insurance are not covered expenses eligible for before-tax payment or reimbursement from your Medical Care Expense Reimbursement Account under the Nontaxable Benefit Plan. All questions concerning what are covered expenses will be decided by the Plan Administrator. You may appeal if you disagree with the Plan Administrator’s decision. However, if there is any question as to whether an expense is covered which you wish to pay for on a before-tax basis under your Medical Care Expense Reimbursement Account, you should ask about such coverage in advance.

In deciding how much you want to contribute to your Medical Care Expense Reimbursement Account you should consider the amount of your co-pay, deductible and coinsurance payments under the Health Benefit Plan, dental and/or vision plan. For instance, after the co-pay and any applicable deductible is paid by you, you and your employer share in paying medical costs as coinsurance. You might elect to put money into your Medical Care Expense Reimbursement Account for your medical co-pays, deductibles and your share of coinsurance you reasonably expect to pay so you will be paying these on a
You should note that the above description of medical expenses which may be reimbursed from your Medical Care Expense Reimbursement Account does not describe those employer self-insured medical benefits, or insured dental and/or vision benefits. Those benefits are described in their own summary plan description sections of this Handbook.

Also, you should note that, like premiums you pay for medical coverage through an insurance company, even if you never use your coverage, you don't get back the money you paid for that coverage. Likewise, under federal tax law, the balance in your Medical Care Expense Reimbursement Account at the end of the Plan Year will **not** be repaid to you except in those cases where reimbursement is requested by March 31 for services received by December 31 of the prior year.

However, effective with Plan Year 2015, unused Medical Care Expense Reimbursement Account balances of up to $500.00 may be carried over to the subsequent Plan Year. You are urged to limit contributions from your pay to your Medical Care Expense Reimbursement Account to that amount you think you will use as covered expenses during the upcoming Plan Year. This is very important: this "use it or lose it" rule is required by federal tax law.

### 7. What is the carryover provision in my Medical Care Expense Reimbursement Account?

Beginning with Plan Year 2015, Medical Care Expense Reimbursement Account balances of up to $500 may be carried over to the next Plan Year to reimburse covered medical expenses incurred in a subsequent Plan Year. Carryover amounts will be determined and available after the end of the runout period for the previous Plan Year. The runout period for a Plan Year begins on January 1 and ends on March 31 of the next Plan year. After March 31, remaining balances from the previous Plan Year in excess of the $500 carryover will be forfeited.

The carryover provision applies only for so long as you are eligible to participate in the NHC Health Benefit Plan and are not enrolled in the HSA Value Plan. If you lose that eligibility, or become enrolled in the HSA Value Plan, you will forfeit whatever carryover balance you have in your Medical Care Expense Reimbursement Account.

If your employment terminates during a year in which you have carried over amounts under your Medical Care Expense Reimbursement Account from a prior year, you will continue to be able to claim covered medical expenses incurred during the year in which your employment terminated through the end of the runout period for that year. However, you will not be able to carryover any amounts to the year following the year in which you terminated employment. All account balances not claimed by March 31 in the year following the year in which your employment terminated will be forfeited.

### 8. Are there any limits to covered expenses under, or contributions to, the Medical Care Expense Reimbursement Account?

You will not be reimbursed for expenses covered by any insurance or employer self-insured plan. In other words, you cannot be reimbursed twice, and trying to do so may be a crime.

There is a $2,650 (indexed annually) overall cap on your contributions to your Medical Care Expense Reimbursement Account. Also, you cannot be reimbursed for expenses in excess of the limit set out in the Nontaxable Benefit Plan Election Form. You may make a withdrawal at any time up to this limit if you first certify the covered expenses – even if your withdrawal exceeds your payroll deductions for your Medical Care Expense Reimbursement Account at that time. If your withdrawal exceeds your contributions to your Medical Care Expense Reimbursement Account, your employer will be reimbursed by you out of future payroll contributions you make to your Medical Care Expense Reimbursement Account, or your employer will offset other amounts it owes to you to the extent permitted by law. Tax laws may further limit the before-tax contribution or reimbursement of medical expenses for highly compensated partners.

### 9. Can I, as a plan participant, also deduct reimbursed medical expenses when I prepare my income tax return at year end?

No, you should **not** deduct any of these reimbursed medical expenses on your personal income tax return (IRS Form 1040) since you have already received the “tax benefit” at the time your pay was adjusted to pay the reimbursed expenses. In effect, a tax deduction has already been taken by you.

Actually, in all cases you are better off from an income tax viewpoint under the Nontaxable Benefit Plan when you get a dollar for dollar “tax benefit”. Otherwise, you generally get only a deduction for medical expenses (other than prescriptions) in excess of ten percent of your adjusted gross income when you itemize deductions on your tax return.

### 10. How can my dependent care assistance expenses be paid on a before-tax basis?

The Nontaxable Benefit Plan lets you pay for dependent care assistance expenses on a before-tax basis out of a **Dependent Care Assistance Expense Reimbursement Account** (also sometimes called a dependent care flexible spending account).
11. How does the before-tax payment of dependent care assistance expenses work?

You decide how much money (up to the limits provided) you want to contribute to your Dependent Care Assistance Expense Reimbursement Account for the Plan Year. Your contributions are made each pay period to your Dependent Care Assistance Expense Reimbursement Account before taxes are calculated on your pay. After these contributions are in your Dependent Care Assistance Expense Reimbursement Account, you simply submit receipts or other required documentation on the claim form for your covered dependent care assistance expenses to the Nontaxable Benefit Plan. The Nontaxable Benefit Plan will then reimburse you for your covered expenses from your Dependent Care Assistance Expense Reimbursement Account for the Plan Year up to the amount which you have then contributed. The reimbursement will be included on your payroll check. Your contributions to your Dependent Care Assistance Expense Reimbursement Account are made on a before-tax basis, and your reimbursement of your dependent care assistance expenses also will be paid on a before-tax basis. (Your Dependent Care Assistance Expense Reimbursement Account may be charged an administrative fee.)

Your check stub shows how much money has gone into your account and how much has been paid. You will also receive periodic account statements during the Plan Year. All services paid for from the Plan must be incurred (date service provided) January 1 through December 31, but you have 90 days after the end of the Plan Year to claim your money from the prior Plan Year. Again, the money that you claim is added to your net pay on your payroll check. It is never included in your taxable wages.

12. What expenses are covered under my Dependent Care Assistance Expense Reimbursement Account?

Expenses for dependent care assistance services performed either in your home or a qualifying day care center for your children under age 13 or for your spouse or other qualifying dependents (if they live with you and cannot take care of themselves), which are necessary for you and your spouse to work, are expenses covered by your Dependent Care Assistance Expense Reimbursement Account. However, it does not cover services provided by another of your dependents, your spouse or one of your children under 19 years of age. Services that are performed by a qualifying day care center must charge a fee and provide care to six or more individuals who are not residents there.

Please note that if you select dependent care assistance expense coverage, you must be careful to specify the amount that you want your pay adjusted each pay period. Your contribution should equal only the dependent care assistance expenses you expect to have during a pay period. If you overestimate your expenses, you cannot get the excess money back under federal tax law. Also, you cannot take any more out of your Dependent Care Assistance Expense Reimbursement Account at any time than is in the Dependent Care Assistance Expense Reimbursement Account.

Federal tax law requires that you use the amount in your Dependent Care Assistance Expense Reimbursement Account or you will lose it at the end of the Plan Year. Be conservative with your pay period participation.

You may, however, if your dependent care assistance costs significantly increase or decrease during the Plan Year, make a prospective corresponding increase or decrease in your contributions to your Dependent Care Assistance Expense Reimbursement Account, provided the cost change is imposed by a dependent care assistance provider who is not your relative. For this purpose, a relative is (1) your son or daughter, or a descendent of either, (2) your stepson or stepdaughter, (3) your brother, sister, stepbrother or stepsister, (4) your father or mother, (5) your stepfather or stepmother, (6) a son or daughter of your brother or sister, (7) a brother or sister of your father or mother or (8) your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law. The term “brother” and “sister” will include a brother or sister by the half-blood. Furthermore, the term “son” or “daughter” includes a legally adopted child, or a child placed with you for adoption by an authorized placement agency, who is a member of your household and has your home as his or her principal place of abode.

13. Are there any limits to my covered expenses under, or contributions to, my Dependent Care Assistance Expense Reimbursement Account?

Yes, there are some restrictions on the amount of your pay which may be adjusted to provide benefits under your Dependent Care Assistance Expense Reimbursement Account. For instance, you cannot draw more out of your Dependent Care Assistance Expense Reimbursement Account than you have contributed.

Also, your contributions for a Plan Year are limited to the earned income of either you or your spouse, whichever is less. Consequently, your pay adjustments should not exceed this amount. If your spouse is incapacitated or a student in a bona fide college or university for five or more months each calendar year, then, even if your spouse actually had no earned income, your spouse will be deemed by law to have earned income of $200.00 a month if only one dependent is eligible for day care assistance, and $400.00 a month if more than one dependent is eligible for day care assistance. Furthermore, there is a $5,000.00 overall annual cap on your contributions under the law. (The annual cap is $2,500 if you are married, but filing a separate federal income tax return). There is also an overall legal limit on contributions made by people who own more than five percent of your employer. If this applies to you, you should ask the Plan Administrator about this limitation.

Finally, you cannot take another deduction or tax credit with respect to expenses you receive reimbursement for on a before-tax basis as a reimbursed dependent care expense benefit under the Nontaxable Benefit Plan.
14. Would I be better off taking the tax credit provided by tax law for household and dependent care services necessary for gainful employment instead of paying my dependent care expenses under the Nontaxable Benefit Plan?

You might be better off taking the tax credit, but it depends on your income level (considering the income of your spouse), whether you file joint or separate tax returns with your spouse, and the number of dependents you have. In general, the more taxable income you have, the better off you are in participating in the Dependent Care Assistance Expense Reimbursement Account. However, this is a complicated matter, and we urge you to seek competent advice your personal tax adviser before you make the decision.

15. Can I change my election under the Nontaxable Benefit Plan?

Your benefit election is good for the remainder of the Plan Year after you make it, and cannot be changed under the tax law for that Plan Year unless you experience what federal tax law refers to as a “change in status”. The law limits a change in status to the following situations:

- **A change in legal marital status.** Events that change your legal marital status, including the following: marriage, death of spouse, divorce, legal separation and annulment.

- **A change in number of dependents.** Events that change your number of dependents, including the following: birth, death, adoption and placement for adoption.

- **A change in employment status.** Any of the following events that change the employment status of you, your spouse, or your dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence and a change in worksite. In addition, if the eligibility conditions of a Health Benefit Plan, or the medical care plan of your spouse's employer or your dependent's employer, depend upon employment status and there is a change in that employment status with the consequence that the individual becomes (or ceases to be) eligible under the Health Benefit Plan or other medical care plan, then that change constitutes a change in employment.

- **Dependent satisfies or ceases to satisfy eligibility requirements.** Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage under the medical care Health Benefit Plan on account of attainment of age, student status, or any similar circumstance.

- **A change in residence.** A change in the place of residence of you, your spouse, or your dependent.

The change you make in your benefit election because of a change in status must be consistent with your change in status. In other words, following a birth of a dependent, you cannot elect to stop making Premium Conversions.

You may also revoke an election for the remainder of a Plan Year and make a new election that corresponds with special enrollment rights you have under HIPAA. Special enrollment rights under HIPAA arise in situations similar to those that are changes in status just discussed above. However, the HIPAA special enrollment rights do not apply to your Dependent Care Assistance Expense Reimbursement Account. Additionally, if you lose coverage because another employer's contributions are terminated to another medical care plan other than yours, this gives you special enrollment rights under HIPAA in any medical care plan we sponsor.

Likewise, you may make an election change for the remainder of a Plan Year if you, your spouse or dependent becomes enrolled in Medicare, Medicaid or other similar state program taking the place of Medicare or Medicaid (other than the program for pediatric vaccines under Social Security or similar state program). You also may make a change if such coverage is lost.

You may also make an election change regarding your participation in the Health Benefit Plan, the Dental Plan, the Vision Plan or your Medical Care Expense Reimbursement Account in accordance with a qualified medical child support order issued by a Court.

You must give written notice to the Plan of the change in your benefit election. Any such change will be effective as soon as administratively possible.

The Nontaxable Benefit Plan Election Form is included in this Handbook as part of the Enrollment Form.

You may also change your benefit elections for the next Plan Year for the Nontaxable Benefit Plan by submitting a new election during the Annual Enrollment period for the following Plan Year.

16. What happens if I am participating in the Nontaxable Benefit Plan and I take FMLA leave?

You may continue coverage under any Medical Care Plan to which you contribute. However, because FMLA leave is unpaid leave, you generally will not be receiving pay from which to instruct your Employer to make before-tax contributions on your behalf. Consequently, if you decide to continue your coverage in any Health Benefit Plan, you must continue to make contributions for your part of the applicable premiums during the FMLA leave. However, if you are due any unused sick days,
perfect attendance or ETO days and if that pay is due during the leave, you can use what otherwise would be taxable pay to make before-tax contributions to the Nontaxable Benefit Plan.

If your FMLA leave is foreseeable, it is to your advantage to plan ahead regarding how your contributions to the Nontaxable Benefit Plan will be made during the leave. Contact the Plan Administrator for more information.

17. What happens if my employment terminates?
If your employment terminates, you may have COBRA continuation coverage rights under the Health Benefit Plan, the Dental Plan and the Vision Plan.

Also, if your employment terminates, you will be deemed to have made an election to terminate contributions to your Medical Care Expense Reimbursement Account. No further contributions to your Medical Care Expense Reimbursement Account will be required or permitted. You may continue to claim, up to your Medical Care Expense Reimbursement Account balance as of the date your contributions stopped, reimbursement for medical expenses incurred during the Plan Year. However, if you have already received Medical Care Expense Reimbursement Account benefits equal to or in excess of the amount you contributed, you will not be eligible for further reimbursement.

You have until March 31 of the following Plan Year to claim reimbursement under your Medical Care Expense Reimbursement Account for medical expenses incurred in the year in which you left your employment. All Medical Care Expense Reimbursement Account balances from the prior Plan Year not claimed by March 31 will be forfeited. You will not be able to carryover any amounts to the year following the year in which you terminated employment.

If your employment terminates, or if you otherwise disenroll in the HSA Value Plan, your contributions to your Health Savings Account will cease. Your Health Savings Account may continue to reimburse you for any medical expenses you incur after that point, to the extent allowed by law.

If your employment terminates, you will also be deemed to have made an election to terminate contributions to your Dependent Care Assistance Expense Reimbursement Account. No further contributions to your Dependent Care Assistance Reimbursement Account will be required or permitted. You may continue to claim, up to your Dependent Care Assistance Reimbursement Account balance as of the date your contributions stopped, dependent care assistance expenses incurred during the remainder of that Plan Year. However, if you have already received Dependent Care Assistance Expense Reimbursement Account benefits equal to the amount you contributed, you will not be eligible for further reimbursement. You will have until March 31 of the following Plan Year to claim reimbursement for dependent care assistance expenses incurred in the year in which you left your employment. All account balances from the prior Plan Year not claimed by March 31 will be forfeited.

18. What happens if I become ineligible to participate in the NHC Health Benefit Plan, but my employment does not end?
A special rule applies in connection with your Medical Care Expense Reimbursement Account. If you become ineligible to participate in the NHC Health Benefit Plan, federal law requires your participation in your Medical Care Expense Reimbursement Account to end automatically. Here are some examples as to how this works. Both examples assume the partner is not enrolled in the HSA Value Plan for 2016.

Example 1. A partner who is eligible to participate in the NHC Health Benefit Plan transfers to a part-time position in 2016 and loses eligibility at the end of the 2017 stability period. Because each stability period under the NHC Health Benefit Plan begins each January 1, the partner will have until March 31, 2017 (i.e., the end of the Medical Care Expense Reimbursement Account runout period for 2016 - the Plan Year in which the partner changed positions) to submit claims for reimbursement for medical care expenses incurred during 2016. However, the partner’s participation in the Medical Care Expense Reimbursement Account ends on December 31, 2016, and no carryover from 2016 to 2017 will be allowed because the partner is ineligible to participate in the NHC Health Benefit Plan after December 31, 2016. Any unused balance in the partner’s Medical Care Expense Reimbursement Account left over at the end of the 2016 Plan Year runout period is forfeited.

Example 2. A partner who is eligible to participate in the NHC Health Benefit Plan transfers to a part-time position in 2016, but works enough hours during the measurement period attributable to that plan’s 2017 stability period to remain eligible in the NHC Health Plan for the 2017 Plan Year. Since this part-time partner’s eligibility to participate in the NHC Health Benefit Plan does not end until December 31, 2017, the partner may continue to participate in the Medical Care Expense Reimbursement Account for 2017, unless the partner elects the HSA Value Plan for 2017. Assuming the partner does not elect HSA Value Plan coverage for 2017, carryover amounts from 2015 and 2016 (to 2016 and 2017, respectively) are permitted. However, the partner’s participation in the Medical Care Expense Reimbursement Account ends on December 31, 2017, and no carryover from 2017 to 2018 is allowed, because the partner’s eligibility in the NHC Health Benefit Plan ends on December 31, 2017. The partner will have until March 31, 2018 (i.e., the end of the runout period for the Medical Care Expense Reimbursement Plan’s 2017 Plan Year) to make claims for reimbursement of medical care expenses incurred during 2017. Any unused balance in the partner’s Medical Care Expense Reimbursement Account left over at the end of the 2017 Plan Year runout period is forfeited.
Another special rule applies for your Health Savings Account. If you are enrolled in the HSA Value Plan and subsequently become ineligible to participate in, or disenroll from, that Plan, your HSA contributions will automatically cease. Also, if you become enrolled in Medicare, you no longer have the right to make Health Savings Account contributions. You will need to notify the Plan Administrator of your enrollment in Medicare.

19. Does reducing my Social Security taxes reduce my Social Security benefits?

Yes, it may very slightly reduce your Social Security benefits because the amount of salary subject to Social Security taxes is reduced. But these Social Security tax savings go to provide you with tax benefits now.

20. Who provides recordkeeping services for the Nontaxable Benefit Plan?

The Nontaxable Benefit Plan is administered by National Health Corporation, which is officially the Plan Administrator. The Plan Administrator, however, may appoint office personnel or a third party administrator to handle the day-to-day operations of the Nontaxable Benefit Plan. Their job is to make sure that the Nontaxable Benefit Plan works smoothly. However, the Plan Administrator makes the final determination about how the Nontaxable Benefit Plan is administered. Benefits under the Nontaxable Benefit Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator has discretionary authority to determine eligibility for benefits under the Nontaxable Benefit Plan and to interpret the provisions of the Nontaxable Benefit Plan.

21. Can the Nontaxable Benefit Plan be amended or terminated?

The Nontaxable Benefit Plan is intended to be of indefinite duration, but National Health Corporation reserves the right in its sole discretion to amend or terminate the Nontaxable Benefit Plan at any time for any reason.

22. What are the Nontaxable Benefit Plan’s claims procedures?

If you believe you have a claim for benefits under the Nontaxable Benefit Plan which has been overlooked or denied, your claim should be submitted to the Plan Administrator which administers the Nontaxable Benefit Plan. You can contact the Plan Administrator through your supervisor. Payment of claims under the Nontaxable Benefit Plan will be made by the Plan Administrator. However, if benefits provided under the Health Benefit Plan, the Dental Plan and/or the Vision Plan are provided through group insurance policies, the insurer’s claims procedures will apply to claims under those plans instead of the claims procedures in this Handbook, and the insurer will pay such claims.

Since all benefit claims made under the Nontaxable Benefit Plan will be made after care is received, all benefit claims are post-service claims. If you make a benefit claim and your claim is wholly or partially denied, the Nontaxable Benefit Plan Administrator will notify you of the adverse decision within a reasonable period of time, but no later than 30 days after the Nontaxable Benefit Plan Administrator's receipt of your claim.

If the Nontaxable Benefit Plan Administrator determines that an extension of time for processing your claim is needed due to matters beyond the control of the Nontaxable Benefit Plan Administrator, the Nontaxable Benefit Plan Administrator will notify you of the reason or reasons for the extension and the extended due date before the end of the 30-day period after your filing of the claim.

The extended period will not exceed 45 days after the date of your filing of your claim. If the extension is due to your failure to submit specific information, the notice of extension will describe the required information that you will need to provide to the Nontaxable Benefit Plan Administrator, and you will be given 45 days from the date of your receipt of the notice to submit the information. If additional information is requested, the time period for making the benefit decision will be tolled (i.e., suspended) from the date on which the notice is sent to you until the date you respond to the request for information.

The notice of an adverse benefit determination will be provided in writing or electronic form. The notice will provide the following information, written in a manner to be understood by you:

(1) the specific reason or reasons for the adverse determination;

(2) reference to the specific provision or provisions of the Nontaxable Benefit Plan on which the adverse determination was based;

(3) that you will be provided, upon your request and free of charge, access to and copies of all documents, records and other information considered relevant to your claim (a document will be considered relevant to your claim if it: (i) was relied upon in making the adverse benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; or (iii) demonstrates compliance in making the benefit decision with the requirement that benefit determinations must follow the terms of the Nontaxable Benefit Plan and be consistent when applied to similarly situated claimants);
(4) that the reviewer on appeal will consider all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(5) that the reviewer on appeal will not defer to the initial adverse benefit determination and will not be the individual who made the initial adverse determination nor the subordinate of such individual;

(6) that in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the Nontaxable Benefit Plan fiduciary conducting the appeal review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment (a health care professional includes a physician or other health care professional licensed, accredited or certified to perform specified health services under state law);

(7) that the health care professional engaged with respect to the review of the claim on appeal may not be an individual who was consulted in connection with the initial adverse benefit decision nor the subordinate of such individual; and

(8) that medical or vocational experts whose advice was obtained on behalf of the Nontaxable Benefit Plan in connection with the claim on appeal will be identified (even if the advice was not relied upon in the benefit determination).

You will have 180 days following receipt of the notice of the adverse benefit determination in which to file an appeal of the decision to the Plan Administrator.

The Plan Administrator will notify you of the appeals decision (whether adverse or not) within a reasonable period of time, but no later than 60 days after the Plan Administrator's receipt of your appeal request. A notice of a benefit determination on appeal will be provided in written or electronic form. If the determination is adverse, the notice will provide the following information, written in a manner to be understood by you:

(1) the specific reason or reasons for the adverse determination;

(2) reference to the specific provision or provisions of the Nontaxable Benefit Plan on which the determination is based;

(3) a statement that you are entitled to receive, upon your request and free of charge, access to and copies of all documents, records and other information relevant (as that term is described above) to the benefit claim;

(4) a description of any voluntary appeal procedures offered under the Nontaxable Benefit Plan, your right to obtain information about such procedures (if there are any such procedures) and a statement regarding your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

(5) if applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to you upon your request; and

(6) if the adverse determination is based in whole or in part on a medical judgment, (including whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate), or is based on a similar exclusion or limit in the Nontaxable Benefit Plan that a health care professional (as that term is defined above) who has appropriate training and experience in the field of medicine involving medical judgment was consulted and the health care professional's explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to you upon your request.

The above rights you have in pursuing an initial benefit claim or appeal of an adverse benefit determination of that claim may be exercised by your authorized representative acting on your behalf. The Plan Administrator, however, may establish procedures for determining whether an individual has been authorized to act on your behalf.

23. What are my rights under ERISA?

One of the purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”) is to provide participants with better information concerning their benefit plans. It also granted additional rights to plan members and beneficiaries. This description of the Nontaxable Benefit Plan summarizes the information, protection and rights available to participants and beneficiaries of the Nontaxable Benefit Plan. Your employer’s health, dental and vision coverages are subject to ERISA, as well as your Medical Care Expense Reimbursement Account.

You may examine, without charge, at the Plan Administrator's office, the legal instruments composing the Nontaxable Benefit Plan and the latest annual reports (Form 5500 series) filed with the U.S. Department of Labor for the benefit options offered thereunder. You may obtain copies of all the above materials upon written request to the Plan Administrator. There will be a reasonable charge for copies.
In addition to creating rights for the Nontaxable Benefit Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plans offered thereunder. The people who operate those benefit options, called “fiduciaries” of the plan; have a duty to do so prudently and in the interest of you and other participants and beneficiaries of the plan. No one at your employer will or may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

While almost any disagreement over the Nontaxable Benefit Plan and its operation should be able to be settled honestly and fairly, on rare occasions disputes may exist. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that the Nontaxable Benefit Plan fiduciaries misuse the Nontaxable Benefit Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. An example of this would be if it finds your claim is frivolous. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S., Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

This summary plan description is intended to provide you with easy-to-understand general explanations of the more significant provisions of the Nontaxable Benefit Plan. It does not describe, or have any effect upon, the benefits available or covered under the Health Benefit Plan or any other welfare benefit plan sponsored by your employer. Every effort has been made to make these general explanations as accurate as possible. However, the Nontaxable Benefit Plan is legally very complex. If any conflict should arise between this summary plan description and the provisions of the Nontaxable Benefit Plan document itself, or if any provision is not covered or only partially covered, the terms of the actual legal instrument composing the Nontaxable Benefit Plan will govern in all cases.
GENERAL INFORMATION ABOUT THE NONTAXABLE BENEFIT PLAN

Your employer is the Sponsor of the Nontaxable Benefit Plan for its partners. It is also the agent for service of legal process under the law. Some general information about the Nontaxable Benefit Plan for National Health Corporation partners follows:

<table>
<thead>
<tr>
<th>Sponsor's Identification Number:</th>
<th>62-1294263</th>
</tr>
</thead>
</table>
| Sponsor's Address:              | 100 Vine Street  
                                  | Murfreesboro, TN 37130 |
| Plan Name:                      | Nontaxable Benefit Plan |
| Plan Number:                    | 506 |
| Plan Administrator:             | National Health Corporation |
| Address:                        | 100 Vine Street  
                                  | Murfreesboro, TN 37130 |
| Nontaxable Benefit Plan Year:   | January 1 through December 31 |
Retirement Plans

NHC offers two Retirement Plans. By the federal government’s standards and definitions, both are qualified defined contribution plans and are on file with the Department of Labor as such. The Plans are:

401(k) Plan

The 401(k) Plan was introduced in 1990 to all NHC and NHC affiliated companies. Partners make contributions to their own individual accounts and their employer adds contributions to their accounts referred to as company matching contributions. The partner contributions come from earnings that are not taxed with federal income taxes.

Each participant chooses how they want their contributions invested within the 6 investment options available. Participants may also choose a target date portfolio as a portion or all of the partner’s investment allocation.

This is a RETIREMENT PLAN and the federal government has established 401(k) retirement plans to allow employees to save for their retirement with dollars that are not taxed and allow employers to contribute to their employees’ individual retirement accounts.

The federal government’s expectation is that funds from 401(k) Plans will be used to supplement Social Security payments when an employee RETIRES from the workforce.

ESOP

The National Health Corporation Leveraged Employee Stock Ownership Plan, more commonly referred to as the “ESOP”, is a retirement plan sponsored by National Health Corporation. Various forms of the ESOP have been in place since 1977.

This Plan is specific to National Health Corporation as an employer and the Plan is funded totally by the employer with shares of company related stock.

Since the ESOP is totally funded by company stock of the employer, the only employers and partners that can participate in the ESOP are those for which NHC has ownership.

NHC manages many locations that are owned by an owner/company independent of NHC. Based on federal ESOP regulations the companies are not eligible for participation in the ESOP Retirement Plan.

The section of this Handbook tabbed ESOP will only be applicable to partners who are employed by an NHC owned company. Your Administrator or Supervisor can answer questions related to your ESOP eligibility.

As of December 14, 2009 the ESOP became frozen.

Employer contributions, participant forfeitures and annual additions of new Plan participants ceased for the indefinite duration of the Plan freeze.

All other Plan provisions remain the same.

Current participation in one or both plans can be a valuable addition to your retirement income. Obviously, the more years of participation, the greater the asset for you when you reach retirement.
401(k) Plan

The 401(k) Plan is a retirement savings plan that allows deferring taxes on income and earnings until after retirement. No Federal Income Taxes are withheld on each contribution. However, Social Security Taxes are withheld. Contributions must be made through payroll deduction.

The 401(k) Plan provisions include:

1) All partners (except temporary) who are at least 18 years old or older can contribute to the 401(k) Plan.

2) $10.00 per pay period is the minimum contribution required and a maximum contribution of the lesser of 100% of gross income or $18,500 (2018, adjusted annually for inflation). Contributions are made 26 times per calendar year (26 pay periods). Annual Catch-Up contributions of up to $6,000 are available for plan participants age 50 or over at the end of the calendar year. Maximum contributions are indexed annually.

3) Your employer currently matches every dollar contributed in the 401(k) Plan with an additional 50 cents until the partner contributions reach 2 1/2% of their quarterly wages. The match is invested in NHC stock. The match is made quarterly. The matching contribution will be 100% vested after 3 years of service (paid for 1,000 hours per year). Years of service prior to January 1, 1990, which is the effective date of the 401(k) Plan, will not be counted for vesting purposes.

4) Six (6) investment options: (Partner Chooses)
   - NHC Common Stock (non-diversified employer securities)
   - Aggressive Allocation Portfolio
   - Target Allocation Portfolio
   - Diversified Stocks Portfolio
   - Diversified Bonds Portfolio
   - Stable Return Portfolio

5) Target Allocation Portfolios: Partners may also choose a target date portfolio for a portion or all of the partner’s investment allocation. Each of the target allocation portfolios is invested in a different mix of the Plan’s diversified investment options, and allocations are adjusted over time by the Plan’s investment adviser, with longer target dates exhibiting higher risks and volatility. Portfolios are designed to meet broad investment goals, not unique needs and circumstances.

6) The 401(k) plan allows for two different investment selections using the investment options available, including the individual investment options and the Target Allocation Portfolios. The two options for participants’ balances are defined below.
   - “Future Contribution Investments” applies to all contributions made into the 401(k) Plan, in the future, starting with the first deduction / contribution for new partners and partners without prior plan participation. For partners already participating, the investment change will be effective for all future contributions beginning with the next pay period after the change request is made.
   - “Current Account Balance Investments” applies to the account balance at the end of each calendar month. All account balances at the end of the current month will be moved to the new selection at the beginning of the next month after the change request is made.

7) Partners can start, stop, or change their contribution at any time. Investment options can also be changed at any time. Future investment changes will be effective the next payroll processing following receipt. Current account balance investment changes will be effective on the first of the month following receipt of the change.
8) If contributions are stopped, the money remains in the 401(k) Plan until the partner becomes eligible for a distribution.

9) Lump sum rollovers from another qualified pension plan are accepted into the NHC 401(k) Plan immediately after employment starts. However, the money must be eligible for distribution from the prior plan before the NHC 401(k) Plan can accept it. All rollover funds are always 100% vested. The Plan can also accept rollovers from 457 (governmental) Plans as well as IRAs. To “roll” funds into this 401(k) Plan, contact the 401(k) Customer Service Hotline at 1-800-538-3628.

10) Each participant receives a quarterly statement as long as they maintain an account balance.

11) Each account is charged an annual $21.00 administration fee by the 401(k) Plan Recordkeeper. The administration fee will show on the quarterly statement, pro-rated quarterly ($5.25 each quarter).

12) Withdrawals are available based on retirement, termination, age and service, death, and disability and are lump sum withdrawals.

13) Normal retirement age for this 401(k) Plan is 65 and early retirement is age 55 with 10 years of service.

14) When a partner terminates, the vested account balance will be available for distribution as soon as administratively possible after the end of the quarter in which the partner terminates (normally within 8 to 10 weeks after the end of the quarter.)

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

16) IRS allows the 401(k) Plan to offer loans to plan participants. When offering a loan provision, the 401(k) Plan is legally obligated to follow the rules that IRS has provided. For loan eligibility determinations and applications, contact the NHC 401(k) Customer Service Hotline at 1-800-538-3628.

17) Under certain circumstances, hardship withdrawals are available.

18) The recordkeeping for the 401(k) Plan is administered by The Trust Company of Knoxville in Knoxville, Tennessee. All inquiries about the 401(k) Plan should be made to the NHC 401(k) Customer Service Hotline at 1-800-538-3628.

NHC BENEFITS HOTLINE
Retirement Inquiries
1-800-538-3628
National Health Corporation 401(k) Plan
DESIGNATION OF BENEFICIARY FORM

Partner Name ____________________________________________________________

Social Security Number ___________________________________________________

Address / City / State / Zip _________________________________________________

Center Name and Location __________________________________________________

This designation of beneficiary may be changed at any time. The beneficiary assignment should be reviewed as life changes occur, i.e. marriage, divorce, death, birth or adoption. When making a Beneficiary change, you must change or confirm both your Primary and Contingent Beneficiary designations. Leaving a section blank constitutes an update and will delete any previous Primary or Contingent Beneficiaries you may have on file for this account.

Check One:          ___ Single       ___ Married (Even if legally separated)

Married Participants - under federal law, if you are currently legally married and you designate anyone other than your spouse as your primary beneficiary, your spouse must sign the spousal consent portion at the bottom of this form in the presence of a notary public. If your spouse does not waive the right to be your Primary Beneficiary, you must list the spouse’s name as Primary Beneficiary with complete address information. This Retirement Plan does not recognize (1) common law marriage or (2) any domestic relationship other than marriage that is legally recognized as such by the State of residence.

Non-Married Participants – If you are not married, you should name a Beneficiary to receive your benefit in the event of your death and a Contingent Beneficiary in the event that the Beneficiary you name predeceases you.

If a primary or contingent beneficiary does not survive you, his or her interest and the interests of his or her heirs shall terminate completely, and the percentage share of the remaining beneficiary(s) shall be increased on a pro-rata basis. If no primary or contingent beneficiary survives you and you are not married then the benefits will go to your estate.

Primary Beneficiary(s)                                                                

1) Name ___________________________  _____%  ___________________________  _____%  
   Relationship _______________________  Social Security Number __________________
   Address ____________________________
   City / State / Zip ____________________

2) Name ___________________________  _____%  ___________________________  _____%  
   Relationship _______________________  Social Security Number __________________
   Address ____________________________
   City / State / Zip ____________________

Contingent Beneficiary(s)                                                                

1) Name ___________________________  _____%  ___________________________  _____%  
   Relationship _______________________  Social Security Number __________________
   Address ____________________________
   City / State / Zip ____________________

2) Name ___________________________  _____%  ___________________________  _____%  
   Relationship _______________________  Social Security Number __________________
   Address ____________________________
   City / State / Zip ____________________

SPOUSE CONSENT OF NON-SPOUSE BENEFICIARY DESIGNATION

I, ______________________________________, spouse of ___________________________, approve the designation of ___________________________ as Primary Beneficiary and ___________________________ as Contingent Beneficiary. I understand that I am forfeiting my right to any benefit to which I would be entitled under the Plan pursuant to the Retirement Equality Act.

Spouse’s Signature ______________________ Date: ____________________________

Notary Signature ____________________ Commission Expires __________________

Partner Signature: ___________________________ Date: ____________________________

Return completed form to The Trust Company, Attn. NHC, 4823 Old Kingston Pike, Suite 100, Knoxville, TN 37919
NATIONAL HEALTHCARE CORPORATION 401(k) PLAN

SUMMARY PLAN DESCRIPTION

(Reflecting the IRS Required Final EGTRRA Remedial Amendments)
THE NATIONAL HEALTHCARE CORPORATION

401(k) Plan
(The “401(k) Plan”)

This section of this Handbook is the general explanation and description of benefits under the National HealthCare Corporation 401(k) Plan.

This is only a summary of the 401(k) Plan. Discrepancies between this section of the Handbook and the actual 401(k) Plan, as well as the resolution of any differences, are governed by the provisions of the actual 401(k) Plan document itself and its related legal instruments. These documents are available from the 401(k) Plan Administrator. National Health Corporation reserves the right to modify, revoke, suspend, terminate or change any or all of the provisions of the 401(k) Plan and the policies under which it is administered at any time. This right can be exercised retroactively in certain circumstances and can be generally implemented with or without advance notice, consultation or reaching agreement with anyone, at any time. However, under federal law, the 401(k) Plan provisions cannot be changed in a way that reduces your then current vested account balance in the 401(k) Plan.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION TO THE 401(k) PLAN</td>
<td>11</td>
</tr>
<tr>
<td>PARTICIPATION IN THE PLAN</td>
<td>11</td>
</tr>
<tr>
<td>Am I eligible to participate in the Plan?</td>
<td>11</td>
</tr>
<tr>
<td>When am I eligible to participate in the Plan?</td>
<td>11</td>
</tr>
<tr>
<td>When is my entry date for participation if I am eligible?</td>
<td>11</td>
</tr>
<tr>
<td>What happens if I’m a participant, terminate employment and then I’m rehired?</td>
<td>11</td>
</tr>
<tr>
<td>CONTRIBUTIONS</td>
<td>12</td>
</tr>
<tr>
<td>What kind of Plan is this?</td>
<td>12</td>
</tr>
<tr>
<td>Do I have to contribute money to the Plan in order to participate?</td>
<td>12</td>
</tr>
<tr>
<td>How much may I contribute to the Plan?</td>
<td>12</td>
</tr>
<tr>
<td>How often can I modify the amount I contribute?</td>
<td>13</td>
</tr>
<tr>
<td>Will contributions be made to the Plan by my employer?</td>
<td>13</td>
</tr>
<tr>
<td>Will I share in such contributions during the year of my early, normal or late retirement, total and permanent disability or death?</td>
<td>13</td>
</tr>
<tr>
<td>How will such contributions be allocated to my account?</td>
<td>13</td>
</tr>
<tr>
<td>What compensation is used to determine my Plan benefits?</td>
<td>13</td>
</tr>
<tr>
<td>Is there a limit on the amount of compensation which can be considered?</td>
<td>14</td>
</tr>
<tr>
<td>Is there a limit on how much can be contributed to my account each year?</td>
<td>14</td>
</tr>
<tr>
<td>May I roll over payments from another retirement plan or IRA?</td>
<td>14</td>
</tr>
<tr>
<td>How is the money in the Plan invested?</td>
<td>14</td>
</tr>
<tr>
<td>RETIREMENT BENEFITS</td>
<td>14</td>
</tr>
<tr>
<td>What benefits will I receive at normal retirement?</td>
<td>14</td>
</tr>
<tr>
<td>What benefits will I receive at early retirement?</td>
<td>15</td>
</tr>
<tr>
<td>What is my late retirement date?</td>
<td>15</td>
</tr>
<tr>
<td>What happens if I leave the workforce covered by the Plan before I retire?</td>
<td>15</td>
</tr>
<tr>
<td>What is my vested interest in my accounts?</td>
<td>15</td>
</tr>
<tr>
<td>How do I determine my “years of service for vesting purposes”?</td>
<td>15</td>
</tr>
<tr>
<td>Does all my service count for vesting purposes?</td>
<td>16</td>
</tr>
<tr>
<td>As a veteran of the uniformed services, will my military service count as service with my covered employer?</td>
<td>16</td>
</tr>
<tr>
<td>What happens to my non-vested account balance if I’m rehired?</td>
<td>16</td>
</tr>
<tr>
<td>What happens to the non-vested portion of a terminated participant’s account balance?</td>
<td>16</td>
</tr>
<tr>
<td>DISABILITY BENEFITS</td>
<td>16</td>
</tr>
<tr>
<td>How is disability defined?</td>
<td>16</td>
</tr>
<tr>
<td>What happens if I become disabled?</td>
<td>16</td>
</tr>
<tr>
<td>FORM OF BENEFIT PAYMENT</td>
<td>16</td>
</tr>
<tr>
<td>How will my benefits be paid?</td>
<td>16</td>
</tr>
<tr>
<td>DEATH BENEFITS</td>
<td>17</td>
</tr>
<tr>
<td>What happens if I die when working while covered by the Plan?</td>
<td>17</td>
</tr>
<tr>
<td>Who is the beneficiary of my death benefit?</td>
<td>17</td>
</tr>
<tr>
<td>How will the death benefit be paid to the beneficiary?</td>
<td>17</td>
</tr>
<tr>
<td>When must the last benefit be paid to a beneficiary?</td>
<td>17</td>
</tr>
<tr>
<td>What happens if I’m a participant, terminate employment and die before receiving all of my benefits?</td>
<td>17</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS, CONT.

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN-SERVICE DISTRIBUTIONS</strong></td>
<td>17</td>
</tr>
<tr>
<td>Can I withdraw money from my accounts while working?</td>
<td>17</td>
</tr>
<tr>
<td>Can I withdraw money from my accounts if I am a reservist called to active duty?</td>
<td>18</td>
</tr>
<tr>
<td>Can I withdraw money from my accounts in the event of financial hardship?</td>
<td>18</td>
</tr>
<tr>
<td>What constitutes a hardship?</td>
<td>18</td>
</tr>
<tr>
<td>Are there any conditions to receiving a hardship distribution?</td>
<td>18</td>
</tr>
<tr>
<td><strong>TAX TREATMENT OF DISTRIBUTIONS</strong></td>
<td>18</td>
</tr>
<tr>
<td>What are my tax consequences when I receive a distribution from the Plan?</td>
<td>18</td>
</tr>
<tr>
<td>Can I reduce or defer tax on my distribution?</td>
<td>19</td>
</tr>
<tr>
<td><strong>HOURS OF SERVICE</strong></td>
<td>19</td>
</tr>
<tr>
<td>What is an “hour of service”?</td>
<td>19</td>
</tr>
<tr>
<td>How are hours of service credited?</td>
<td>19</td>
</tr>
<tr>
<td><strong>LOANS</strong></td>
<td>19</td>
</tr>
<tr>
<td>May I borrow money from the Plan?</td>
<td>19</td>
</tr>
<tr>
<td>What are the loan rules and requirements?</td>
<td>19</td>
</tr>
<tr>
<td><strong>YOUR PLAN’S TOP HEAVY RULES</strong></td>
<td>20</td>
</tr>
<tr>
<td>What is a top heavy plan?</td>
<td>20</td>
</tr>
<tr>
<td>What happens if the Plan becomes top heavy?</td>
<td>20</td>
</tr>
<tr>
<td><strong>PROTECTED BENEFITS AND CLAIMS PROCEDURES</strong></td>
<td>20</td>
</tr>
<tr>
<td>Is my benefit protected?</td>
<td>20</td>
</tr>
<tr>
<td>Are there any exceptions to the general rule?</td>
<td>20</td>
</tr>
<tr>
<td>Can the Plan be amended?</td>
<td>21</td>
</tr>
<tr>
<td>What happens if the Plan is discontinued or terminated?</td>
<td>21</td>
</tr>
<tr>
<td>How do I submit a claim for Plan benefits?</td>
<td>21</td>
</tr>
<tr>
<td>What if my benefits are denied?</td>
<td>21</td>
</tr>
<tr>
<td>What is the claims review procedure?</td>
<td>21</td>
</tr>
<tr>
<td>What are my rights as a Plan participant?</td>
<td>22</td>
</tr>
<tr>
<td>What can I do if I have questions or my rights are violated?</td>
<td>23</td>
</tr>
<tr>
<td><strong>PLAN EXPENSES</strong></td>
<td>23</td>
</tr>
<tr>
<td><strong>GENERAL INFORMATION ABOUT THE PLAN</strong></td>
<td>23</td>
</tr>
<tr>
<td>General Plan Information</td>
<td>23</td>
</tr>
<tr>
<td>Employer Information</td>
<td>24</td>
</tr>
<tr>
<td>Administrator Information</td>
<td>24</td>
</tr>
<tr>
<td>Trustee Information</td>
<td>25</td>
</tr>
<tr>
<td>Service of Legal Process</td>
<td>25</td>
</tr>
<tr>
<td>Plan Notices</td>
<td>25</td>
</tr>
</tbody>
</table>
INTRODUCTION TO THE 401(k)

National HealthCare Corporation 401(k) Plan (“Plan”) has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This description of the Plan is a summary of valuable information in the Plan document itself regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this summary to get a better understanding of your rights and obligations under the Plan. You may consult the Plan document itself for more details of the Plan’s provisions anytime during regular business hours, but especially you are encouraged to consult the Plan document when you make important decisions about participation and benefits.

We have attempted to answer typical questions you may have regarding your participation and benefits in the Plan. Also please feel free to contact the administrator of the Plan anytime if you have questions. The “administrator” of the Plan as set forth in the Plan document is National Health Corporation, which has appointed a Retirement Plan Committee to administer the day-to-day operations of the Plan in accordance with the Plan document. You may contact the Retirement Committee through the NHC Partner Benefits Department anytime during regular business hours.

This summary attempts to describe the Plan’s benefits and obligations as contained in the legal Plan document, which governs the provisions and operation of the Plan—especially as to the beginning and termination of coverage by the 401(k) plan of employers affiliated with National Health Corporation using this Plan document to reflect their own individual plans. The Plan document is written in much more technical, complete and precise legal language. If the non-technical language under this summary SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator through the NHC Partner Benefits Department.

This summary describes the current provisions of the Plan, as designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as ERISA (that is, the “Employee Retirement Income Security Act”), the Internal Revenue Code and other federal and applicable state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service or Department of Labor. We may also amend or terminate this Plan at any time for any reason. If the provisions of the Plan that are described in this summary plan description change, we will notify you.

PARTICIPATION IN THE PLAN

Am I eligible to participate in the Plan?

Provided you are not an “excluded employee” as defined below, you are eligible to participate in the Plan once you satisfy the Plan’s eligibility conditions described in the next question. The following employees are “excluded employees” and are not eligible to participate in the Plan:

- employees who are leased employees.
- employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in this Plan.
- employees of an affiliated employer unless such affiliated employer has specifically adopted this Plan document in writing in order to reflect its own 401(k) plan—but only while such adoption is effective (contact the NHC Benefits Department for a current list of such adopting employers that are covered by the Plan).
- employees who are independent contractors under IRS rules.

When am I eligible to participate in the Plan?

Provided you are not an excluded employee as described above, you will be eligible to participate in the Plan once you satisfy the age 18 eligibility requirement.

When is my entry date for participation if I am eligible?

Once again, provided that you are not an excluded employee described above, you may begin participating under the Plan once you have satisfied age 18 eligibility requirement, which is also your “entry date” into the Plan. You will also need to determine contribution and investment information in order to reflect your Plan participation. Your choices must be entered in the Retirement section of the NHC Partner Benefits website, https://nhcpartnerbenefits.com.

What happens if I’m a participant, terminate employment and then I’m rehired?

You will no longer be a participant if your employment terminates for any reason. If you are rehired, then you will begin to participate again in the Plan as of your date of rehire provided you complete the participation form.
CONTRIBUTIONS

What kind of Plan is this?

This plan is a type of retirement plan qualified by the IRS for favorable tax treatment so that taxes on that portion of compensation contributed to the Plan by you or your employer are deferred from immediate taxation. This type of Plan is commonly referred to as a 401(k) plan. In effect, you are deferring your actual receipt of part of your compensation to a later date where benefits are paid. This defers taxes. Such deferrals are called “salary deferrals”. Salary deferrals ALWAYS 100 percent belong to you. You yourself choose how much you want to defer as described later.

In addition to salary deferrals, we may make additional contributions to the Plan on your behalf. This section describes the types of contributions that may be made to the Plan and how these monies will be allocated to accounts set up in your name to provide you benefits described herein.

Do I have to contribute money to the Plan in order to participate?

No, you are not required to contribute any money in order to participate in the Plan. However, you may receive additional amounts if you do decide to defer part of your compensation. The reason you will want to consider making as much salary deferral as you prudently can is because your salary deferrals may be matched as described later, and thus may give you an immediate increase on your money in your accounts.

How much may I contribute to the Plan?

As a participant, you may generally elect to defer up to the maximum limit permitted by law instead of receiving that amount in taxable cash. This maximum limit may change each year by law based on inflation rates. In 2018 this maximum limit is $18,500. However, if you are a highly compensated employee the Retirement Committee may at any time limit your deferrals to the Plan in order to ensure that all categories of participants contributing to the Plan are fairly represented. But if your deferrals are going to be limited, the Retirement Committee will contact you to explain how your deferrals as elected by you will be affected.

Since October 1, 2007, as of January 1st of that year and thereafter participants projected to attain age 50 before the end of a calendar year may elect to defer additional amounts of compensation to the Plan (called “catch-up contributions”). Each year such a participant can make these catch-up contributions. The additional catch-up contributions may be deferred regardless of any other limitations on the salary deferrals that you may make to the Plan. The maximum catch-up contribution that you can make in 2018 is $6,000. Each year this maximum catch-up contribution may increase by law for inflation.

The amount you elect to defer, and any earnings on that amount, will not be subject to income tax until it is actually distributed to you as benefits. However, by law all salary deferrals you defer (including catch-up contributions) are counted as compensation for employment taxes in the year in which deferred.

You should also be aware that if an annual dollar limit is exceeded (including because you made salary deferrals under another employer’s plan, 403(b) tax sheltered annuity or deferral arrangement of your own), then the excess deferrals must be included in your income for the year. For this reason, it is desirable to request in writing that any such excess salary reduction amounts and catch-up contributions as applicable be returned to you when you are contacted with this opportunity. If you fail to request such a return, you may be taxed a second time when the excess deferral amount is ultimately distributed from the Plan or the other deferral arrangement you are in.

Consequently, you must decide which plan or arrangement you would like to have return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Retirement Committee no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the dollar limit is exceeded in this Plan or any other deferral arrangement you are in, then you will be deemed to have notified the Retirement Committee of the excess as being in this Plan. The excess deferral and any earnings in the Plan will then be returned to you by April 15th.

You will always be 100% vested in ownership rights to the amounts you defer. This means that you will always be entitled to all amounts that you defer. This money will be affected by any investment changes, be they gains or losses. If there is an investment gain, then the balance in your accounts will increase. If there is an investment loss, then the balance in your accounts will decrease.
You may elect to receive an early distribution of your vested accounts once you have attained age 59-1/2. Any earlier in-service distributions from amounts attributable to your salary deferrals would generally not be permitted by law without the imposition of an additional 10% tax. Before attaining age 59-1/2 distributions are permitted only in the following circumstances:

(a) for reasons of being called to active duty as a reservist, and
(b) for reason of proven financial hardship.

(See the questions found in the section of this summary entitled “In-Service Distributions” for an explanation of such distributions.)

The 10% additional tax will not apply on the amount of such distributions, but ordinary income taxes will be assessed on these amounts by the IRS.

In the event you receive a hardship distribution from your deferrals to this Plan pursuant to your certification and the Retirement Committee’s agreement that one of the above conditions are satisfied, you will not be allowed to make additional salary deferrals for a period of six (6) months after you receive the hardship distribution because of IRS rules.

Any early distributions from your accounts for hardship or active reservist duty are distributions of retirement benefits, so such distributions will reduce the benefits you ultimately will receive from the Plan.

How often can I modify the amount I contribute?

The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Retirement Committee. The procedure will require that you enter into a written salary deferral agreement after you satisfy the Plan’s age 18 eligibility requirement. You will be permitted to modify your election during the year. You are also permitted to revoke your election any time during the year. But by law no elections can be given retroactive effect.

Will contributions be made to the Plan by my employer?

In addition to your own salary deferrals to the Plan, each quarter your employer hopes to make matching contributions to the Plan equal to a uniform percentage of the amount of the salary deferrals you elected. The making of matching contributions and percentage of such matching contributions will be determined by the company on a year by year basis.

Your account will be credited with this matching contribution if you are actively employed anytime during the year.

Furthermore, on behalf of each participant who is NOT a non-highly compensated participant, the company may make under the law something called a “discretionary qualified non-elective contribution” equal to a uniform percentage of that participant’s compensation, which percentage also will be determined on a year to year basis.

You will share in this company discretionary qualified non-elective contribution if you are actively employed anytime during the year.

Will I share in such company contributions during the year of my early, normal or late retirement or total and permanent disability or death?

You will be eligible to share in the company contributions for a year if the reason your employment terminated is due to your early, normal or late retirement, total and permanent disability, or in the case of your death during that year.

How will such company contributions be allocated to my account?

All contributions to the extent made will be allocated as of each quarter end to the accounts maintained in your name. Company matching contributions act as an immediate return on your own salary deferral contributions to the Plan. In addition to company contributions made to your accounts, your accounts will be credited monthly with a share of the actual investment returns on your accounts. These company contribution accounts will vest (that is, your ownership rights will become complete) in accordance with the vesting schedule. (See the question “What is my vested interest in my accounts?” found in this summary entitled “Retirement Benefits” for an explanation of your ownership vesting rights.)

What compensation is used to determine my Plan benefits?

For the purposes of the Plan, compensation has a special meaning. Compensation is defined as your total compensation that is subject to income tax: that is, all of your compensation paid to you by the company during a calendar year, but

- excluding reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits.
- including your salary deferral contributions to any plan or arrangement maintained by your employer.

In the first year of participation in the Plan, your compensation will be recognized for benefit purposes from your entry date into the Plan.
Is there a limit on the amount of compensation which can be considered?
The Plan, by law, cannot recognize annual compensation each year in excess of a certain dollar limit. The limit for 2013 is $255,000. The dollar limit may increase for inflation adjustments by the IRS each year.

Is there a limit on how much can be contributed to my accounts each year?
Generally, the law imposes a maximum limit on the amount of contributions you may be credited with under the Plan each year. This limit applies to all company matching or qualified non-elective contributions made on your behalf, all salary deferral contributions you make to the Plan (excluding catch-up contributions—which have its own separate legal limit) and any other amounts allocated to any of your accounts during the year, excluding earnings and any transfers/rollovers. For 2013, this total cannot exceed $51,000 or, if less, 100% of your annual compensation. For this purpose, compensation includes your salary deferrals (but excluding any “catch-up contributions”). The IRS may increase the dollar limit for inflation on a year by year basis.

May I roll over payment from another retirement plan or IRA?
At the discretion of the Retirement Committee, a participant may deposit into the Plan distributions received from other retirement plans or IRAs, excluding a ROTH IRA, provided these have not already been included as taxable income to the participant by operation of law. (However, benefits attributable to after-tax employee contributions you make to another employer’s retirement plan cannot be rolled over.) Such a deposit is called a “rollover” and may result in tax savings to you. So ask a tax professional about this. You may then ask your prior retirement plan administrator or trustee to directly transfer (called a “direct rollover”) to this Plan all or a portion of any amount which you are entitled to receive as a distribution from that other retirement plan or IRA. However, if you actually receive a distribution from a prior retirement plan, you must elect to deposit any amount eligible for rollover within 60 days of your receipt of the distribution. Once again, you should consult a tax professional to determine if a rollover is in your best interest.

The Retirement Committee will confirm for you if the prior retirement plan or IRA may make such a rollover contribution.

Your rollover will be placed in a separate account in your name designated for such rollover. You will always be 100% vested in your ownership rights in “rollovers” and “direct rollovers.” This means that you will always be entitled to all of your rollover contributions. Like all other accounts, rollover contributions will be credited or debited with any investment returns.

When you become eligible to receive Plan benefits, the value of your special rollover account will be used to provide additional benefits for you or your designated beneficiary or beneficiaries.

How is the money in the Plan invested?
You will be able to direct the investment of certain contributions to the Plan. The Retirement Committee will provide you from time to time with information on the investment choices available to you, on the frequency with which you can change your investment choices and other related investment information. Periodically, you will receive a benefit statement that provides information on the balance of your accounts and investment returns on those accounts. If you have any questions about the investment of your Plan accounts, please contact the NHC Partner Benefits Department. To the extent you do not direct the investment of your applicable Plan accounts, then your accounts will be invested on your behalf in accordance with the default investment alternatives as established under the Plan. If a default investment is made on your behalf with the default investment alternative, you will be assumed to have chosen this investment option yourself.

When you direct investments, your accounts are segregated for purposes of determining the gains or losses on these investments. You should be assured your accounts do not share in the investment performance for other Participants who have directed their own investments.

You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Investment returns will be gains as well as losses, both of which can occur. There are no guarantees of investment performance, and neither your employer, the Retirement Committee, the Trustee, nor any of their representatives provide investment advice or insure or otherwise guarantee the value or performance of any investment you yourself choose or are deemed to have chosen.

RETIREMENT BENEFITS

What benefits will I receive at normal retirement?
Your normal retirement date under the Plan is when you reach your 65th birthday.

You will be entitled to all your accounts under the Plan when you reach your normal retirement age of 65. Actual payment of your benefits will, at your election, begin as soon as administratively feasible following your normal retirement date. If you continue working after your normal retirement date, your benefits will be deferred until you actually retire at a later date.
What benefits will I receive at early retirement?

Your early retirement date is any December 31st following the date you have both attained age 55 and, if later, have also completed 10 years of service with us. You will have completed a year of service if you are credited with at least 1000 hours of service during a calendar year. (See the section in this summary entitled “Hours of Service” for an explanation of what is counted as an hour of service.) You may elect to retire when you reach the early retirement date if you choose.

You will be entitled to all your accounts under the Plan when you reach your early retirement date. Payment of your early retirement benefits will, at your election, begin as soon as administratively feasible following your December 31st early retirement date if you choose to retire. However, if you retire early and the value of your vested benefit is less than $1,000, a distribution will automatically be made to you within a reasonable time after you terminate employment without your request.

What is my late retirement date?

You may remain employed past your normal retirement date and instead retire on a later date. Your late retirement date is then the date you choose to retire after reaching your normal retirement date. On your late retirement date, you will be entitled to all your accounts under the Plan. Actual payment of your benefits will, at your election, begin as soon as administratively feasible following your late retirement date.

What happens if I leave the workforce covered by the Plan before I retire?

The Plan is designed to encourage you to stay with us until retirement. Consequently, payment of your account balances under the Plan is generally available automatically upon your retirement, or if earlier, your disability or death. Your accounts become fully vested on your retirement, disability or death regardless of your credited vesting years of service with the company.

However, if your employment terminates for reasons other than your retirement, you will be entitled to receive only the vested percentage of the balance of your account (other than your own salary deferral account and any rollover account you may have which ARE ALWAYS FULLY VESTED). The term “vested” means full ownership or interest.

You may elect to have your vested interest in your accounts distributed to you as soon as administratively feasible following your termination of employment. Nevertheless, if the value of your vested benefit is less than $1,000, a distribution will be made to you automatically within a reasonable time after you terminate employment. (See the question “How will my benefits be paid?” found in this summary entitled “Form of Benefit Payment” for an explanation of the dollar “cash-out” threshold.)

What is my vested interest in my accounts?

You always will be 100% vested in your salary deferral accounts, your rollover account (if you have one) and all of your company contribution accounts upon your early, normal or late retirement. However, if your service terminates for any reason other than retirement, disability or death, the vested percentage in your company contribution accounts is determined under the following vesting schedule and is based on your vesting years of service.

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<th>Vesting Years of Service</th>
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<tr>
<td>Less than 3</td>
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<td>3 or more</td>
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Also company matching contributions attributable to your salary deferrals (but not your salary deferrals themselves) in excess of the dollar limit (described in the question in this summary entitled “How much may I contribute to the Plan?”) to determine the dollar limit), or matching contributions attributable to salary deferral amounts that are distributed in a corrective distribution to highly compensated employees, will be forfeited as well.

Once again, please remember that regardless of the vesting schedule above, you are always 100% vested in your salary deferrals and any of the company’s qualified non-elective contributions contributed to the Plan, as well as your rollover account (if you have one).

Your vested benefit will be distributed to you or your beneficiary or beneficiaries upon your retirement, disability or death as described in this summary.

How do I determine my “years of service for vesting purposes”?

To earn a “year of service”, you must be credited with at least 1000 hours of service during a calendar year in which your employer is covered by the Plan. (See the section in this summary entitled “Hours of Service” for an explanation of what is counted as an hour of service.) The plan contains specific rules for crediting hours of service for vesting purposes. The Retirement Committee will track your service and will credit you with a vesting year of service for each calendar year in which you are credited with the required hours of service in accordance with the terms of the Plan. If you have any questions regarding your vesting service, or whether your employer is covered by this Plan (and the period of such coverage) you should contact the NHC Partner Benefits Department.
Does all my service count for vesting purposes?  

In calculating your vested percentage, all service you perform for your employer while your employer is covered by the Plan will generally be counted. However, there are some exceptions to this general rule.

Years of service prior to the effective date of coverage under the Plan with respect to your employer will not count for vesting purposes.

Also, there are important “break in service” rules you should note. If you terminate employment and are rehired, you may not be credited for prior service under the Plan’s break in service rules as described below.

For vesting purposes, you will have a break in service if you complete less than 501 hours of service during the calendar year. However, if you are absent from work for certain leaves of absence such as maternity or paternity leave, you may be credited with 501 hours of service to prevent a break in service.

As a veteran of the uniformed services, will my military service count as service with my covered employer?

If you are a veteran and are reemployed, then under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with your covered employer. If you may be affected by this law, ask the NHC Partner Benefits Department for further details.

What happens to my non-vested account balance if I’m rehired?

If you have no vested percentage in your company account balance attributable to company contributions when you leave (that is, you were 0% vested), that account balance will be forfeited as of the end of the fifth year thereafter in which you are not eligible to receive an allocation of company contributions.

What happens to the non-vested portion of a terminated participant’s account balance?

The non-vested portion of the account which is attributable to company contributions of a participant whose employment terminates remains in the Plan and is called a forfeiture. Forfeitures may be used by the Plan for several purposes such as the payment of the Plan expenses. Any forfeitures not used by the Plan may also be used as company contributions to the Plan.

DISABILITY BENEFITS

How is disability defined?

Under the Plan, disability is defined as a physical or mental condition resulting from bodily injury, disease, or mental disorder which renders you incapable of continuing any gainful occupation with your covered employer. This condition must qualify for Social Security disability benefits.

What happens if I become disabled?

If you become disabled while a participant, you will be entitled to 100% of the balance of your accounts. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your vested benefits is less than $1,000, a distribution will be made to you automatically within a reasonable time after you terminate employment.

FORM OF BENEFIT PAYMENT

How will my benefits be paid?

If your vested benefit under the Plan is not greater than $1,000, then your benefit will be automatically “cashed out” to you in a single lump-sum payment as soon as possible following the event that entitles you to a distribution. However, if your vested benefit under the Plan is $1,000 or more, then you must consent to receive the distribution before your 65th birthday, at which point the distribution will automatically be made to you. You may elect to receive a distribution under one of the following methods:

- a single lump-sum payment in cash.
- installments over a period of not more than your assumed life expectancy (or your and your beneficiary’s assumed life expectancies).

If the administrative processing fee equals or exceeds a very small benefit amount, the benefit will be $0 to reflect its offset of that administrative fee. A lost participant will also be assessed the administrative fee incurred in finding that lost participant. So always keep the NHC Partner Benefits Department advised of your current address so you do not become a “lost participant”.
DEATH BENEFITS

What happens if I die when working while covered by the Plan?

If you die when working while your employer is covered by the Plan, then the entire balance of your accounts will vest and be used to provide your beneficiary or beneficiaries with a death benefit.

Who is the beneficiary of my death benefit?

If you are married at the time of your death, by law your then current spouse at the time of your death automatically will be the beneficiary of the death benefit, unless you make an election to name another person other than your spouse as your beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR THEN CURRENT SPOUSE, YOUR SPOUSE MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE’S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NON-SPouse BNEEFICIARY OR BENEFICIARIES TO RECEIVE THE DEATH BENEFIT.

If you are married and you wish to change your beneficiary designation from the beneficiary or beneficiaries your spouse approved, then your spouse must again consent to the change. You may elect a beneficiary or beneficiaries other than your spouse without your spouse’s consent only if your spouse cannot be located.

You may designate your beneficiary or beneficiaries on a beneficiary designation form you may get from the NHC Partner Benefits Department through the Retirement section of its website at https://nhcpartnerbenefits.com.

In the event no valid designation of beneficiary exists, or if the beneficiary is not alive at the time of your death, the death benefit will be paid to your estate.

How will the death benefit be paid to a beneficiary?

The death benefit will generally be paid, unless otherwise provided in the next question, to a beneficiary in one of the following methods as elected by the beneficiary (unless you had already elected one of the following forms of distribution for the death benefit prior to your death):

• a single lump-sum payment in cash.
• installments over a period of not more than your beneficiary’s IRS expected life expectancy.

When must the last payment be made to a beneficiary?

Regardless of the method of distribution selected, if your designated beneficiary is a person (rather than your estate or certain types of trusts) then minimum annual distributions of your death benefit will begin by the end of the year following the year of your death (“1-year rule”) and must be paid over a period not extending beyond your beneficiary’s life expectancy. If your spouse is the beneficiary, then under the “1-year rule,” the start of payments will be delayed until the year in which you would have attained age 70-1/2 had you lived, unless your spouse elects to begin distributions over his or her own IRS life expectancy before then. However, instead of the “1-year rule” your beneficiary may elect to have the entire benefit paid by the end of the fifth year following the year of your death (the “5-year rule”). Generally, if your beneficiary is not a person, your entire death benefit must be paid under the “5-year rule.”

Since your then current spouse has an exclusive right to your death benefit, you should immediately report any change in your marital status (for example, on marriage or divorce) to the NHC Partner Benefits Department.

What happens if I’m a participant, terminate employment and die before receiving all of my benefits?

If you terminate employment while covered by the Plan and subsequently die, your beneficiary or beneficiaries then will be entitled to the vested percentage as of your termination of employment of your remaining balance of your accounts.

IN-SERVICE DISTRIBUTIONS

Can I withdraw money from my accounts while working?

You will be entitled to receive a pre-retirement in-service distribution of the vested balances in your accounts if you have reached age 59-1/2. However, any distribution will reduce the value of the benefits you will receive at any later date. This pre-retirement in-service distribution is made at your election.
Can I withdraw money from my accounts if I am a reservist called to active duty?

Starting January 1, 2010, if you are a reservist called to active duty for 179 days or more (or indefinitely) after the 9/11 terrorist attacks, you may elect to make an in-service withdrawal of your own salary deferrals from the Plan. Also starting January 1, 2010, if you are on duty for more than 30 days you may elect to make an in-service withdrawal, but in this case (unlike the 179 day or more in-service withdrawal just described) when you return to work by law you may not make salary deferrals to the Plan for six months once you begin again to participate in the Plan. (Company contributions are not available for withdrawal for either of these reservist withdrawal provisions.) Reservist distributions will reduce the value of benefits the reservist is eligible to receive at a later date. However, a reservist who receives such a distribution may repay all or a portion of the distributed salary deferrals or rollover any time throughout the 2-years following the end of the active duty period and thereby reestablish his or her salary deferral or rollover accounts.

Can I withdraw money from my account in the event of financial hardship?

Yes, if you satisfy certain conditions the Retirement Committee may direct the Trustee to distribute up to 80% of the balance in your accounts attributable to your salary deferrals or 100% of your rollover/transfer (if you have one) in the event of hardship. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at your termination of employment, early in-service post-age 59-1/2 withdrawal, retirement, death or disability.

What constitutes a hardship?

A hardship is allowed only on account of an immediate and heavy financial need, which is caused by one of the following:

(a) expenses for medical care previously incurred by you, your spouse or your dependent or your designated beneficiary (or beneficiaries) under the Plan, or necessary for you or any of the above to obtain medical care;

(b) costs directly related to the purchase of your principal residence (excluding mortgage payments);

(c) tuition, related educational fees, and room and board expenses for the next twelve months of post-secondary education for yourself, your spouse or dependent, or your designated beneficiary (or beneficiaries) under the Plan;

(d) amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence;

(e) payments for burial or funeral expenses for your deceased parent, spouse, children or other dependents; and

(f) expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under the Internal Revenue Code.

Are there any conditions to receiving a hardship distribution?

A distribution will be made from the above accounts, but only if you certify that ALL of the following conditions are satisfied:

(a) The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the hardship distribution.

(b) You have obtained all distributions, other than hardship distributions, and all nontaxable (at the time of the loan) loans currently available under any other plan maintained by your covered employer.

(c) That your elective salary deferral contributions, with respect to hardship distribution after December 31, 2001, will be suspended for at least six months after your receipt of the hardship distribution.

TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution (other than a loan) in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution.
Can I reduce or defer tax on my distribution?

You may reduce or defer the tax due on your distribution through use of one of the following methods:

(a) The rollover of all or a portion of the distribution to a regular traditional Individual Retirement Account (IRA) or to another qualified employer plan. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, the direct transfer option described in paragraph (b) below might be the better choice for you.

(b) For most distributions, you may request that a direct transfer of all or a portion of a distribution be made to either a regular IRA or another qualified employer plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the regular IRA or other qualified employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer, e.g., a distribution of less than $200 will not be eligible for a direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld by law for federal income tax purposes.

WHENEVER YOU RECEIVE A DISTRIBUTION, THE RETIREMENT COMMITTEE WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATEMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH A QUALIFIED TAX ADVISOR BEFORE MAKING A CHOICE.

HOURS OF SERVICE

What is an “hour of service”?

You will be credited with an hour of service for:

(a) each hour for which you are directly or indirectly compensated while covered by the Plan for the performance of duties during the calendar year;

(b) each hour for which you are directly or indirectly compensated while covered by the Plan for reasons other than performance of duties (such as vacation, holidays, sickness, disability, military duty, jury duty or leave of absence during the year); and

(c) each hour for back pay awarded or agreed to by the Plan.

You will not be credited for the same hours of service both under (a) or (b), as the case may be, and under (c).

How are hours of service credited?

You will be credited with your actual hours of service.

LOANS

May I borrow money from the Plan?

Yes. You may request a participant loan by calling the NHC Retirement Hotline at 1-800-538-3628. Your ability to obtain a participant loan depends on several factors. The Retirement Committee determines whether you satisfy these factors.

What are the loan rules and requirements?

There are various rules and requirements that apply for any loan which are outlined in this question. In addition, we have established a written loan program which explains these requirements in more detail. You can request a copy of the loan program by calling the NHC Retirement Hotline at 1-800-538-3628. The rules for loans include the following:

- Loans are available to participants on a reasonably equivalent basis. Loans will be made to participants who are creditworthy. The Retirement Committee may request that you provide additional information, such as financial statements, tax returns and credit reports to make this determination.

- All loans must be adequately secured. You must sign a promissory note along with a loan pledge. You must use the vested balance in your accounts as security for the loan, provided the outstanding balance of all your loans does not exceed 50% of your vested balance. In certain cases, the Retirement Committee may require you to provide additional collateral to receive a loan.
• You will be charged a reasonable rate of interest for any loan received from the Plan. The Retirement Committee will determine a reasonable interest rate by reviewing the interest rates charged for similar types of loans by other lenders.

• If approved, your loan will provide for level amortization with payments to be made not less frequently than quarterly. Generally, the term of the loan may not exceed five (5) years. However, if the loan is for the purchase of your principal residence, the Retirement Committee may permit a longer repayment period. Generally, the Retirement Committee will require that you repay your loan by agreeing to payroll deduction. If you have an unpaid leave of absence or go on military service leave while you have an outstanding loan, please contact the NHC Retirement Hotline at 1-800-538-3628 to find out your repayment options.

• All loans will be considered a directed investment from your account under the Plan. All payments of principal and interest by you on a loan will be credited to your accounts.

• The amount the Plan may loan to you is limited by rules under the Internal Revenue Code. All loans, when added to the outstanding balance of all other loans from the Plan, will be limited to the lesser of:
  
  (a) $50,000 reduced by the excess, if any, of your highest outstanding balance of loans from the Plan during the one-year period prior to the date of the loan over your current outstanding balance of loans; or

  (b) 1/2 of your vested balance in your accounts.

Also, no loan in an amount less than $1,000 will be made nor will a loan be made if a prior loan is currently outstanding.

• If you fail to make payments when they are due under the terms of the loan, you will be considered to be “in default.” The Trustee will consider your loan to be in default if any scheduled loan repayment is not made by the end of the calendar quarter following the calendar quarter in which the missed payment was due. The Plan would then have authority to take all reasonable actions to collect the balance owing on the loan. This could include filing a lawsuit or foreclosing on the security for the loan. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan, and could result in taxable income to you. In any event, your failure to repay a loan will reduce the benefit you would otherwise be entitled to from the Plan.

• The loan application fee is $75.00, and there is an annual maintenance fee of $25.00

YOUR PLAN’S TOP HEAVY RULES

What is a top heavy plan?

A retirement plan that primarily benefits “key employees” is called a “top heavy plan.” Key employees are certain owners or officers. A plan is generally a “top heavy plan” when more than 60% of the Plan assets are attributable to such key employees.

Each year, the Retirement Committee is responsible for determining whether the Plan is a “top heavy plan.”

What happens if the Plan becomes top heavy?

If this Plan becomes top heavy in any Plan Year, then the company may be required to make a contribution on behalf of non-key employees in order to provide such employees with at least “top heavy minimum benefits” for the year.

PROTECTED BENEFITS AND CLAIMS PROCEDURES

Is my benefit protected?

As a general rule, your interest in your accounts, including your vested interest, may not be “alienated”. This means that your interest may not be sold, used as collateral for a loan (other than a Plan loan), given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your accounts.

Are there any exceptions to the general rule?

There are two exceptions to the general rule. The Retirement Committee must honor a “qualified domestic relations order.” A qualified domestic relations order is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, child or other dependent. If a qualified domestic relations order is received by the Retirement Committee, all or a portion of your benefits may be used to satisfy the obligation. The Retirement Committee will determine the validity of any domestic relations order received. You and your beneficiaries can obtain, without charge, a copy of the QUALIFIED DOMESTIC RELATIONS ORDER PROCEDURE from the NHC Retirement Hotline at 1-800-538-3628.
The second exception applies if you are involved with the Plan’s administration. If you are found liable for any action that adversely affects the Plan, the Retirement Committee can offset your benefits by the amount you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

Can the Plan be amended?

Yes. National Health Corporation has the right to amend the Plan for any reason at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your accounts.

What happens if the Plan is discontinued or terminated?

Although National Health Corporation intends to maintain the Plan indefinitely, it reserves the right to terminate the Plan for any reason at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. Distribution of accounts will be made in the manner permitted by the Plan as soon as practicable. (See the question “How will my benefits be paid?” found in the section of this summary entitled “Form of Benefit Payment.”) Furthermore, if your employer is an affiliated employer using this National Health Care Plan document to reflect its own 401(k) Plan (that is, your employer is a covered employer), then if your covered employer becomes no longer affiliated with National Health Care, your coverage under this Plan document will automatically immediately terminate, (as will your employment for purposes of the Plan) unless your employer uses another tax qualified 401(k) document to reflect its plan.

How do I submit a claim for Plan benefits?

Benefits will be paid to you and your beneficiaries without the necessity of formal claims. However, if you think an error has been made in determining your benefits, then you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Retirement Committee.

If the Retirement Committee determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Retirement Committee will provide you with a written or electronic notification of the Plan’s adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Retirement Committee, unless the Retirement Committee determines that special circumstances require an extension of time for processing your claim. If the Retirement Committee determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90 day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

The Retirement Committee’s written or electronic notification of any adverse benefit determination must contain the following information:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination is based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) Appropriate information as to the steps to be taken if you or your beneficiary want to submit your claim for review.

If your claim has been denied, and you want to submit your claim for review, you must follow the Claims Review Procedure in the next question.

What is the claims review procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Retirement Committee.

(a) **YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN OR ELECTRONIC NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.**
(b) You may submit written comments, documents, records, and other information relating your claim for benefits.

(c) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Retirement Committee will provide you with written or electronic notification of the Plan’s benefit determination on review. The Retirement Committee must provide you with notification of this denial within 60 days after the Retirement Committee’s receipt of your written claim for review, unless the Retirement Committee determines that special circumstances require an extension of time for processing your claim. If the Retirement Committee determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60 day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. In the case of an adverse benefit determination, the notification will set forth:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination is based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

If you have a claim for benefits which is denied upon review, in whole or in part, you may file suit in a state or Federal court.

What are my rights as a Plan participant?

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan participants are entitled to:

(a) Examine, without charge, at the NHC Partner Benefits Department during regular business hours and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Retirement Committee, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Retirement Committee may make a reasonable charge for the copies.

(c) Receive a summary of the Plan’s annual financial report. The Retirement Committee is required by law to furnish each participant with a copy of this summary annual report.

(d) Obtain a statement telling you whether you have a right to receive a retirement benefit at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a retirement benefit, the statement will tell you how many years you have to work to get a right to such a benefit. THIS STATEMENT MUST BE REQUESTED IN WRITING AND IS NOT REQUIRED TO BE GIVEN MORE THAN ONCE EVERY TWELVE (12) MONTHS. The Plan must provide this statement free of charge.

In addition to creating rights for Plan participants, the law called the Employee Retirement Income Security Act (or “ERISA”) imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA which governs the Plan.

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Retirement Committee to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Retirement Committee.
If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state of Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the qualified domestic relations order (or “QDRO”) procedures from the NHC Partner Benefits Department.

If it should happen that the Plan’s fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

What can I do if I have questions or my rights are violated?

If you have any questions about the Plan, you should contact the Retirement Committee. If you have any questions about this summary or about your rights under ERISA, or if you need assistance in obtaining documents from the NHC Partner Benefits Department, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries. Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration.

PLAN EXPENSES

The Plan permits the payment of Plan expenses to be made from the Plan assets. If we do not pay these expenses from the company’s own assets, then the expenses paid using the Plan’s assets will generally be allocated among the accounts of all participants in the Plan. These expenses will be allocated either proportionately based on the value of the account balances or as an equal dollar amount based on the number of participants in the Plan. The method of allocating the expenses depends on the nature of the expense itself. For example, certain administrative (or recordkeeping) expenses would typically be allocated proportionately to each participant. For example, if the Plan pays $1,000 in expenses and there are 100 participants, your account balance would be charged $10 ($1,000 divided by 100 equals $10) of the expense.

After you terminate employment with your covered employer, the right is reserved to charge your account for your pro rata share of the Plan’s administration expenses, regardless of whether some of these expenses are paid on behalf of current employees.

There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because these expenses are directly attributable to you under the Plan. The Retirement Committee will inform you when there will be a charge (or charges) directly to your account.

The Plan may, from time to time, change the manner in which expenses are allocated.

GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this section.

General Plan Information

National HealthCare Corporation 401(k) Plan is the name of the Plan.

The Plan has been assigned Number 003.

The amended and restated provisions of the Plan became effective on January 1, 2007.

The Plan’s records are maintained on a twelve-month period of time. This is known as the “Plan Year”. The Plan Year is the calendar year beginning on January 1 and ending on December 31.

Certain valuations and distributions are made on the “Anniversary Date” of the Plan. This date is the last day of the Plan Year.

The contributions made to the Plan will be held and invested by the Trustee of the Plan.

The Plan and Trust will be governed by the laws of the State of Tennessee to the extent not preempted by ERISA.

Benefits provided by the Plan are provided from your accounts as described under the Plan document. This is not the type of plan which must be insured by the Pension Benefit Guaranty Corporation because the insurance provisions under the Employee Retirement Income Security Act are not applicable to the 401(k) plans like this Plan.
Employer Information

The Employer which has adopted the legal document reflecting the Plan is sponsored by:

   National Health Corporation
   100 Vine Street
   Murfreesboro, Tennessee 37130
   EIN:  62-1294263

National Health Corporation has adopted this Plan as an employer. The Plan document allows certain other employers on their own to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of such employers, if any, who have adopted the Plan at any time during regular business hours by making a written request to the Retirement Committee.

Administrator Information

The Retirement Committee is responsible for the day-to-day administration and operation of the Plan. For example, the Retirement Committee maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation and directs the payment of your account at the appropriate time. The Retirement Committee will also allow you to review the formal National Health Corporation Plan document and certain other materials related to the Plan. If you have any questions about the Plan and your participation, you should contact the Retirement Committee through the Benefits Department. The Administrator of the Plan, however, is National Health Corporation, it has just authorized the Retirement Committee to perform its day-to-day duties as the Administrator. If for any reason the Retirement Committee is vacant, then references in this summary will mean National Health Corporation itself.

The Administrator itself shall have the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply, and interpret the Plan document, its associated Trust and any other Plan documents, instruments or communications, and to decide all matters arising in connection with the operation or administration of the Plan document and its associated Trust, as well as the investment of the Plan assets. Without limiting the generality of the foregoing, the Administrator shall have the sole and absolute discretionary authority:

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

All determinations made by the Administrator with respect to any matter arising under the Plan, its associated Trust, and any other Plan documents, instruments or communications shall be final and binding on all parties. Benefits under this Plan will be paid only if the Plan Administrator decides in its sole and exclusive discretion that the applicant is entitled to such benefits.

The name, address and business telephone number of both the Retirement Committee and the Administrator are:

   National Health Corporation
   100 Vine Street
   Murfreesboro, Tennessee 37130
   (615) 890-2020

You can also contact the Retirement Committee through the NHC Partner Benefits Department.
Trustee Information

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund. The trust fund established by the Trustee will be the funding medium used for the accumulation of assets from which benefits will be distributed.

The name of the Plan’s Trustee is:

The Trust Company of Knoxville, Inc.

The principal place of business of the Plan’s Trustee is:

4823 Old Kingston Pike, Suite 100
Knoxville, Tennessee 37919

Service of Legal Process

The name and address of the Plan’s agent for service of legal process are:

The Retirement Committee of the National HealthCare Corporation 401(k) Plan
100 Vine Street
Murfreesboro, Tennessee 37130

Service of legal process may also be made upon the Trustee.

Plan Notices

All notices made by the Plan may be delivered by electronic media.
AS OF DECEMBER 14, 2009, THE NATIONAL HEALTH CORPORATION LEVERAGED EMPLOYEE STOCK OWNERSHIP PLAN (ESOP) WAS FROZEN.

EMPLOYER CONTRIBUTIONS, PARTICIPANT FORFEITURES AND ANNUAL ADDITIONS OF NEW PLAN PARTICIPANTS CEASED FOR THE INDEFINITE DURATION OF THE PLAN FREEZE.

THE PLAN WAS AMENDED ON DECEMBER 14, 2009 TO REFLECT THE FROZEN PLAN STATUS.

ALL OTHER PLAN PROVISIONS REMAIN THE SAME AS SUMMARIZED IN THE SUMMARY PLAN DESCRIPTION.
ESOP (National Health Corporation Leveraged Employee Stock Ownership Plan)

The ESOP is a retirement plan that is fully funded by your employer. It is available only to eligible partners whose employers are owned companies of NHC.

- The employer is responsible for all annual Plan contributions. There are no partner contributions, meaning that money is never deducted from your paycheck for the ESOP. The ESOP was “frozen” as of December 14, 2009. In compliance with Federal Regulations there will be no contributions for the duration of the frozen plan status.
- A partner must be paid at least 1,000 hours of service, annually, to receive an annual contribution, when applicable.
- A year of service is defined as a payroll year (stops with the final payroll ending date of the calendar year, which may be prior to 12/31) with at least 1,000 hours of service.
- All partners with account balances became 100% vested on December 14, 2009. The prior vesting schedule is not applicable for the duration of the frozen plan status.
- Each participant receives an annual statement.
- The partner, if vested, will receive the full value of the account after retirement. Normal retirement age for the ESOP is 65 and early retirement is age 55 with at least 10 full years of participation in the ESOP Plan. Distributions are made once annually for previous year retirees and other eligible ESOP participants.
- Withdrawals can be one lump sum or paid out over a 5 year period. The entire vested account balance can remain in the ESOP plan indefinitely except for the required age related distributions starting at age 70 ½. Vested account balances will continue to receive the annual plan revaluing. The account value can increase or decrease annually based on the value of all NHC related stock performances, as well as NHC's profitability for the year.
- Participants who leave their employment for reasons other than retirement, death, or disability must have a one year break in service before their vested account balance can be withdrawn. A break in service is a calendar year in which a participant is paid for or receives credit for less than 500 hours. Distributions for reasons other than retirement, death or disability will be made in the year following the break in service.
- Distributions of vested account balances for retirement and terminations are made midyear following the ESOP plan year in which the eligible event occurs.

Example: Partner retires (age 65 or age 55 with at least 10 years of plan participation) on May 1. Funds will be available midyear, of the following calendar year. (No break in service required, regardless of paid hours in year of termination).

Partner terminates employment on August 21, and has been paid for 1,201 hours. Funds will be available midyear, of the second calendar year following termination. Termination distributions require at least a 1 year break in service (calendar year of less than 500 hours).

- Death and disability distributions are made (with proper qualifying documents) as the event occurs.
- If you do not report to your workstation and you do not report your absence on a day you have been scheduled to work, the company will consider that you have abandoned your job and voluntarily resigned without notice. Another person may be employed in your position. If you leave the premises without notifying your supervisor or walk off the job, you may be charged with job abandonment. This may lead to discipline up to and including termination, and may result in the forfeiture of earned benefits.
- The ESOP Plan is valued annually. The account balance only changes annually. The value of each ESOP account can either increase or decrease annually based on stock market prices and other business evaluations. All distributions are made based on the account value as of the prior plan year end.

NHC BENEFITS HOTLINE — 1-800-538-3628
National Health Corporation ESOP Plan
DESIGNATION OF BENEFICIARY FORM

Partner Name _______________________________ Social Security Number _______________________________
Address / City / State / Zip _______________________________ Center Name and Location _______________________________

This designation of beneficiary may be changed at any time. The beneficiary assignment should be reviewed as life changes occur, i.e. marriage, divorce, death, birth or adoption. When making a Beneficiary change, you must change or confirm both your Primary and Contingent Beneficiary designations. Leaving a section blank constitutes an update and will delete any previous Primary or Contingent Beneficiaries you may have on file for this account.

Check One: ___ Single ___ Married (Even if legally separated)

Married Participants - under federal law, if you are currently legally married and you designate anyone other than your spouse as your primary beneficiary, your spouse must sign the spousal consent portion at the bottom of this form in the presence of a notary public. If your spouse does not waive the right to be your Primary Beneficiary, you must list the spouse's name as Primary Beneficiary with complete address information. This Retirement Plan does not recognize (1) common law marriage or (2) any domestic relationship other than marriage that is legally recognized as such by the State of residence.

Non-Married Participants – If you are not married, you should name a Beneficiary to receive your benefit in the event of your death and a Contingent Beneficiary in the event that the Beneficiary you name predeceases you.

If a primary or contingent beneficiary does not survive you, his or her interest and the interests of his or her heirs shall terminate completely, and the percentage share of the remaining beneficiary(s) shall be increased on a pro-rata basis. If no primary or contingent beneficiary survives you and you are not married then the benefits will go to your estate.

1) Primary Beneficiary(s)

Name ____________________________ % ____________________________
Relationship ____________________________ Social Security Number ____________________________
Address ____________________________
City / State / Zip ____________________________

2) Primary Beneficiary(s)

Name ____________________________ % ____________________________
Relationship ____________________________ Social Security Number ____________________________
Address ____________________________
City / State / Zip ____________________________

1) Contingent Beneficiary(s)

Name ____________________________ % ____________________________
Relationship ____________________________ Social Security Number ____________________________
Address ____________________________
City / State / Zip ____________________________

2) Contingent Beneficiary(s)

Name ____________________________ % ____________________________
Relationship ____________________________ Social Security Number ____________________________
Address ____________________________
City / State / Zip ____________________________

SPOUSE CONSENT OF NON-SPOUSE BENEFICIARY DESIGNATION

I, ____________________________, spouse of ____________________________, approve the designation of ____________________________ as Primary Beneficiary and ____________________________ as Contingent Beneficiary. I understand that I am forfeiting my right to any benefit to which I would be entitled under the Plan pursuant to the Retirement Equality Act.

Spouse's Signature ____________________________ Date ____________________________
Notary Signature ____________________________ Commission Expires ____________________________

Partner Signature: ____________________________ Date: ____________________________
Return completed form to The Trust Company, Attn. NHC, 4823 Old Kingston Pike, Suite 100, Knoxville, TN 37919

1/2013
THE NATIONAL HEALTH CORPORATION
LEVERAGED EMPLOYEE STOCK OWNERSHIP PLAN

This section of this Handbook is the general explanation and description of benefits under the National Health Corporation Leveraged Employee Stock Ownership Plan (the “ESOP”).

This is only a summary of the ESOP. Discrepancies between this section of the Handbook and the actual ESOP, as well as the resolution of any differences, are governed by the provisions of the actual ESOP document itself and its related legal instruments. These documents are available from the ESOP Plan Administrator. National Health Corporation reserves the right to modify, revoke, suspend, terminate or change any or all of the provisions of the ESOP and the policies under which it is administered at any time. This right can be exercised retroactively in certain circumstances and can be generally implemented with or without advance notice, consultation or reaching agreement with anyone, at anytime. However, under federal law, the ESOP provisions cannot be changed in a way that reduces your then current vested account balance in the ESOP.

Revised July 1, 2010
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION TO THE ESOP</td>
<td>11</td>
</tr>
<tr>
<td>WHO IS ELIGIBLE FOR THE ESOP?</td>
<td>11</td>
</tr>
<tr>
<td>HOW THE ESOP GENERALLY WORKS</td>
<td>11</td>
</tr>
<tr>
<td>WHAT IS IN IT FOR YOU?</td>
<td>12</td>
</tr>
<tr>
<td>THE COMPANY’S COMMITMENT</td>
<td>12</td>
</tr>
<tr>
<td>BENEFITING FROM THE ESOP</td>
<td>12</td>
</tr>
<tr>
<td>HOW DO YOU KNOW WHAT YOUR ESOP ACCOUNT IS WORTH?</td>
<td>13</td>
</tr>
<tr>
<td>BENEFITS ON RETIREMENT</td>
<td>13</td>
</tr>
<tr>
<td>PRE-RETIREMENT DISTRIBUTION RIGHT</td>
<td>13</td>
</tr>
<tr>
<td>BENEFITS ON DEATH</td>
<td>14</td>
</tr>
<tr>
<td>BENEFITS ON DISABILITY</td>
<td>14</td>
</tr>
<tr>
<td>BENEFITS ON OTHER TERMINATION OF SERVICE</td>
<td>14</td>
</tr>
<tr>
<td>HOW BENEFITS ARE PAID</td>
<td>14</td>
</tr>
<tr>
<td>CONTACT US WITH YOUR QUESTIONS</td>
<td>15</td>
</tr>
<tr>
<td>ADDITIONAL INFORMATION</td>
<td>15</td>
</tr>
</tbody>
</table>
INTRODUCTION TO THE ESOP

This is a summary of the important provisions of the National Health Corporation Leveraged Employee Stock Ownership Plan, or ESOP. The ESOP was adopted on January 1, 1988 and that same year the National Health Corporation and Subsidiaries Employees Stock Purchase Plan was merged into the ESOP. The ESOP is intended to help you build benefits for your retirement.

The ESOP has fully repaid the loans that it used to purchase shares of National Health Corporation and was “frozen” as of December 14, 2009. No new Participants are eligible to enter the ESOP on or after this date. In addition, the ESOP account balances of all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of January 1, 2009. Benefits payable under the ESOP will continue to be paid at the time and in the manner described in this section of the handbook. The word “you” refers to all partners who became ESOP Participants prior to December 14, 2009.

WHO IS ELIGIBLE FOR THE ESOP?

The ESOP was “frozen” as of December 14, 2009. No new Participants are eligible to enter the ESOP on or after that date.

All partners of National Health Corporation and partners of business organizations affiliated with the Company which were authorized to adopt, and did adopt, the ESOP were eligible to participate in the ESOP. For ease of communication, National Health Corporation and these affiliated business organizations are called collectively “the Company” in this Section of the Handbook.

If you were a partner of the Company on January 1, 1988, you automatically were a Participant in the ESOP. Additionally, all participants in the National Health Corporation and Subsidiaries Employee Stock Ownership Plan automatically became Participants in the ESOP as a result of the merger of that plan into the ESOP. All other partners became Participants on the first day of the month coincident with or next following the performance of their first “Hour of Service” (as explained below) for the Company prior to December 14, 2009. Partners covered by collective bargaining agreements in which retirement benefits were the subject of good faith bargaining were not covered by the ESOP, unless the collective bargaining agreement specifically provided for coverage. Leased partners also were not eligible to participate in the ESOP.

HOW THE ESOP GENERALLY WORKS

The ESOP holds assets in a special related trust (the “Trust”) which is tax-exempt. Individual Accounts are set up within the Trust in each Participant's name and these Accounts reflect each individual Participant’s ESOP benefits.

The ESOP borrowed money to buy common stock of National Health Corporation (“Company Stock”) which was deposited in the Trust. The Company Stock in the Trust which was bought with borrowed money was held in a suspense account in the ESOP while the loan was being repaid. While the loan was outstanding, as the Company contributed to the ESOP each year, the Company contributions paid off the loan and the Company Stock acquired with the borrowed money was released from the ESOP suspense account as the loan was paid off for allocation among Participants' Accounts. The ESOP fully repaid the loans that it used to purchase shares of Company Stock and was “frozen” as of December 14, 2009. You were not required or permitted to make any contributions to the ESOP.

Voting on the Company Stock in your Account is passed through to you in certain major corporate events.

The bookkeeping of the ESOP is kept on a yearly basis. This is called the “Plan Year”. The Plan Year is a period consisting of 26 or 27, as the case may be, biweekly payroll periods of National Health Corporation with the last such payroll period ending nearest to (and prior to) December 31.

In order to have received an allocation of Company Stock or other Company contributions under the ESOP for a Plan Year, you must have been credited with 1,000 or more Hours of Service in that Plan Year. Hours of Service are strictly defined by the law. Of course, the hours you actually worked for the Company were counted as Hours of Service. You also got credit for certain times you were not at work for the Company, such as vacation, holidays, sickness, layoffs or disability leave. You also got credit because of a back pay award at the Company, but in no case did you get credit twice for the same time period with the Company. As required by law, you may also have gotten credit for certain periods in which you were absent from work with the Company and did not get paid, but these instances are limited to events like jury duty or military service. Because the law places many technicalities on the measurement of service, you should contact the Plan Administrator if you have any questions.
WHAT IS IN IT FOR YOU?

For purposes of the ESOP, the term “Compensation” means the total compensation you received from the Company for the applicable Plan Year that was subject to FICA tax. Your Compensation was determined as if there was no dollar limit on the amount of income on which FICA taxes were payable. Your Compensation included overtime pay, bonus payments and commissions. It also included your contributions to our 401(k) Plan and your contributions to our Internal Revenue Code Section 125 flexible benefit or cafeteria plan. Prior to January 1, 1996, nonqualified deferral compensation was also considered part of your Compensation, and prior to January 1, 1997, tax law required that the Compensation of your spouse, or son or daughter under age 19, who works here was included in your Compensation if you were a very highly compensated partner. Also as a matter of law, Compensation above certain limits was not counted for purposes of the ESOP. That limit was $245,000 in 2009 (the year in which the ESOP was frozen and all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of January 1, 2009) and is adjusted for inflation as time goes by. Also only the Compensation you make while you are an ESOP Participant is counted for purposes of the ESOP.

Your ESOP Account's share of the Company Stock, Company contributions or other assets allocated each Plan Year were allocated to your ESOP Account based on the percentage that your Compensation for the Plan Year was to the total Compensation of all the ESOP's Participants to share in the allocation that Plan Year. In other words, your share is a fraction where the top number of the fraction was your Compensation and the bottom number of the fraction was the total of Compensation of all partners entitled to share in the allocation for that Plan Year. Dividends paid on Company Stock in the ESOP suspense account in a Plan Year were allocated the same way each Plan Year. In other words, your percentage of dividends paid on Company Stock in the ESOP suspense account was the same as your percentage of Company Stock, Company contributions and other assets allocated that Plan Year. Your share of any ESOP forfeitures were also calculated the same way. Dividends paid on Company Stock already allocated to your Account for the entire Plan Year were allocated to your Account.

For instance, let’s say you became an ESOP Participant in a Plan Year prior to the freeze and made $10,000 working full time. Let's assume you were credited with at least 1,000 Hours of Service in that Plan Year and you were employed by the Company on the last day of the Plan Year. Also assume that the total Compensation of all Participants in that Plan Year amounted to $60,000,000. This means that your share or allocations for that Plan Year would be determined by dividing your Compensation of $10,000 by $60,000,000. Consequently, your share or allocation for that Plan Year would equal .0167%. Your ESOP Account would also be credited with .0167% of the dividends paid on Company Stock held in the ESOP suspense account. Your ESOP Account would be credited with .0167% of ESOP forfeitures for that Plan Year and all of the dividends paid on Company Stock held in your Account the entire Plan Year.

The ESOP Committee also reserved the right to distribute dividends to all Participants rather than credit those dividends to Participants' Accounts. Such a distribution would have been made within 90 days after the end of the Plan Year the dividends were paid.

With everyone's hard work, as the value of Company Stock increases, so will the value of your Company Stock Sub-Account. Any earnings or loses from other investments each Plan Year are allocated pro-rata among Participants' Other Investment Sub-Accounts based on each Participant's Other Investment Sub-Account balance.

THE COMPANY'S COMMITMENT

Through the Company’s commitment to contribute an annual amount to the ESOP, the ESOP was able to repay the loan that it used to purchase Company Stock, as well as the interest payments due on the loan. Once the loan was repaid, neither the making of further contributions to the ESOP nor the payment of future dividends on the ESOP’s shares of Company Stock was required and the Company decided against making and/or paying any discretionary contributions or dividends to the ESOP. The ESOP therefore was frozen as of December 14, 2009.

BENEFITING FROM THE ESOP

The ESOP account balances of all Participants who entered the ESOP prior to January 1, 2009 became fully vested as of that date. Being fully vested means you are entitled to the full value of your ESOP Account which can be paid at the time and in the manner described in this section of the handbook.
HOW DO YOU KNOW WHAT YOUR ESOP ACCOUNT IS WORTH?

As of each December 31st, all Participant ESOP Accounts will be valued. This is called the ESOP's “Valuation Date”.

Each Plan Year the ESOP retains an independent appraisal company which has knowledge and expertise in appraising the ESOP assets. The appraiser arrives at a “fair market value” of each share of Company Stock in your Account as of December 31st. There are many, many factors which are taken into account by the appraising company, some of which are the value of the National HealthCare Corporation stock shares owned by the Company, the real estate value of the healthcare properties owned by the Company, and the operational value of the healthcare centers, assisted living centers, retirement centers, homecare offices and other affiliated companies, which is, of course, very dependent upon creating and maintaining excellence in performance by all partners. The ESOP has securities which are valued at the trading price of National HealthCare Corporation stock shares, as well as securities that were acquired with borrowed money. As that borrowed money was repaid by Company contributions, the repayment had positive effects on the value of the securities. Your year-end “Statement of Account” takes all of these values into account and is the annual basis for any distributions to which you may become eligible. The value of your Account on each Plan Year's Valuation Date will be reported to you approximately five months after the end of the Plan Year. Any distribution under the ESOP may be delayed so that the value of your Account may be determined.

BENEFITS ON RETIREMENT

As a Participant in the ESOP, you are entitled to receive the full value of your ESOP Account coincident with or immediately following your “Normal Retirement Date”. Your Normal Retirement Date is the date you attain age 65. You may also retire prior to your Normal Retirement Date and receive the full value of your ESOP Account as of the Valuation Date coincident with or immediately following your “Early Retirement Date”. Your Early Retirement Date is the date you have both attained age 55 and been credited with at least 10 full Years of Vesting Service. You are fully vested at either retirement date regardless of your credited Years of Vesting Service.

You may work past your Normal Retirement Date. If you do, you will continue to participate in the ESOP and you may elect to receive an in-service distribution of all or a portion of your ESOP Account on each succeeding Valuation Date. Once you do retire, you will be entitled to receive the full value of your ESOP Account coincident with or immediately following your termination of employment (your “Delayed Retirement Date”) less any in-service distributions you already received or are scheduled to receive. If you still have a balance in your ESOP Account past age 70-1/2, the law may require the ESOP to begin distribution of benefits to you.

PRE-RETIREMENT DISTRIBUTION RIGHT

If you have attained age 55 and have been credited with at least 10 full years of participation in this ESOP by the beginning of a Plan Year, then you have the right to elect a distribution of your ESOP Account balance in that Plan Year. This is referred to as a “Pre-Retirement Distribution Right”. The election period is the first 90 days in that Plan Year. The Pre-Retirement Distribution Right begins with the first Plan Year after you reach age 55 and have been credited with 10 years of participation in the ESOP and ends with the fifth Plan Year thereafter. For example, if you first become eligible to elect a Pre-Retirement Distribution in the Plan Year beginning January 1, 2010, you will be entitled to elect a Pre-Retirement Distribution in the period January 1, 2010 through March 30, 2010. If you elect such distribution, the distribution will be made within 90 days after the end of the 90 day election period at the beginning of the Plan Year. The amount which may be elected for distribution during the first such election period is 25% of your Account balance. The amount which may be elected for distribution upon future elections, during successive election periods, is determined by multiplying your Account balance (including amounts which have been previously distributed to you in Pre-Retirement Distributions) by 25% or, with respect to your fifth and final election period, by 50%, reduced by the amount of any prior distributions. If the balance of your Account is less than five hundred dollars ($500.00) as of the Valuation Date immediately preceding the first day of an election period, then you will not be entitled to elect to receive a Pre-Retirement Distribution for that election period.
BENEFITS ON DEATH

If your employment with the Company is terminated by your death, the amount in your ESOP Account as determined on the Valuation Date coincident with or immediately following the date of death will be paid to your Beneficiary. Your Beneficiary by law will be your surviving spouse if you are married on that date. This will be the case whether or not you designated your spouse as your beneficiary on your Designation of Beneficiary form, or whether you even have not filed such a form. Your spouse, however, can waive this legal right to be your Beneficiary if you are married. This waiver must take the form of a consent to the non-spouse beneficiary on a properly completed Designation of Beneficiary form. If your surviving spouse cannot be located after your date of death, or you and your surviving spouse were legally separated as evidenced by a valid court order, then your Beneficiary will be as you designate in your Designation of Beneficiary form.

If you are not married on the date of your death, your beneficiary will be as designated in your Designation of Beneficiary form. A Designation of Beneficiary form is included in this Handbook or you can also obtain the form from your employer or by contacting the Benefits Hotline at 1-800-536-3628. Subject to a surviving spouse’s right to your death benefit required by law as just described, you may designate a person or persons (including a trust or estate) to receive your death benefit on the Designation of Beneficiary form.

BENEFITS ON DISABILITY

If your employment with the Company is terminated by reason of your total and permanent disability, the amount in your ESOP Account on the Valuation Date coincident with or immediately following the date of your total and permanent disability will be paid to you on your “Disability Benefit Date.” Your Disability Benefit Date will be the date as of which the Social Security Administration determines that you are totally and permanently disabled.

If the date that your total and permanent disability actually occurs precedes the determination of your Disability Benefit Date, then the distribution of your total and permanent disability may be made before the time just described, provided you waive basing the value of your disability benefit on the value of your Account for the Plan Year in which your Disability Benefit Date occurred and instead you request that the value of your Account be paid without waiting by determining the value of your Account with reference to the Valuation Date of the Plan Year in which your total and permanent disability actually occurred.

BENEFITS ON OTHER TERMINATION OF SERVICE

If your employment with the Company terminates for any reason other than by normal retirement, early retirement, delayed retirement, disability or death, your ESOP benefit will be the amount in your ESOP Account on the Valuation Date coincident with or immediately preceding the date of the distribution. Your ESOP benefit will be distributed on your written request in a form acceptable to the ESOP. If the amount in your ESOP Account on the Valuation Date immediately preceding the Plan Year during which a distribution is scheduled to occur is $1,000 or less, your benefits under the ESOP will be immediately distributable to you without your consent.

HOW BENEFITS ARE PAID

Benefits are normally paid out in one lump sum payment (but allowing for separate distributions of cash and Company Stock within the same calendar year from your Account). However, Participants and Beneficiaries may elect to receive their benefits in equal annual payments over a five year period. This installment distribution for Participants and Beneficiaries who have more than $500,000 in their accounts will be extended for one additional year for each additional $100,000 (or fraction thereof) in their ESOP Accounts. Your benefit distribution can be made in cash, or if you prefer, to the extent your Account holds Company Stock, in whole shares of Company Stock. If you want Company Stock, you must give the ESOP at least 30 days advance notice, but you should note that once you give the ESOP this notice, your decision cannot be changed.

If you elect a distribution that includes Company Stock, you will have a right to have the Company buy back the Company Stock from you at the Company Stock’s fair market value. This is called a “put option” right. The put option may be exercised at anytime during the 60-day period following the date of the distribution of Company Stock to you. If the put option is not exercised during such 60-day period, you may exercise your put option during an additional period of 60 days following the end of the Plan Year in which the distribution was made at the then current fair market value. This put option will be available to you even if the ESOP is terminated. The Company may elect to pay for Company Stock in substantially equal periodic installments (not less frequently than annually) over a period beginning not later than 30 days after exercise of the put option and not exceeding five years. The Company in that case will provide security and pay reasonable interest.
The Company also has a right of first refusal of the Company Stock you elect to receive in a distribution at a price equal to the greater of the then fair market value of the Company Stock or at the same price and on the same terms as a bona fide offer from a third party. If this right of first refusal is not exercised by the Company within 14 days, this right of first refusal expires.

If, at the time of your distribution, the Company's charter or by-laws restricts Company Stock ownership to partners, or the Company is an S corporation, your distributions by law will be only in cash. In this case, no distribution will be made in Company Stock.

CONTACT US WITH YOUR QUESTIONS

If you have questions about how the ESOP works or you want a copy of the actual ESOP document, all you have to do is contact the Benefits Hotline at 1-800-538-3528.

ADDITIONAL INFORMATION

In accordance with Section 102 of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), the following additional information is furnished to Participants and Beneficiaries with respect to the ESOP:

1. The name of the ESOP is the National Health Corporation Leveraged Employee Stock Ownership Plan.
2. National Health Corporation, which is located at 100 Vine Street, Murfreesboro, Tennessee 37130, is the employer of the partners covered by the ESOP and the ESOP’s Sponsor. Other affiliated employers may be authorized to be a Sponsor. You may receive from the Plan Administrator, upon written request, information as to whether an employer or other organization is a sponsor and the sponsor's address.
3. The Employee Identification Number assigned to National Health Corporation by the Internal Revenue Service is 62-1294263, and the ESOP's Plan Number for use by the United States Department of Labor as well as the Internal Revenue Service is 002.
4. The ESOP is an employee stock ownership plan. The ESOP invests primarily in common stock of National Health Corporation. The ESOP is intended to satisfy the requirements of an employee stock ownership plan within the meaning of Section 4975(e)(7) of the Internal Revenue Code.
5. The ESOP is administered by National Health Corporation.
6. The Plan Administrator is the ESOP Committee appointed by the Board of Directors of National Health Corporation, the address of which is 100 Vine Street, Murfreesboro, Tennessee 37130, and the phone number of which is (615) 890-2020. You should contact the Plan Administrator by calling the Benefits Hotline at 1-800-538-3836.
7. In the event of any lawsuit, the agent for service of legal process for the ESOP is John K. Lines, whose address is 100 Vine Street, Murfreesboro, Tennessee 37130. Service of process can also be made upon the Plan Administrator or the Trustee.
8. The Trustees of the ESOP are Richard F. LaRoche, Jr. and Daniel K. McDaniel, 100 Vine Street, Murfreesboro, Tennessee 37130.
9. A copy of the ESOP's qualified domestic relations order (“QDRO”) procedures can be found at the end of this section in this handbook. In the event of a QDRO, all or part of your benefit may become payable to an Alternate Payee. Generally, this means that your spouse or children may gain a right to all or some portion of your ESOP Account through divorce proceedings.
10. National Health Corporation reserves, in its sole discretion, the exclusive right to terminate the ESOP at any time, to amend the ESOP at any time and from time to time and to eliminate prospective contributions to the ESOP at any time. If the ESOP is terminated, all Account balances will then immediately become fully vested.
11. Because your benefits depend solely on the amount in your Account in the ESOP, the law provides that the ESOP is not insured as a pension plan under Title IV of ERISA.
12. The Internal Revenue Code states that the annual addition to your account may not exceed the lesser of (a) $51,000 for 2013 (which may be adjusted in the future for changes in the cost of living) or (b) 100% of your annual Compensation. This limitation applies to the combined Company contributions made under the ESOP as well as the 401(k) Plan.

13. In the unlikely event that the ESOP becomes “top-heavy”, additional provisions will apply. The ESOP is top-heavy if sixty percent (60%) of the funds held in the ESOP are used to provide benefits for certain highly compensated key partners as defined in the ESOP. If the ESOP is top-heavy, a minimum contribution of 3% of your Compensation for the Plan Year will likely be made for all Participants who are not key partners. This minimum contribution will be made to the 401(k) Plan.

14. An ESOP Committee is appointed by the Board of Directors of National Health Corporation. The Committee has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the ESOP, its associated Trust and any other ESOP documents, instruments or communications and to decide all matters arising in connection with the operation or administration of the ESOP and its associated Trust. Without limiting the generality of the foregoing, the Committee has the sole and absolute discretionary authority:

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

All determinations made by the Committee with respect to any matter arising under the ESOP, Trust Agreement and any other ESOP documents, instruments or communications shall be final and binding on all parties. Benefits under this ESOP will be paid only if the Committee decides in its sole and exclusive discretion that the applicant is entitled to them.

15. At such time as you are eligible to receive benefits, your claim for benefits should be made to the Plan Administrator in writing in a form acceptable to the Plan Administrator.

16. Upon application for benefits made by you or your Beneficiary, if the Plan Administrator should determine that the benefits applied for will be denied either in whole or in part, the following provisions will govern. The Plan Administrator will notify you of the Plan Administrator's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of your claim by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing your claim is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the benefit determination.

In the event that a period of time is extended as provided herein due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The Plan Administrator will provide you with written or electronic notification of any adverse benefit determination. The notification will set forth the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific ESOP provision or provisions on which the determination is based;
• a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and

• in the case of an adverse disability benefit determination, if the adverse disability benefit determination relies upon an internal rule, guideline, protocol or other specific direction, then the specific rule, guideline, protocol or other similar criterion relied upon will be provided to you free of charge.

If the benefit determination is adverse to you, you will have 60 days following receipt of the notification of the adverse benefit determination within which to appeal the determination. You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits.

You must exhaust all of the remedies available to you under these claim procedures in order to bring a civil action in court under Section 502(a) of ERISA. Except where the Plan Administrator fails to follow these claim procedures, you must appeal an initial adverse benefit determination as described in these claims procedures in order to exhaust the remedies available to you. You will have 180 days, and only 180 days, following an initial adverse benefit determination to appeal an initial adverse determination of your benefit claim. If you do not file an appeal of the initial adverse benefit determination within such 180 days following your receipt of the notice of the initial adverse benefit determination, then you will be time-barred from appealing the initial adverse benefit determination.

The Plan Administrator will notify you of the Plan Administrator's benefit determination on review within a reasonable period of time, but not later than 50 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing your claim is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review. The period of time within which any benefit determination on review is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as provided herein due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled (that is, stopped) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The Plan Administrator will provide you with written or electronic notification of the benefit determination on review. In the case of an adverse benefit determination, the notification will set forth the following:

• the specific reason or reasons for the adverse determination; and

• reference to the specific ESOP provision or provisions on which the benefit determination is based.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to a denial on review of your claim for benefits. You have a right to bring an action in court under Section 502(a) of ERISA no later than 10 days after the denial of the claim on review; and if you do not bring an action in court under Section 502(a) of ERISA within 180 days of the denial of your claim on review, then you will be time-barred from bringing an action in court under Section 502(a) of ERISA.

In the case of the failure by the Plan Administrator to follow the claim procedures set forth herein, you will be deemed to have exhausted the administrative remedies available under the ESOP and you will be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the ESOP failed to provide reasonable claim procedures that would yield a decision on the merits of your claim.

These claim procedures may be utilized by any authorized representative acting on your behalf. The Plan Administrator, however, may establish procedures for determining whether an individual has been authorized to act on your behalf.

17. As a participant in the National Health Corporation Leveraged Employee Stock Ownership Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all ESOP participants shall be entitled to:
• Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the ESOP, and a copy of the latest annual report (Form 5500 Series) filed by the ESOP with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the ESOP, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for ESOP Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your ESOP, called “fiduciaries” of the ESOP, have a duty to do so prudently and in the interest of you and other ESOP Participants and Beneficiaries. No one, including the Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the ESOP documents or the latest annual report from the ESOP and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that ESOP fiduciaries misuse the ESOP's assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your ESOP, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

18. Your ESOP participation does not give you the right to ongoing employment with National Health Corporation or any of its affiliates nor does it guarantee your right to benefits, except as outlined in the ESOP. No provision of the ESOP gives you rights to continued employment, prohibits changes in terms of employment or prohibits your termination of employment.
EMPLOYEE STOCK PURCHASE PLAN

Common Stock of: National HealthCare Corporation
Trading Symbol: NHC
Traded On: NYSE-MKT Stock Exchange

Partners may buy NHC stock through payroll deduction. Purchases are made with after tax dollars. No brokerage fees are charged.

Stock will be purchased after the end of the calendar year at the lower of the market (closing) price on the first trading day of the calendar year or the last trading day of the calendar year.

The stock is issued in book-entry form to each participating partner after the end of the calendar year. After the issue, the stock is treated as if it were purchased by the partner through the stock market.

Open Enrollment for purchasing stock is January 1 through March 31 each year.

Payroll deductions for current partners can be stopped at any time during the year. The partner has the choice to withdraw the funds or leave them in the Employee Stock Purchase Plan and purchase stock at the end of the year.

If the partner terminates employment (other than for retirement or death), the money already deducted will be refunded, without interest.
NATIONAL HEALTHCARE CORPORATION EMPLOYEE STOCK PURCHASE PLAN
REQUEST FOR PARTICIPATION FORM

1. The undersigned employee at _____________________________________________ (Employer), hereby requests participation in the National HealthCare Corporation (“NHC”) Employee Stock Purchase Plan (“ESPP”) and authorizes my employer to deduct from my paycheck, until further notice, the amount of $_____________ each pay period. (This amount cannot be less than $10 per pay period or more than the total compensation to the employee for that pay period).

2. The undersigned employee directs that the Contribution Account balance funded with the above payroll deduction and the NHC Common Stock purchased therewith be owned and registered as follows:

(PLEASE PRINT CLEARLY)

Name: __________________________________________________________________________________
Street Address: ____________________________________________________________________________
City: _________________________________________    State: ___________________ Zip:_____________

Social Security Number _____________________________________________

3. I acknowledge receipt of the Prospectus for the National HealthCare Corporation Employee Stock Purchase Plan.

_________________________________________       _________________________________
Date                                             Signature of Employee

_____________________________________________
Name of Center or Affiliate                      Approved By

Please also complete Form W-9, Request for Taxpayer Identification Number and Certification.
Please return this completed form and the completed W-9 to your employer or to:
NHC PAYROLL DEPARTMENT, P.O. BOX 1398, MURFREESBORO, TENNESSEE 37133.

NOTICE: ALL EMPLOYEES MUST HAVE THEIR FORM APPROVED BY THE ADMINISTRATOR OR THEIR IMMEDIATE SUPERVISOR. THE FOLLOWING GUIDELINES SHOULD BE USED TO HELP IN COMPLETING YOUR FORM ACCURATELY.

Please check your subscription form carefully, and, if you have questions, check with your Administrator or Supervisor. If the form is incorrectly completed or lacking an approval signature, it will be returned to you and the payroll deduction will not be processed until it is properly completed.

One Final Note: Be sure to carefully read the section in the Prospectus regarding the tax consequences.
### NHC BENEFITS HANDBOOK

**1500 – Employee Stock Purchase Plan • PAGE 5**

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**W-9**

**Form (Rev. November 2017)**

Department of the Treasury

Internal Revenue Service

**Request for Taxpayer Identification Number and Certification**

Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

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<tr>
<th>Give Form to the requester. Do not send to the IRS.</th>
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<tbody>
<tr>
<td>1. Name (as shown on your income tax return. Name is required on this line; do not leave this line blank.)</td>
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<tr>
<td>2. Business name/disregarded entity name, if different from above</td>
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<tr>
<td>3. Check appropriate box for federal tax classifications of the person whose name is entered on line 1. Check only one of the following seven boxes.</td>
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<td>[ ] Individual/sole proprietor or single-member LLC</td>
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<td>[ ] C Corporation</td>
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<td>[ ] Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership)</td>
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<td>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if this LLC is characterized as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</td>
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<td>[ ] Other (see instructions)</td>
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<td>4. Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3)</td>
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<td>[ ] Exempt payee code (if any)</td>
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<td>[ ] Exemption from FATCA reporting code (if any)</td>
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<td>[ ] Applies to accounts maintained outside the U.S.</td>
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<td>5. Address (number, street, and apt. or suite no.) See instructions.</td>
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<td>6. City, state, and ZIP code</td>
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<td>7. List account number(s) here (optional)</td>
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<td>Requester's name and address (optional)</td>
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### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give the Requester for guidelines on whose name to enter.

<table>
<thead>
<tr>
<th>Social security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here**

<table>
<thead>
<tr>
<th>Signature of U.S. person</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] [ ] [ ] [ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

**Date**

| [ ] [ ] [ ] [ ] [ ] [ ] |

### General Instructions

**Section references are to the Internal Revenue Code unless otherwise noted.**

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1000-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-G (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.
By signing the filled-out form, you:
1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:
- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1441 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-8 has not been received, the rules under section 1441 require a partnership to presume that a partner is a foreign person, and pay the section 1441 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1441 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:
- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust, and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form B233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:
1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form B233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:
1. You do not furnish your TIN to the requester.
2. You do not certify your TIN when required (see the instructions for Part II for details).
3. The IRS tells the requester that you furnished an incorrect TIN.
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1992 only).

Certain payees and payments are exempt from backup withholding. See Exempt payee code, later, and the separate instructions for the Requester of Form W-9 for more information. Also see Special rules for partnerships, earlier.

What is FATCA Reporting?
The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See Exemption from FATCA reporting code, later, and the instructions for the Requester of Form W-9 for more information.

Updating Your Information
You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are a tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties
Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.
Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.
### Specific Instructions

**Line 1**

You must enter one of the following on this line; do not leave this line blank. The name should match the name on your tax return.

- **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

- **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business name or “doing business as” (DBA) name on line 2.

- **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity’s name as shown on the entity’s tax return on line 1 and any business, trade, or DBA name on line 2.

- **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

- **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a “disregarded entity.” See Regulations section 301.7701-2(c)(2)(ii). Enter the owner’s name on line 1. The name of the entity entered on line 1 should not be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner’s name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity’s name on line 2. “Business name/disregarded entity name.” If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

**Line 2**

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

**Line 3**

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

<table>
<thead>
<tr>
<th>IF the entity/person on line 1 is an</th>
<th>THEN check the box for . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporation</td>
<td>Corporation</td>
</tr>
<tr>
<td>Individual</td>
<td>Individual/single proprietor or single-member LLC</td>
</tr>
<tr>
<td>Sole proprietorship, or</td>
<td>LLC treated as a partnership for U.S. federal tax purposes,</td>
</tr>
<tr>
<td>Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.</td>
<td>LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or</td>
</tr>
<tr>
<td></td>
<td>LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.</td>
</tr>
<tr>
<td></td>
<td>Partnership</td>
</tr>
<tr>
<td></td>
<td>Trust/estate</td>
</tr>
</tbody>
</table>

**Line 4, Exemptions**

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate spaces on line 4 any code(s) that may apply to you.

- **Exempt payee code.** Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- **Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.** Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions. Corporations are not exempt from backup withholding with respect to attorneys’ fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.
- **The following codes identify payees that are exempt from backup withholding.** Enter the appropriate code in the space in line 4.
  1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(k)(2)
  2. The United States or any of its agencies or instrumentalities
  3. A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities
  5. A corporation
  6. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
  7. A futures commission merchant registered with the Commodity Futures Trading Commission
  8. A real estate investment trust
  9. An entity registered at all times during the tax year under the Investment Company Act of 1940
  10. A common trust fund operated by a bank under section 586(a)
  11. A financial institution
  12. A middleman known in the investment community as a nominee or custodian
  13. A trust exempt from tax under section 664 or described in section 4947.
The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

<table>
<thead>
<tr>
<th>IF the payment is for...</th>
<th>THEN the payment is exempt for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and dividend payments</td>
<td>All exempt payees except for 7</td>
</tr>
<tr>
<td>Broker transactions</td>
<td>Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.</td>
</tr>
<tr>
<td>Barter exchange transactions and patronage dividends</td>
<td>Exempt payees 1 through 4</td>
</tr>
<tr>
<td>Payments over $5000 required to be reported and direct sales over $50,000</td>
<td>Generally, exempt payees 1 through 5</td>
</tr>
<tr>
<td>Payments made in settlement of payment card or third party network transactions</td>
<td>Exempt payees 1 through 4</td>
</tr>
</tbody>
</table>

1 See Form 1099-MISC, Miscellaneous Income, and its instructions.
2 However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys’ fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with “Not Applicable” (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
B—The United States or any of its agencies or instrumentalities
C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
D—a corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)
E—a corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)
F—a dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
G—a real estate investment trust
H—a regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
I—a common trust fund as defined in section 584(a)
J—a bank as defined in section 581
K—a broker
L—a trust exempt from tax under section 504 or described in section 4947(a)(1)

M—A tax exempt trust under a section 401(a) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5
Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6
Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)
Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see "How to get a TIN below."

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separately from its owner, enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a corporation or partnership, enter the entity’s EIN.

Note: See What Name and Number To Give the Requester, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately.

To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213.

Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/Businesses and clicking on Employer Identification Number (EIN) under Starting a Business. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-9.

Part II. Certification
To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 5, or 1 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see Exempt payee code, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.
1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification before attaching the Form 8847/8847-E. You must cross out item 2 on the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have a 2018 income tax return filed with the Internal Revenue Service.

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, charitable contributions, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to nonemployees in the course of a trade or business for rents, royalties, gasoline, oil, and other property.

What Name and Number To Give the Requester

<table>
<thead>
<tr>
<th>For this type of account:</th>
<th>Give name and SSN of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual</td>
<td>The name and SSN of:</td>
</tr>
<tr>
<td>2. Two or more individuals (joint account) other than an account maintained by an FFI</td>
<td>The actual owner of the account or, if combined funds, the first individual on the account</td>
</tr>
<tr>
<td>3. Two or more U.S. persons (joint account maintained by an FFI)</td>
<td>Each holder of the account</td>
</tr>
<tr>
<td>4. Custodial account of a minor (Uniform Gifts to Minors Act)</td>
<td>The minor</td>
</tr>
<tr>
<td>5. A trust or estate (not a grantor trust)</td>
<td>The grantor-trustee</td>
</tr>
<tr>
<td>6. A grantor trust or discretionary entity owned by an individual</td>
<td>The actual owner</td>
</tr>
<tr>
<td>7. Grantor trust filing under Optional Form 1099-Filing Method 2 (see Regulations section 1.671-4B(2)(ii)(A))</td>
<td>The grantor</td>
</tr>
</tbody>
</table>

For this type of account: | Give name and EIN of: |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Disregarded entity not owned by an individual</td>
<td>The owner</td>
</tr>
<tr>
<td>9. A valid trust, estate, or pension trust</td>
<td>Legal entity</td>
</tr>
<tr>
<td>10. Corporation or LLC electing corporate status on Form 8832 or Form 2553</td>
<td>The corporation</td>
</tr>
<tr>
<td>11. Association, club, religious, charitable, educational, or other tax-exempt organization</td>
<td>The organization</td>
</tr>
<tr>
<td>12. Partnership or multi-member LLC</td>
<td>The partnership</td>
</tr>
<tr>
<td>13. A broker or registered nominee</td>
<td>The broker or nominee</td>
</tr>
</tbody>
</table>

1. List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person’s number must be furnished.

2. Circle the minor’s name and furnish the minor’s SSN.

3. You must show your individual name and you may also enter your business or DBA name on the “Business name/disregarded entity” name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

4. List first and circle the name of the trust, estate, or pension trust (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see Special rules for partnerships, earlier.

*Note: The grantor also must provide a Form W-9 to trustee of trust.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

- To reduce your risk:
  - Protect your SSN.
  - Ensure your employer is protecting your SSN, and
  - Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-909-4478 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free communication line at 1-877-777-4778 or TTY/TDD 1-800-909-1059.

**Protect yourself from suspicious emails or phishing schemes.** Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common types being used for identity theft.
Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3408, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties also may apply for providing false or fraudulent information.
NATIONAL HEALTHCARE CORPORATION
EMPLOYEE STOCK PURCHASE PLAN
REQUEST FOR TERMINATION OF PARTICIPATION

The undersigned, an employee of _____________________________________________(Employer), hereby requests termination of contributions to the National HealthCare Corporation (“NHC”) Employee Stock Purchase Plan (“ESPP”). I, the undersigned employee, request my Employer to terminate the deduction from my paycheck of $_____________ each pay period.

In discontinuing participation in the Plan, the undersigned employee directs that the current funds in the contribution account be handled as follows (choose one):

___ a. refund as soon as possible.
___ b. leave in the account for purchase of shares at the end of the Plan Year.
___ c. partial withdrawal of $_____________, with remaining funds left in the account for purchase of shares at the end of the Plan Year.

The Contribution Account is registered as follows:

Name ___________________________________________________________________________

Address _____________________________________________________________________________

City______________________________ State_____________________ Zip______________________

Social Security Number ______________________

PLEASE NOTE: The discontinuance will become effective as soon as practical but not more than 30 days following the receipt of this notice by National HealthCare Corporation. Once discontinued, Employee cannot enter the Plan again until the next Plan Year (January 1) following termination of participation.

Date: ______________________                      __________________________________________

(Signature of Employee)

________________________________________
Employer

By:_______________________________________

Please return this completed form to your employer or to:
NHC PAYROLL DEPARTMENT, P.O. BOX 1398, MURFREESBORO, TN. 37133.
NATIONAL HEALTHCARE CORPORATION
EMPLOYEE STOCK PURCHASE PLAN
REQUEST FOR PARTIAL WITHDRAWAL OF FUNDS

The undersigned, an employee of ________________________(Employer), hereby requests a partial withdrawal of funds from the National HealthCare Corporation ("NHC") Employee Stock Purchase Plan ("ESPP") in the amount of $______________.

The Contribution Account is registered as follows:

Name _____________________________________________________________________________

Address _____________________________________________________________________________

City______________________________ State_____________________ Zip______________________

Social Security Number ______________________

PLEASE NOTE: The partial withdrawal will become effective as soon as practical but not more than 30 days following the receipt of this notice by National HealthCare Corporation. Only one partial withdrawal is allowed per year. A second request for partial withdrawal will terminate your participation in the Plan. Once discontinued, Employee cannot enter the Plan again until the next Plan Year (January 1) following termination of participation.

Date: ______________________                      __________________________________________

(Signature of Employee)

________________________________________
Employer

By:_______________________________________

Please return this completed form to your employer or to:
NHC PAYROLL DEPARTMENT, P.O. BOX 1398, MURFREESBORO, TN. 37133.
75,000 SHARES
OF COMMON STOCK

NHC
NATIONAL HEALTHCARE CORPORATION

This Prospectus relates to the offering by National HealthCare Corporation (the “Company”) of shares of its common stock purchasable by certain employees or affiliates of the Company, pursuant to the Company’s:

NATIONAL HEALTHCARE CORPORATION
2010 EMPLOYEE STOCK PURCHASE PLAN

THESE SECURITIES HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION NOR HAS THE COMMISSION PASSED UPON THE ACCURACY OR ADEQUACY OF THIS PROSPECTUS. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

***

No person is authorized to give any information or make any representation not contained in this Prospectus, and any information or representation not contained herein must not be relied upon as having been authorized by the Company. This Prospectus does not constitute an offer to sell or a solicitation of an offer to buy, nor shall there be any sale of these securities in any jurisdiction in which such offer, solicitation or sale would be unlawful prior to registration or qualification under the securities law of any such jurisdiction. Neither the delivery of this Prospectus nor any sale made hereunder shall under any circumstances create any implication that there has been no change in the affairs of the Company since the date hereof.

***

The Date of this Prospectus is June 22, 2010.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Information</td>
<td>15</td>
</tr>
<tr>
<td>Incorporation of Certain Documents by Reference</td>
<td>15</td>
</tr>
<tr>
<td>The Company</td>
<td>16</td>
</tr>
<tr>
<td>Administration of the Plan</td>
<td>16</td>
</tr>
<tr>
<td>Questions and Answers</td>
<td>17</td>
</tr>
<tr>
<td>U.S. Federal Income Tax Consequences</td>
<td>20</td>
</tr>
<tr>
<td>Current Plan Information</td>
<td>22</td>
</tr>
<tr>
<td>Description of the Common Stock of NHC</td>
<td>22</td>
</tr>
<tr>
<td>Indemnification of Directors and Officers</td>
<td>22</td>
</tr>
<tr>
<td>Federal Securities Law Aspects</td>
<td>22</td>
</tr>
<tr>
<td>Legal Opinions and Experts</td>
<td>23</td>
</tr>
<tr>
<td>Appendix A: Text of National HealthCare Corporation Employee Stock Purchase Plan</td>
<td>24</td>
</tr>
</tbody>
</table>
AVAILABLE INFORMATION

National HealthCare Corporation (the “Company” or “NHC”) is subject to the informational requirements of the Securities Exchange Act of 1934, and in accordance therewith files reports, proxy statements and other information with the Securities and Exchange Commission (the “Commission”). Such reports, proxy statements and other information may be inspected and copied at the Public Reference Room of the Commission, 1101 L Street, N.W., Washington, D.C. and at the Commission’s Regional Offices at 219 South Dearborn Street, Chicago, IL; 26 Federal Plaza, New York, NY; and 10960 Wilshire Boulevard, Los Angeles, CA. Copies of such material can be obtained from the Public Reference Section of the Commission, Washington, D.C., 20549, at prescribed rates. NHC’s common stock is listed and traded on the NYSE-MKT Stock Exchange. Reports, proxy material and other information concerning the Company may also be inspected at the offices of the NYSE-MKT Stock Exchange at its address at 86 Trinity Place, New York, NY 10006. This document is part of a Registration Statement required by the rules of the Securities and Exchange Commission. Such rules do not require that you receive the entire Registration Statement. However, upon written or oral request, participants may obtain, without charge, copies of all documents incorporated by reference into Part II, Item 3 of the Registration Statement, and such documents are incorporated herein by reference. Upon written or oral request, participants may also obtain, without charge, all documents required to be delivered to participants pursuant to SEC Rule 428(b).

INCORPORATION OF CERTAIN DOCUMENTS BY REFERENCE

The following documents filed with the Commission by the Company are incorporated herein by reference as of the dates thereof, or upon subsequent filing:

2. The Company’s Amendment No. 1 on Form 10-K/A for the year ended December 31, 2009.
4. The Company’s Current Reports on Form 8-K filed on March 5, 2010; May 7, 2010; and May 14, 2010.
5. The Company’s registration statement on Form 10 (SEC File No. 1-13487), filed October 14, 1997 and amended through Amendment No. 1 on December 5, 1997.
6. The description of the Company’s Common Stock as contained in the Company’s Registration Statement on Form S-4 (SEC File No. 333-37185), filed October 3, 1997, amended through Amendment No. 1 on December 20, 1997, amended through Amendment No. 2 on December 4, 1997, amended through Amendment No. 3 on December 5, 1997 and amended through Amendment No. 4 on December 5, 1997.
8. All documents filed by the Company pursuant to Section 13(a), 13(c), 14, and/or 15(d) of the Securities Exchange Act of 1934 after the date of this Prospectus and prior to the filing of a post-effective amendment indicating that shares offered herein have been sold or deregistering all shares then remaining unsold, shall be deemed to be incorporated by reference into this Prospectus and to be a part hereof from the date of filing of such documents. See AVAILABLE INFORMATION above

The Company hereby undertakes to provide, without charge, to each person to whom a copy of this Prospectus has been delivered, upon the written or oral request of such participant, a copy of any or all of the documents which have been or may be incorporated in this Prospectus by reference, other than exhibits to such documents. Requests for such copies should be directed to: Secretary, National HealthCare Corporation, 100 E. Vine Street, Suite 1400, Murfreesboro, Tennessee 37130, Telephone No. (615) 890-2020.
THE COMPANY

National HealthCare Corporation, together with its subsidiaries and operating divisions, is a health care company engaged in the operation of long term health care programs, rehabilitative services, retirement centers, homecare and hospice services principally in the southeastern portion of the United States. NHC is a Delaware corporation with its executive offices located at 100 E. Vine Street, Suite 1400, Murfreesboro, Tennessee 37130, and its telephone number is (615) 890-2020. NHC’s website is: www.nhccare.com.

ADMINISTRATION OF THE PLAN

The Plan is administered by the Board of Directors of the Company (hereinafter “Board”) and is generally subject to the administrative procedures and other rules set forth in the Plan. The Board has the authority in its discretion to make rules and regulations for the administration of the Plan, and its interpretations and decisions with respect to the Plan are final. The Board may appoint such other persons as it deems appropriate to administer the Plan. The Board receives no additional compensation for administering the Plan. Board members and their addresses are as follows:

W. Andrew Adams
Lawrence C. Tucker
Richard F. LaRoche, Jr. 801
Mooreland
140 Broadway
2103 Shannon Drive
Murfreesboro, TN 37128
New York, NY 10005
Murfreesboro, TN 37129

Ernest G. Burgess III
J. Paul Abernathy
Robert G. Adams
7097 Franklin Road
2102 Greenland Avenue
2217 Battleground Drive
Murfreesboro, TN 37128
Murfreesboro, TN 37130
Murfreesboro, TN 37129

Emil E. Hassan
1704 Irby Lane
Murfreesboro, TN 37127
EMPLOYEE STOCK PURCHASE PLAN

This Prospectus relates to shares of the common stock (hereinafter “Shares”) of National HealthCare Corporation offered under its Employee Stock Purchase Plan (the “Plan”). As of May 6, 2010, the date of the adoption of the Plan by the shareholders, the Company has been authorized to issue a maximum of 75,000 shares of the Company’s common stock pursuant to the Plan as provided under the terms of the National HealthCare Corporation 2010 Equity Incentive Plan.

The Plan is not subject to any provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and is intended to be a qualified plan under Section 401(a) of the Internal Revenue Code of 1954 as amended.

As presently in effect, the Plan is designed to be perpetual, with modifications to be made by the Board until the total number of shares authorized under the Plan (75,000 shares) have been subscribed, granted and exercised.

The employee contributions described below will not be held separately but will be held in the general funds of the Company.

The following description, in the form of questions and answers, is intended to help you to understand the provisions of the Plan. Accordingly, it is recommended that you read and become familiar with the text of the Plan as set forth in full in Appendix A attached to this Prospectus.

All terms in bold type herein have the meaning set forth in the Plan.

WHAT IS THE PRINCIPAL PURPOSE OF THE PLAN?

The Plan is intended to facilitate employee participation in the ownership and economic progress of the Company.

WHO ADMINISTERS THE PLAN?

The Plan is administered by the Board of Directors of the Company (“Board”). Refer to caption “Administration of the Plan” in the Prospectus for more detailed information.

WHAT IS THE PLAN YEAR?

The Plan Year is the 12-month calendar year beginning on January 1 and ending on December 31 of each calendar year.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

All employees of the Company or its subsidiaries, operating divisions and affiliates may elect to participate in the Plan, regardless of whether they are full or part-time employees.

HOW MAY I PARTICIPATE IN THE PLAN?

You should fill out the attached Request for Participation Form and Form W-9 Request for Taxpayer Identification Number and Certification (Form W-9) and submit them to your employer at any time prior to March 31 of any year, unless extended by Board action. Payroll deductions will begin with paychecks issued for the next pay period after your Request for Participation Form and Form W-9 have been received at the Corporate Office’s Payroll Department.

HOW MUCH MAY I CONTRIBUTE?

You may contribute at each pay period whatever amount of your normal pay period compensation you elect. The minimum contribution accepted will be $10.00 per pay period and the maximum contribution is your normal pay period compensation. Your contributions each year cannot exceed $25,000.00.
CAN I MAKE CASH PAYMENTS TO MY CONTRIBUTION ACCOUNT IN ADDITION TO PAYROLL DEDUCTIONS?

No. Only payroll deductions can be accepted under the Plan. However, in locations where payroll deductions are not permitted by law, the Board may adopt appropriate alternative methods by which employees in such locations may make payments.

MAY I CHANGE THE AMOUNT OF MY PAYROLL DEDUCTIONS?

You may change the amount of your contribution during a Plan Year, subject to the minimum and maximum contribution limits, but not after March 31, unless extended by the Board for that Plan Year. At any time during a Plan Year, you may discontinue your contributions by notifying the Company in writing on forms provided in this booklet for that purpose.

HOW WILL MY PURCHASE PRICE FOR THE SHARES OF STOCK BE DETERMINED?

The Issue Price paid by the participating employee is a price per share as determined by the Board, but not less than eighty-five percent (85%) of the fair market value of a share of stock on the lesser of: (1) the closing price of the Company’s shares on the first trading date of the Plan Year (grant date); or (2) the closing price of the Company’s shares on the last trading date of the Plan Year (exercise date).

THE FOLLOWING IS AN EXAMPLE FOR PURPOSES OF ILLUSTRATION ONLY AND NOT A REPRESENTATION OF FUTURE TRADING PRICES OF THE COMPANY’S STOCK:

If the closing price per share on the grant date (January 1) was $15.00 and the closing price per share on the exercise date (December 31) of the Plan Year was $18.00, the purchase price would be $15.00 per share. If, however, the closing price per share was $12.00 on the exercise date, the purchase price would be $12.00.

HOW MANY SHARES WILL I BE ABLE TO BUY?

On an exercise date, shares are purchased for you. Only whole shares will be purchased. The number of shares that will be purchased for you on the exercise date will depend upon the issue price that day and the amount of money in your contribution account on the exercise date.

For example, if the issue price is $12.00 (as assumed above) and you have $260.00 in your contribution account on the exercise date, you will purchase 21 shares at a total cost of $252.00. The balance of $8.00 remaining in your contribution account will be carried over automatically to the next Plan Year, unless you provide the Company with written instructions to the contrary or you cease to be a member in the Plan, in which case the balance of $8.00 will be refunded to you without interest.

MAY I TERMINATE MY PARTICIPATION IN THE PLAN?

Yes, you may notify the Company at any time during the Plan Year if you wish to discontinue your contributions. This notice shall be in writing and on forms provided by the Company. The discontinuance will become effective as soon as practical, but not more than 30 days following the receipt of notice by the Company. If you discontinue your contributions under the Plan but remain employed by the Company, you may elect either to withdraw all of the funds in your contribution account or leave such funds for purchase of shares at the end of the Plan Year. Partial withdrawals are allowed, but are limited to one such withdrawal each year.

WHAT ABOUT MY RIGHTS AS A SHAREHOLDER?

You will become a shareholder of record upon the date of issuance of your shares purchased (with respect to the first Plan Year in which you participate) and at that time will have all of the benefits, which arise from ownership of NHC shares.
IN WHOSE NAME MAY SHARES BE REGISTERED?

Shares may be registered only in the name of the employee.

WHEN WILL I RECEIVE NOTIFICATION MY SHARES HAVE BEEN REGISTERED?

Shares will be registered in your name in book-entry form on the books of the transfer agent as soon as practical after the exercise date with respect to such purchase. The Company will make its best efforts to have the shares registered in your name within 45 days after such exercise date. You will receive confirmation from the transfer agent when the shares are issued.

IF I WITHDRAW FROM THE PLAN, MAY I RESUME MY PARTICIPATION IN IT AT A LATER DATE?

Yes, but you cannot enter the Plan until the next Plan Year following your termination of participation.

WHAT IF I LEAVE THE COMPANY?

If you leave the employ of the Company or its subsidiaries, divisions or affiliates for any reason, except death or retirement, you immediately cease being a member of the Plan. The funds in your contribution account will be paid to you or your beneficiary without interest as soon as practical and the options held by you to purchase stock will be null and void.

Upon the date of your death or retirement, your contributions will cease being accumulated in your contribution account. From that date until the end of the Plan Year, either you or your estate may withdraw the balance in your contribution account by notifying your specific employer in writing. If no decision to withdraw is made, the funds in your contribution account shall be used to purchase stock (which will be registered as previously designated) on the exercise date of the Plan Year during which your death or retirement has occurred.

ARE MY RIGHTS UNDER THE PLAN TRANSFERABLE?

No, you may not transfer your right to purchase stock under the Plan, and such rights are exercisable only by you.

WHEN CAN I SELL MY STOCK?

You may sell your stock at any time after you have received notification the shares have been registered in your name; however, if you sell any stock obtained through the Plan less than one year after the exercise date on which you purchased such stock, you must notify the Company in writing. You should, of course, consider the income tax consequences of selling your stock, which are more fully discussed under the caption U. S. Federal Income Tax Consequences.

HOW DO I SELL MY STOCK?

If you wish to sell your stock purchased under the Plan, it is recommended that you seek the advice and assistance of a stockbroker or other financial adviser. Generally, upon your sale, you will be required to pay a commission or fee to such broker or adviser. Once the shares are registered in your name, the Company has no responsibility regarding your subsequent sale.

IS INTEREST PAID ON THE AMOUNT IN MY CONTRIBUTION ACCOUNT?

No, interest is not paid on the balance in your contribution account. If you withdraw your funds or leave the Company, you will receive the exact amount, which has been withheld, from your paychecks.
WHAT REPORTS DO I RECEIVE?

The payroll deductions made under the Plan will appear on your regular earnings and deductions statements, which are issued as part of your paycheck. After shares of stock have been registered in your name, you will receive any report issued to the Company shareholders.

WHAT IS THE EFFECT OF A STOCK SPLIT OR STOCK DIVIDEND?

Proportional changes in the number of shares subject to the Plan and affecting the calculation of the issue price per share during a Plan Year will be made in the event of a stock dividend, stock split or combination which increases or decreases the Company’s outstanding shares during the Plan Year.

WHO DO I CONTACT ABOUT MY STOCK REGISTRATION?

If you have any questions about the original registration of your stock, you should contact the NHC Home Office and request the Benefits Department. Once the shares are registered in your name, you should contact the transfer agent, Computershare at 1-800-568-3476. You may also access your account at www.computershare.com/investor.

WHAT IF I HAVE OTHER QUESTIONS REGARDING THE PLAN?

All questions regarding the Plan should be discussed with the Benefits Department of home office.

SHOULD I PARTICIPATE IN THE PLAN?

The decision is up to you. Company personnel are not authorized to suggest what your decision should be. Stock ownership has certain risks and may not be a wise investment for you unless you have provided for your other financial needs. Accordingly, you should carefully consider your personal financial goals and requirements to determine whether buying stock in NHC is consistent with your personal financial plans. Participation in the Plan is entirely voluntary.

A copy of the Company’s Annual Report to Shareholders is available for inspection at your place of employment. A copy is also available on the Company website at www.nhccare.com. An additional copy will be furnished upon written request.

WHAT ARE THE U.S. FEDERAL INCOME TAX CONSEQUENCES OF PARTICIPATION IN THE PLAN?

Stock purchased under the Plan is deemed to be “qualifying stock options” under the United States Federal Income Tax Law. If, in exercising your option, you pay less than the market price for each share purchased under the Plan, then there are no tax consequences unless you sell the shares within 12 months of the exercise date.

If certain requirements are met, no gain or loss is generally realized by the employee when an option is granted or exercised under the ESPP (Code Sec. 421(a)). Instead the employee is not subject to income tax until shares acquired by the exercise of the option are sold.

Gain or loss from the sale of the stock received in an ESPP is a capital gain or loss if: (1) the taxpayer does not dispose of the stock for at least two years from the date on which the option is granted; and (2) the stock is held for at least one year after the option is exercised (Code Sec. 423(a)). The amount of gain or loss is the difference between the amount the taxpayer paid for the stock (the option price) and the amount the taxpayer received when he or she sold the stock.

If the option price is less than 100 percent (but not less than 85 percent) of the fair market value of the stock, then the favorable tax treatment does not apply when the taxpayer disposes of the stock. Instead, the employee recognizes ordinary income in the amount of the lesser of:

• the excess of the fair market value of the shares when sold or on the employee’s death, over the option price, or
• the excess of the fair market value of the shares when the option was granted, over the option price.

The balance of any gain is treated as capital gain. If the taxpayer realizes any loss from the sale, then it is a capital loss (Code Sec. 423(c)).
If the employee sells the stock before the required holding period ends (a disqualifying disposition), gain on the sale is ordinary income equal to the fair market value of the stock when the option was exercised, less the exercise price (Code Sec. 421(b)); Reg. §1.421-2(b)). Any excess gain is capital gain, and any loss is a capital loss. The gain is recognized for the tax year in which the sale occurs. In addition, any gain from a disqualifying disposition is excluded from wages for FICA and FUTA tax purposes and is not subject to income tax withholding (Code Secs. 3121(a)(22) and 3306(b)(19)).

EACH PARTICIPANT IN THE PLAN SHOULD CONSULT WITH HIS OR HER OWN TAX ADVISOR WITH RESPECT TO THE TAX EFFECT OF PARTICIPATION IN THE NSSPP SUB PLAN UNDER THE PLAN AND THE DISPOSITION OF STOCK ACQUIRED PURSUANT TO PARTICIPATION IN THE NSSPP SUB PLAN, AS IT IS NOT FEASIBLE TO DISCUSS ALL FEDERAL, STATE AND LOCAL TAX IMPLICATIONS THEREOF.
CURRENT PLAN INFORMATION

As of the date hereof, the Company and its subsidiaries, divisions and affiliates employ approximately 11,000 employees, all of who are eligible for participation in the Plan. The Company is unable to estimate the number of employees, who will participate in the Plan or the number of shares, which may be purchased, by those employees who do participate. A copy of the Plan itself is attached hereto as Appendix A to this Prospectus. The Plan may be amended from time to time and certain other changes (e.g. changes in the number of employees participating and eligible, changes in the number of shares offered, and changes in applicable law) also may occur. Any such amendments or changes that are material shall be reflected in an appendix hereto, which may be updated from time to time.

DESCRIPTION OF THE COMMON STOCK OF NHC

The common stock of National HealthCare Corporation is freely transferable and is listed on the NYSE-MKT Stock Exchange under the trading symbol “NHC”.

Management of the Company is overseen by the Board of Directors who in turn are elected by all shareholders. Certain matters require the prior approval of either (i) the holders of more than 50% of the shares, together with the unanimous approval of the Board; or (ii) holder of 70% or more of the shares; these matters include a sale or exchange of all or substantially all of the company’s assets, a liquidation, or a merger of the Company. The Company is subject to the reporting requirements of the Securities and Exchange Commission and provides annual reports to shareholders and conducts an Annual Meeting of shareholders.

INDEMNIFICATION OF DIRECTORS AND OFFICERS

The Company has agreed to indemnify, to the fullest extent permitted by law, its officers, directors and employees against liabilities, costs and expenses (including legal fees and expenses) incurred by an officer, director, employee, if it is determined that (i) such person acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the Company and, with respect to any criminal proceeding, had no reasonable cause to believe such conduct was unlawful, and (ii) such person’s conduct did not constitute gross negligence or willful or wanton misconduct. Notwithstanding the foregoing, no officer, director, or employee shall be indemnified from any liabilities, costs and expenses incurred by him/ her in connection with any claim or settlement involving allegations that federal or state securities laws were violated unless there has been a successful adjudication on the merits as a result of a trial or such claim has been dismissed with prejudice on the merits by a court of competent jurisdiction and such indemnification is specifically approved by a court which shall have been advised as to the current position of the Securities and Exchange Commission regarding indemnification for violations of securities laws. Insofar as indemnification for liabilities arising under the Securities Act of 1933 may be permitted pursuant to the foregoing provisions, the Company has been informed that in the opinion of the Commission such indemnification is against public policy as expressed in the Securities Act and is, therefore, unenforceable. The Board of Directors and Management employees shall have no liability to the shareholders for the return of their capital contributions or for any loss, damage, liability or expense arising out of the business of the Company, except as caused by gross negligence, misconduct in the performance of their fiduciary duties to the shareholders or violation of any of the provisions of the Company’s Articles of Incorporation.

FEDERAL SECURITIES LAW ASPECTS

The shares issuable to participants are hereby being registered under the Securities Act of 1933 as amended (the “Act”) on Form S-8, thereby allowing the shares so issued to be sold or otherwise disposed of by those purchasers under the Plan who are not deemed to be affiliates of the Company. An affiliate of the Company is a person who directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with the Company. Persons deemed to be affiliates may resell shares issued hereunder pursuant to Rule 144 promulgated by the Commission or pursuant to a separate prospectus filed as part of this Registration Statement or pursuant to a separate registration statement. Compliance with Rule 144 is subject to certain limitations and requirements, including limitations on the number of shares which may be sold in any 3-month period.
LEGAL OPINIONS AND EXPERTS

Legal Opinion: The legality of the shares purchased under the Plan and the statements contained herein under the caption U.S. Federal Income Tax Consequences for the Company have been passed upon by legal counsel for the Company. Reference is made to the Company’s Annual Report and Proxy Statement.

Experts: The financial statements and schedules included in the Company’s Form 10-K and Annual Report are incorporated by reference in this Prospectus to the extent and for the periods indicated in their reports. These financial statements and reports have been examined by the Company’s independent public auditors, and are incorporated by reference herein in reliance upon the authority of said firm as experts in giving said reports.
APPENDIX A

SECTION 16.   EMPLOYEE STOCK PURCHASE PLAN (ESPP).

16.1.   Definitions. As used in Sections 16 and 17, the following words and phrases shall have the meanings below, unless a different meaning is plainly required by the context:

16.1.1. The term “Closing Price” shall mean the fair market value of a share of the Company’s Common Stock determined by applying the rules set forth in Section 2.12 above.

16.1.2. The term “Contribution Account” shall mean the account established on behalf of an Employee Member to which shall be credited the amount of the Employee Member’s contribution.

16.1.3. The term “Employee” shall mean any person who, at the time an option under this Employee Stock Purchase Plan is granted to such person, is an “employee” of the Employer, as such term is used in Section 423 of the Code and described in Regulations Section 1.421-1(h)(1).

16.1.4. The term “Employee Member” shall mean any Employee of the Employer who has met the conditions and provisions for becoming an Employee Member as provided herein.

16.1.5. The term “Employer” shall mean the Company and any corporation during any period in which such corporation is a “subsidiary corporation” as that term is defined in Section 424(f) of the Code with respect to the Company that the Committee designates to be subject to this Employee Stock Purchase Plan.

16.1.6. The term “Exercise Date” shall mean the last trading date on the NYSE-MKT Stock Exchange (or successor exchange) in the Plan Year.

16.1.7. The term “Grant Date” shall mean the first NYSE-MKT Stock Exchange (or successor exchange) trading date of the Plan Year.

16.1.8. The term “Issue Price” shall mean a price per share of Common Stock as determined by the Board, but not less than eighty-five percent (85%) of the lower of the Closing Price of the shares on either the Grant Date or the Exercise Date as determined on the Exercise Date.

16.1.9. The term “Member’s Contribution Rate” shall be an exact number of dollars elected by the Employee Member to contribute by regular payroll deductions to their Contribution Account.

16.1.10. The term “Plan Year” shall mean a twelve (12) month period beginning on the first day of January and ending on the last day of December.


16.2.1. Each Employee shall become eligible to participate in the Employee Stock Purchase Plan upon his or her date of employment. Options under this Employee Stock Purchase Plan may be granted only to Employees of the Employer.

16.2.2. Each Employee who becomes eligible to participate in the Employee Stock Purchase Plan shall be furnished a summary of the Employee Stock Purchase Plan and a Request for Participation form. If such

3/2014
Employee elects to participate hereunder, said Employee shall complete such form and file it with the Employee’s Employer in accordance with procedures established by the Board (or its designee under Section 17) and will thereby become an Employee Member. The completed Request for Participation form shall indicate the amount of Employee contribution or purchase amount authorized by the Employee Member.

16.2.3. Upon becoming an Employee Member, said Employee Member shall be bound by the terms of this Employee Stock Purchase Plan and the other applicable provisions of the Plan, including any amendments hereto.


16.3.1. In order to participate in this Employee Stock Purchase Plan an Employee must authorize Employer to deduct through payroll deduction an exact number of dollars per pay period, but not less than $10.00 per pay period or more than the payment to the employee that pay period. Such Employee authorization shall be in writing and on such forms as provided by the Company. Such deductions shall begin as of the first pay period after receipt of the Request for Participation form at the corporate offices, but no later than March 31 in any Plan Year, unless extended by the Board. No interest shall accrue on any amounts withheld under this Employee Stock Purchase Plan.

16.3.1.1. The Employee Member’s Contribution Rate, once established, shall remain in effect for all Plan Years unless changed by the Employee Member in writing on such forms as provided by the Company and filed with the Company.

16.3.1.2. At any time during the Plan Year, an Employee Member may notify the Company that such Employee Member wishes to discontinue contributions. This notice shall be in writing and on such forms as provided by the Company and shall become effective as of a date not more than thirty (30) days following its receipt by the Company. Upon such discontinuance, the Employee Member may not again elect to make contributions to the Plan for the remainder of the Plan Year, and all contributions previously made shall be used to purchase shares of Common Stock pursuant to the Plan in accordance with Section 16.3.3 unless withdrawn by the Employee Member pursuant to Section 16.3.1.3.

16.3.1.3. An Employee Member may elect to withdraw some or all of said Employee Member’s contributions once at any time during the Plan Year without being terminated from the Plan. However, if contributions are withdrawn a second time during the Plan Year, no further contributions will be permitted during that Plan Year by that Employee Member.

16.3.2. If the total number of shares of Common Stock to be purchased hereunder by all Employee Members exceeds the number of shares authorized under the Plan, a pro-rata allocation of the available shares will be made among all Employee Members authorizing such payroll deductions based on the amount in their respective Contribution Account on the Exercise Date.

16.3.3. On each Exercise Date the Employee Member’s Contribution Account shall be used to purchase the maximum number of whole shares of Common Stock determined by dividing the Issue Price into the Member’s Contribution Account. Any money remaining in an Employee Member’s Contribution Account may be returned to the Employee Member if requested. If such return is not requested, the balance will remain in the Contribution Account to be used in the next Plan Year along with new contributions in the new Plan Year. All rights or options under this Employee Stock Purchase Plan shall be subject to such amendment or modification as
the Company shall deem necessary to comply with any applicable law, and shall contain such other provisions as
the Company shall deem necessary to comply with any applicable law, and shall contain such other provisions as
the Company shall from time to time approve and deem necessary.

16.3.4. In no event may an Employee Member:

(i) Be granted an option under this Employee Stock Purchase Plan which permits such
Employee’s rights to purchase Common Stock under all employee stock purchase plans of the Employer to accrue
at a rate which exceeds $25,000 of Fair Market Value of such Common Stock (determined at the time such option
is granted) for each calendar year in which such option is outstanding at any time consistent with Section
423(b)(8) of the Code and the Regulations promulgated thereunder;

(ii) Receive an option under this Employee Stock Purchase Plan if he or she would beneficially
own, immediately after the option is granted, 5% or more of the total combined voting power or value of all
outstanding common stock of the Employer and, for purposes of this clause (ii) the rules of Section 424(d) of the
Code shall apply in determining the stock ownership of an individual and stock which the Employee may purchase
under outstanding options shall be treated as stock owned by the Employee; or

(iii) Transfer or otherwise alienate any option granted to him or her under this Employee Stock
Purchase Plan other than by will or the laws of intestate succession.

16.3.5. The Company certificates representing shares of Common Stock purchased through the exercise of the
option granted under this Employee Stock Purchase Plan shall be issued as soon as practical after the date of such exercise.
Notwithstanding the foregoing, shares purchased through the Employee Stock Purchase Plan, may be held electronically by
an uncertificated book-entry by the Company’s transfer agent.

16.3.6. Any Employee whose employment with the Employer is terminated for any reason except death and
retirement during the Plan Year shall cease to be an Employee Member immediately. The balance of the Member’s
Contribution Account shall be paid to such Employee Member, or his legal representative, as soon as practical after
termination. Any options granted to such Employee Member shall be deemed null and void.

16.3.7. If an Employee Member shall die during a Plan Year, no further contributions on behalf of the deceased
Employee Member shall be made. The executor or legal representative of the deceased Employee Member may elect to
withdraw the balance in said Employee Member’s Contribution Account by notifying the Employer in writing. In the event
no election to withdraw has been made, the balance accumulated in the deceased Employee Member’s Contribution Account
shall be used to purchase shares in accordance with this Employee Stock Purchase Plan.

16.3.8. If an Employee Member shall retire during a Plan Year, no further contributions on behalf of the retired
Employee Member shall be made. The Employee Member may elect to withdraw the balance in said Employee Member’s
Contribution Account by notifying the Employer in writing. In the event no election to withdraw has been made, the balance
accumulated in the retired Employee Member’s Contribution Account shall be used to purchase shares in accordance with
this Section 16.
SECTION 17. MISCELLANEOUS PROVISIONS OF THE ESPP.

17.1. Administration of ESPP. The Board or any person delegated such authority by the Board shall administer the Employee Stock Purchase Plan and keep records of individual Employee Member benefits. The Board shall administer the ESPP provided in Sections 16 and 17 in such a manner as to qualify it as an “employee stock purchase plan” intended to satisfy the requirements of Section 423 of the Code (although the Company makes no undertaking nor representation to obtain or maintain qualification under Section 423). The Board shall interpret the Employee Stock Purchase Plan and shall determine all questions arising in the administration, interpretation and application of the Employee Stock Purchase Plan, and all such determinations by the Board shall be conclusive and binding on all persons.

17.2. Limitation of Benefit. Each Employee Member, former Employee Member, or any other person who shall claim the right or benefit under this Employee Stock Purchase Plan, shall be entitled only to look to the Company for such benefit.

17.3. Amendment of ESPP. The Board may at any time or from time to time, amend the Employee Stock Purchase Plan in any respect or terminate same; provided, however, that, without the approval of the holders of a majority of the outstanding Common Stock of the Company entitled to vote thereon at a shareholders’ meeting, the Board of Directors may not amend the Employee Stock Purchase Plan to increase (except for increases due to adjustments in accordance with Section 7 hereof) the aggregate number of shares of Common Stock which may be issued under the Employee Stock Purchase Plan or change the class of Employees eligible to participate in this Employee Stock Purchase Plan. This Employee Stock Purchase Plan will be suspended in the event a tender offer is made to the shareholders of the Company. The Board’s determination that such an offer has been made shall be conclusive. No contributions will be accepted and all Contribution Account balances will be refunded to Employee Members. This Employee Stock Purchase Plan may thereafter be reactivated by Board action at any time.

17.4. Expenses. The Company will pay all expenses of administering this Employee Stock Purchase Plan that may arise in connection with this Employee Stock Purchase Plan.

17.5. Rules, Regulations and Procedures. Any rules, regulations, or procedures that may be necessary for the proper administration or functioning of this Employee Stock Purchase Plan that are not covered in this Employee Stock Purchase Plan shall be promulgated and adopted by the Board.

17.6. Transferability. The option rights under this Employee Stock Purchase Plan are not subject to assignment or alienation. If an Employee Member attempts such assignment, transfer or alienation, the Company shall disregard that action.

17.7. No Right to Employment/Contract. This Employee Stock Purchase Plan will not be deemed to constitute a contract between an Employer and any Employee Member or to be a consideration or an inducement for the employment of any Employee Member or Employee. Nothing contained in this Employee Stock Purchase Plan shall be deemed to give any Employee Member or Employee the right to be retained in the service of an Employer or to interfere with the right of an Employer to discharge any Employee Member or Employee at any time regardless of the effect which such discharge shall have upon said Employee Member or Employee as an Employee Member of the Plan.

17.8. Indemnification. No liability whatever shall attach to or be incurred by any past, present or future shareholders, officers or directors, as such, of the Employer or its affiliates, under or by reason of any of the terms, conditions or agreements contained in this Employee Stock Purchase Plan or implied therefrom, and any and all liabilities of, and any and all rights and claims against the Employer or its affiliates, or any shareholder, officer or director as such, whether arising at common law or in equity or created by statute or constitution or otherwise, pertaining to this Employee
Stock Purchase Plan, are hereby expressly waived and released by every Employee Member, as a part of the consideration for any benefits by the Employers under this Employee Stock Purchase Plan.

17.9. **Approvals.** The Company’s obligation to sell and deliver shares under the Employee Stock Purchase Plan is at all times subject to all approvals of any governmental authorities required in connection with the authorization, issuance, sale or delivery of such securities.

17.10. **Maximum Number of Shares.** Subject to Section 7.1, the maximum number of shares of Common Stock that may be issued with respect to options granted under the Employee Stock Purchase Plan shall be equal to the sum of 75,000 shares of Common Stock.
Tuition Reimbursement

NHC’s Tuition Reimbursement Program operates on the premise that continuing education is mutually beneficial for both the partner and the employer. Participation in the program signals a commitment to work for NHC after completion of academic work sponsored and financially supported by NHC.

The company may support partial or full reimbursement of tuition costs for academic work completed at vocational schools, community colleges, and state colleges and universities. The company may also share tuition expenses with partners who wish to attend a private university.

Reimbursement is given for tuition costs only, with additional financial aid available for books through The Foundation for Geriatric Education (TFGE).

Reimbursement is made upon completion of the course (typically each semester). Students are required to submit grades and tuition receipts prior to receiving reimbursement. To qualify for reimbursement, a grade of C or above is required.

Upon entering the program, a written contract is entered into between the partner and their employer.

The contract commits partners to a specified number of years of service with NHC or an NHC affiliated company in exchange for the tuition reimbursement.

Whether you’re a CNA wanting to become an LPN and/or RN or a non-nursing partner pursuing a new career in the long-term care field, the NHC Tuition Reimbursement Program may be the key to your future career goals.

Please note: Every NHC & NHC affiliated employer may not participate in this plan every year. Ask your employer for their current plan participation.
Payroll Selection

There are two ways to receive your pay: Direct Deposit or Comdata Paycard. You are free to choose either method. You should take time to review this section before making a selection.

**Option 1 - Direct Deposit to a Personal Bank Account:** Your pay is deposited directly into a personal checking account, savings account, or non-checking account (for example, paycards that are not Comdata) every payday.

You have the choice of two accounts in the direct deposit program. The second account may be used for a credit union, savings account, checking account, etc. and must be a specified dollar amount.

- If you only have 1 account in the direct deposit program, the entire amount of your paycheck will be deposited into Account 1.
- If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Account 2. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.
- If you have 2 accounts and close or change Account 1, Account 2 will be suspended until Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Account 1.

**Option 2 – Comdata Paycard:** Pay is loaded directly and electronically into your Comdata Account every payday. You may access available funds by using the Comdata Paycard.

Comdata Paycard features:

- You can take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
- You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. Locations may be found by visiting www.allpointnetwork.com.
- You can use the paycard to make purchases and get cash back with those purchases.

These options give you more control over your pay. Among key benefits inherent in both Direct Deposit and the Comdata payroll options:

- **Immediate access:** pay is automatically deposited into a personal bank account or a Comdata Account every payday. You will be able to access your pay immediately -- rain, snow or shine -- and avoid the hassles of waiting to pick up a check or waiting in line to cash it.
- **Savings:** these options give you instant and convenient ways to access your pay, and can even help eliminate check cashing and money order fees.
- **Safe:** your pay is automatically placed in your account, giving you peace of mind -- you don’t have to worry about lost checks or stolen cash.

**Contents of Payroll Selection:**

- Payroll Selection Form
- Direct Deposit FAQs
- Comdata Paycard Program Enrollment Kit:
  - Comdata Paycard Program Features
  - Enrollment and Activation Instructions
  - Frequently Asked Questions
  - Fee Schedule
PAYROLL SELECTION FORM

See Reverse Side for Instructions.

Location #: ___________________   XXX - XX - ______ ____________________________
Social Security Number  Partner Name (Please Print)

Direct Deposit Choice

☐ I select the Direct Deposit Choice and would like my pay deposited to the following bank account(s)

ACCOUNT 1
☐ Begin Deposit  ☐ Change Information  ☐ Cancel
Bank Name: ____________________________
Account Type: ____________________________
(C for Checking or Paycards; S for Savings)
Account Number: ____________________________
*Account Number:
*(Attach void check for Checking Account. For Savings and nonchecking accounts attach a bank letter or specification sheet which contains ABA and account numbers that will be valid for ACH transactions. Deposit tickets are not accepted.)

ACCOUNT 2
☐ Begin Deposit  ☐ Change Information  ☐ Cancel
Amount $ ____________________________
Bank Name: ____________________________
Account Type: ____________________________
(C for Checking or Paycards; S for Savings)
Account Number: ____________________________
*Account Number:
*(Attach void check for Checking Account. For Savings and nonchecking accounts attach a bank letter or specification sheet which contains ABA and account numbers that will be valid for ACH transactions. Deposit tickets are not accepted.)

Tape Void Check for Direct Deposit Choice Below

Comdata Paycard Choice

☐ I select the Comdata Paycard and would like my employer to enroll me in a Comdata Account and deposit my pay into the Account. I understand that there are fees for certain transactions. I have reviewed and agree to the Comdata Fee Schedule.

ACCOUNT 1
☐ Begin Deposit  ☐ Cancel
Bank Name: Comdata
Account Type: C
Account Number: ____________________________

ACCOUNT 2
☐ Begin Deposit  ☐ Change Amount  ☐ Cancel
Amount $ ____________________________
Bank Name: Comdata
Account Type: C
Account Number: ____________________________

Payroll Authorization
I authorize my employer to disburse my pay by Direct Deposit or Comdata according to the selection(s) above. In the event my employer deposits funds by mistake into my account, I authorize my employer to direct the financial institution or service to return such funds. This authorization will remain in effect until I have filed a new selection form.

Partner Signature: ____________________________ Date __/__/____
Verified By: ____________________________ Bookkeeper's Initials / __/__/____

CD Official Use Only
Pre-Notification _________  Active _________

DD Official Use Only
Pre-Notification _________  Active _________

960 Forms 10/18

10/2018
Instructions for Payroll Selection Form

There are two ways to receive your pay: Direct Deposit or Comdata Paycard. You are free to choose either method. You should take time to review the Payroll Selection section of the Partner Benefits Handbook and the options outlined on this form before selecting the method you choose to use.

The center will provide the 4-digit location number. Complete the last 4 digits of your Social Security Number and print your Name.

**Direct Deposit Choice:** Check this box and complete the appropriate portion of this section if you choose Direct Deposit.

- **Account 1 and Account 2:** You have the choice of two accounts in the direct deposit program. The first account is used for the balance of your pay. The second account may be used for a credit union, savings account, checking account, etc. and must be a specified dollar amount.
  - If you only have 1 account in the direct deposit program, the entire amount of your paycheck will be deposited into Account 1.
  - If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Account 2. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.
  - If you have 2 accounts and close or change Account 1, Account 2 will be suspended until Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Account 1.

- **Begin, Change, Cancel:** Check the appropriate box:
  - **Begin Deposit**
  - **Change Information**
    - If you have a bank account change, mark this box to stop the direct deposit transaction to the current account and initiate a prenotification process for the new account.
    - If you want to change the $ Amount for Account 2, mark this box. Changes to $ Amount for Account 2 do not initiate a prenotification process.
  - **Cancel**

- **Bank Name:** Enter the appropriate financial institution name.

- **Account Type:** Enter C (for Checking or non-Comdata Paycards) or S (for Savings).

- **Account Number:** Enter the correct Account Number.
  - If you choose checking account, you must attach a voided check or bank letter to the Selection Form. Deposit tickets will not be accepted.
  - If you choose savings and/or nonchecking account, you must attach an authorized bank letter or specification sheet that contains ABA# and account numbers that will be valid for Direct Deposit (ACH) transactions. The account information on the checks and deposit slips for savings and nonchecking accounts are likely to be invalid for ACH transactions. Deposit tickets will not be accepted.

**Comdata Paycard Choice:** Check this box if you want to enroll in the Comdata Paycard and have your employer load your pay into your Comdata account each pay day. You can access funds by using a Comdata Paycard at locations shown on the Comdata location finder tool at www.cardholder.comdata.com. Details are included in the Comdata Paycard Program Enrollment Kit.

- **Comdata Paycard:** There is no monthly charge for the paycard. You can take the card to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee. You may also withdraw cash for free at thousands of Allpoint Network ATMs. Locations may be found by visiting www.allpointnetwork.com. Fees may apply for ATM transactions other than In-Network ATMs. You can also use the card to make purchases and get cash back with those purchases.

- **Account 1 and Account 2:** You must choose between Account 1 and Account 2. You must specify a specific dollar amount.
  - If you have 2 accounts, the amount you designate as a specific dollar amount will be deposited into Comdata Account 2. Any remaining amount will be deposited into Direct Deposit Account 1. If the entire amount of your paycheck is less than the designated amount in Comdata Account 2, all of your paycheck will be deposited into Direct Deposit Account 1.
  - If you have 2 accounts and close or change Direct Deposit Account 1, Comdata Account 2 will be suspended until Direct Deposit Account 1 is restored. You will receive a negotiable paper check for both accounts until you set up Direct Deposit Account 1.

- **Begin, Change, Cancel:** Check the appropriate box:
  - **Begin Deposit**
  - **Change Amount**
  - **Cancel**

**Bank Name:** This section has been prefilled with the financial institution name.

**Account Type:** This section has been prefilled with C (for Comdata Paycards)

**Account Number:** Enter the correct Account Number only if you cancel Account 1 or Account 2, or change Amount for Account 2.

**Signature Information:** You must sign and date the form. Submit the completed form to your supervisor.
Direct Deposit

1. What are the advantages of Direct Deposit?
   - Free
   - Timeliness of check receipt
   - Convenience and accessibility
   - Safety
   - Reliability
   - Confidentiality
   - Potential Savings

   Direct Deposit is the safest, most convenient way to be sure that your paycheck is immediately deposited into your account each payday.

   No more hectic trips to deposit your check, no more waiting in teller lines. And if you’re sick on payday, or away from home, you have the peace of mind knowing that your paycheck will be automatically deposited into your account. No special arrangements are needed. With Direct Deposit, you’ll never have to worry about lost, stolen or damaged checks. You may even have savings if you currently pay fees to get your check cashed.

2. What will I receive every pay period instead of a check?

   The same stub as you currently receive and a non-negotiable copy of your check. The non-negotiable check includes the amounts deposited into Account 1 and Account 2 (if applicable).

3. How do I get my money?

   The same way you normally would, by making a withdrawal from your financial institution; either in person, by check, by debit card or ATM card. Once the funds are direct deposited in your financial institution, all options are the same as your current options.

4. What if I do not have a bank account?

   To participate in Direct Deposit, you must have some kind of account set up with an ACH financial institution. Some of the ACH financial institutions offer accounts that are set up to receive only Direct Deposit payroll checks without the charges and transactions associated with a checking or savings account. The institution will provide you with a means to withdraw all of your payroll check on each payday every two weeks on Tuesday. There also may be some no cost options available to you through your employer sponsored credit union plan. The Comdata Paycard is also available if you cannot obtain a bank account.

5. Must my account be with a bank?

   No, all financial institutions that accept ACH (Automated Clearinghouse) transfers are acceptable. These may include (but not all inclusive) banks, credit unions, savings and loan institutions, and investment brokers. There are over 21,000 financial institutions that are members of the ACH network.

6. Can the Direct Deposit be made into any account or is a checking account required?

   It can go into EITHER a checking or savings account. The Payroll Selection Form has specific instructions for different account types.

7. Can I deposit some of my payroll check into my checking account and another portion into my savings account?

   Yes, you may have two accounts in the direct deposit program. You may designate a specified dollar amount to be deposited into Account 2 as your credit union, checking, or savings account, etc. Any remaining amount will be deposited into Account 1. If the entire amount of your paycheck is less than the designated amount in Account 2, all of your paycheck will be deposited into Account 1.
8. When will the deposit be available for withdrawal?
   In the absence of mechanical failures, it will be available on each payday at the beginning of your financial
   institution’s business day. Funds should always be “collected” and available since it is an ACH transfer/Direct
   Deposit.

9. How common are errors?
   Because of the electronic transmission, errors are minimized. If they do occur, there are specific audit trails that
   will be followed. The NHC Payroll Department will work directly with the bank that holds the NHC payroll account
   to trace and correct all errors as soon as administratively possible.

10. Will I have a bank record showing that the deposit was made into my account?
    The Direct Deposit should show on your bank statement as a deposit or an addition to your account on each
    payday. Terminology differs between financial institutions to indicate a payroll direct deposit.

11. Does NHC charge for participation in the Direct Deposit Plan?
    No. It is a free NHC benefit available to each partner receiving a paycheck.

12. Are there any charges or savings related to Plan participation?
    Financial institutions normally do not assess fees for processing Direct Deposits. You may actually recognize
    savings, especially if you have previously paid a fee to get your paycheck cashed; i.e. a charge from a bank in
    which you have no account, a charge from a check cashing establishment or a check cashing charge from a
    grocery store or other retail store.

13. How do I sign-up or enroll in the Direct Deposit Plan?
    You must complete a Payroll Selection Form and follow detailed instructions on the form. Depending on when the
    Payroll Selection Form is received by the NHC Payroll Department the enrollment processing may take 2-3 pay
    periods. You will continue to receive a negotiable paper check until the process is complete.

14. What happens if I change financial institutions or accounts?
    You should submit a new Payroll Selection Form and mark the “Change Information” box and submit the
    appropriate complete information and new additional forms as needed. The Direct Deposit to your account will
    be stopped, and you will receive a negotiable paper check until the process for the new account is complete. You
    should allow 2-3 pay periods for the change. You should not close a current account until you are sure that the
    requested change has been made.

15. Can I cancel participation in the Direct Deposit Plan?
    Yes, at any time. You should submit a new Payroll Selection Form and mark the “Cancel” box. Participation will be
    cancelled as soon as administratively possible after receipt by the NHC Payroll Department. Your current account
    should not be closed until after you receive the first “real” (negotiable) paper check after submitting the
    cancellation.

16. Am I required to participate in the Direct Deposit Plan?
    Currently there is no participation requirement, although our company policy is to pay by direct deposit. For your
    benefit, and that of all partners, NHC would like for all partners to take advantage of this free and efficient
    benefit.

17. Does my payroll information have any impact on the Direct Deposit Plan?
    Yes. Accurate and timely Payroll Selection Forms, additional required forms, and bank change requests are all
    very important for you to receive your biggest benefit from the Direct Deposit Plan.
Comdata Paycard Program

Enrollment Kit

Contents:
Comdata Paycard Program Features
Enrollment and Activation Instructions
Frequently Asked Questions
Fee Schedule

Customer Service
Toll-Free Phone: 1-888-265-8228
Comdata Paycard Program Features

Accommodates individuals that do not have a bank account.
- Everyone is eligible.
- No credit checks or applications necessary.

Features unique to Comdata Paycard Program:
- Comdata Paycard Program has no NSF fees.
- The Comdata Paycard is a prepaid account that does not allow purchases for more than the available balance. You will receive a User Guide with your paycard that provides tips for making purchases.

Easy access to money in the Comdata Account with reliability of receipt on Tuesday payday. Pay is loaded directly and electronically into your Comdata Account every payday. You may access available funds by using a Comdata Paycard.
- Comdata Paycard features:
  - You may take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
  - You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. You may find locations by visiting www.allpointnetwork.com, using the Comdata Prepaid mobile app or logging into the cardholder website at www.cardholder.comdata.com. Fees will apply for ATM transactions at locations not listed on the website.
  - You may make purchases at millions of Mastercard merchants worldwide. You can use the paycard to make purchases and get cash back with those purchases.

Four ways to check your balance for FREE
- **Text Messaging** - Sign up to receive text message alerts of your payroll loads and card usage when you call 1-888-265-8228. Sign up when you activate your card.
- **Customer Service** - Call Comdata automated system (called the IVR – Interactive Voice Response system) at 1-888-265-8228, enter your Comdata card number, enter your activation code (date of birth, MM/DD/YYYY).
- **Mobile App** - Download the Comdata Free Prepaid Mobile App and check your balance – available for both iPhone and Android devices. Also, use the App to locate surcharge free ATMs and view most recent transactions.
- **Cardholder Web** - You must register and create an account on the Comdata Cardholder Website, www.cardholder.comdata.com, to check your balance on the Internet.

Other Comdata Payroll Card Program Benefits
- **Portability:** Do you have another employer and want to have those payroll funds deposited to your paycard? To add funds to your card, log into www.cardholder.comdata.com and click “Direct Funding” to access your Routing and Account Numbers. Provide those numbers to your employer. Eligibility may vary.
- **Companion Card:** The primary cardholder can order a Companion Card for a one-time fee. The primary cardholder and companion share the same balance. The card can be used anywhere Mastercard is accepted. The primary cardholder can order the card from www.cardholder.comdata.com.
Enrollment and Activation Instructions

Enrollment is quick and easy – you’re already approved
No credit check or approval process is necessary.

Enrolling in the Comdata Paycard Program
Complete the Payroll Selection Form and return it to the center bookkeeper.

NHC will provide you a card to use until your personalized card arrives by mail to the home street address on file in the payroll system and will arrive in about two weeks. The Welcome Packet includes:
• Comdata Paycard and Card Carrier
• User Guide
• Fee Schedule

If your address changes before your card arrives or you want to change the mailing address to a PO Box, immediately contact the customer service center at 1-888-265-8228.

After the enrollment process, all future communication regarding the Comdata Account should be directed to Comdata Customer Service (Toll-Free Phone: 1-888-265-8228). Questions regarding the pay amount on the check stub should be directed to the employer.

Activating your Comdata Account
When you receive the card from the bookkeeper, you must immediately call 1-888-265-8228 to activate. Follow the instructions provided in your card packet. Your activation code is your date of birth in MM/DD/YYYY format.

Keep your paycard secure. You will need your Paycard number to access your account information over the phone or online.

After the account is activated, you may access your pay that has been deposited into your Comdata Account. Pay stubs will be available at the receptionist’s desk each payday as normal.

If you do not receive your personalized card packet within 15 business days, call Customer Service to let them know you have not received your personalized card.
Frequently Asked Questions

Q. What is a Comdata Account?
A. If you don’t have a personal bank account, your pay can be loaded directly into a Comdata Account every payday. This easy-to-use payroll solution enables you to access your funds by using a Comdata Paycard. Comdata Paycard features:
   • You may take the paycard to the teller window of any bank that displays the Mastercard logo and withdraw money down to the last penny with no fee.
   • You may withdraw cash for free at thousands of In-Network Allpoint ATMs nationwide. You may find locations by visiting www.allpointnetwork.com, using the Comdata Prepaid mobile app or logging into the cardholder website at www.cardholder.comdata.com. Fees will apply for ATM transactions at locations not listed on the website.
   • You may make purchases at millions of Mastercard merchants worldwide. You can use the paycard to make purchases and get cash back with those purchases.

Q. How do I know how much money is in my Comdata Account?
A. You can check your Account balance for free online www.cardholder.comdata.com, or by phone (1-888-265-8228), Comdata Prepaid mobile app or enroll for text messaging.

Q. Do I get a statement?
A. No, you may login to the Cardholder website at www.cardholder.comdata.com and view transaction activity.

Q. Do I get a new Paycard every pay day?
A. No, your pay is deposited into your Account every payday. You can use your existing Paycard to access the money in your Account at that time.

Q. Do I have to pay a sign-up fee to get a Paycard?
A. No. It is a free benefit offered by your employer.

Q. Is there a monthly fee for the Paycard?
A. No.

Q. What is Portability?
A. Portability allows you to have another employer place earned wages on your payroll card. To add funds to your card, log into www.cardholder.comdata.com and click “Direct Funding” to access your Routing and Account Numbers. Provide those numbers to your employer. Eligibility may vary.

Q. What happens if I stop working here?
A. Your employer will deposit your last pay. You may continue to use your Account with other employers.

Q. I don’t want to pay any fees, what can I do?
A. You may withdraw your money at no charge using one or a combination of the free services and transactions listed on your Fee Schedule. An additional fee or surcharge may be applied by an Out-of-Network owner or operator. To find a surcharge free or In-Network Allpoint ATM, please visit www.allpointnetwork.com.
Q. How do I know if I got my pay, and how much? What do I do if the amount is wrong?
A. Your employer will provide a check stub for you. If your pay amount is incorrect or if your pay is not on your card, contact your employer. In addition, you can check your Account balance one of the following ways for FREE:
   • **Text Messaging** - Sign up to receive text message alerts of your payroll loads and card usage when you call 1-888-265-8228. Sign up when you activate your card.
   • **Customer Service** - Call Comdata automated system (called the IVR – Interactive Voice Response system) at 1-888-265-8228, enter your Comdata card number, enter your activation code (date of birth, MM/DD/YYYY).
   • **Mobile App** - Download the Comdata Free Prepaid Mobile App and check your balance – available for both iPhone and Android devices. Also, use the App to locate surcharge free ATMs and view most recent transactions for free!
   • **Cardholder Web** - You must register and create an account on the Comdata Cardholder Website, www.cardholder.comdata.com, to check your balance on the Internet.

Q. What happens if I lose my Paycard or if it is stolen?
A. Contact Comdata customer service immediately (Toll-Free Phone: 1-888-265-8228).

Q. What do I do if I lose or forget my PIN?
A. A PIN is important since it safeguards your account at the ATM and PIN-accepting retailer. If you do lose or forget your PIN, contact Comdata customer service immediately (Toll-Free Phone: 1-888-265-8228).

Q. Does my employer know where I spend my money?
A. No, your employer does not have access to any of your Account information including purchases and other transactions.

Q. What happens if I need to return a purchase?
A. Each merchant location has its own return policy and will handle the return in the same manner as any other transaction. You may receive a credit to your Paycard, a cash refund, or a store credit. It may take up to one week for a credit to appear.
## FEE SCHEDULE

Comdata Payroll Card Pricing - Cardholder Fees

### Get Cash

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATM Withdrawal, In-Network</td>
<td>$0.00²</td>
</tr>
<tr>
<td>ATM Withdrawal, Out-of-Network</td>
<td>$1.75²</td>
</tr>
<tr>
<td>Bank Teller Withdrawal (at participating banks where Mastercard is accepted)</td>
<td>$0.00¹</td>
</tr>
</tbody>
</table>

### Spend Money

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of Sale Transactions: Signature-Based</td>
<td>$0.00²</td>
</tr>
<tr>
<td>Point of Sale Transactions: PIN-Based</td>
<td>$0.00²,³</td>
</tr>
<tr>
<td>Comchek Draft</td>
<td>$3.00⁴</td>
</tr>
</tbody>
</table>

### Account Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service: Web, IVR, or Live Operator (including card balance and transaction history)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Text Alerts</td>
<td>$0.00⁵</td>
</tr>
<tr>
<td>ATM Balance Inquiries, Declines</td>
<td>$3.00²</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost Card Replacement (One free per year)</td>
<td>$5.00³</td>
</tr>
<tr>
<td>Companion Card (upon request)</td>
<td>$5.00</td>
</tr>
<tr>
<td>Card-to-Bank Transfer</td>
<td>$0.00</td>
</tr>
<tr>
<td>Cross-Border Currency Fee (International Transactions)</td>
<td>1.1%⁶</td>
</tr>
</tbody>
</table>

The Comdata fees listed above represent the maximum amount that Comdata may charge. Comdata reserves the right to reduce or waive a fee at its option. Some fees may be reduced or not charged according to limitations or prohibitions under applicable laws and regulations.

1. Available at all banks that participate in the Mastercard® network.
2. ATM operators outside of Comdata’s surcharge free ATM network and other places where you use your card may charge fees that will be deducted from your card balance. To find locations within the surcharge-free network, visit http://www.allpointnetwork.com/locator.aspx
3. Except where a fee for this transaction is prohibited by applicable law or a lesser amount is required by applicable law.
4. Third-parties may charge you an additional fee to cash a Comchek.
5. Your wireless telecom service provider may charge you to receive text messages.
6. If you use your card outside of the United States, or if you debit funds or make a purchase in a currency other than US Dollars, the amount deducted from your card will be converted into US Dollars. A charge of 1.1% of the original transaction amount will be deducted from your card in US Dollars. The charge is independent of and in addition to any other transaction fee indicated above. Not all cards are eligible for use outside the United States. For information regarding this feature, please call 1.888.265.8228.
Credit Union

Each employer offers an opportunity for partner membership with a local Credit Union.

Direct Deposit participation is required for your employer to electronically transmit funds to your credit union. You may choose to transmit your entire pay (Account 1 on Payroll Selection Form) or a designated dollar amount (Account 2 on Payroll Selection Form) to your credit union. Funds can be used for any services offered by the credit union.

The service is voluntary and provides immediate access on payday to all funds deposited from direct deposit.

Credit unions offer a wide variety of financial services including checking accounts, savings accounts, Christmas Club accounts, and a wide range of loans; i.e. mortgage, auto and personal loans.

Credit union membership is normally available to all family members as well as to the partner.

Information about your local credit union is available through the Business Office where you work.
Discounts

Travel Attractions

National HealthCare Corporation partners are now eligible to take advantage of savings with special offers and discounts for theme parks and attractions nationwide including Dorney Park, Wild Water Kingdom, and Hershey Park all in PA, and Paramount’s Kings Dominion in VA. Discounts are also available for attractions in Orlando, FL including the Walt Disney World® Resort, Universal Studios®, Sea World®, Busch Gardens®, Orlando Dinner Shows & more! The savings don’t stop there; you can also save on admission to popular attractions in California, Texas and other parts of the country.

Through this corporate discount program, you have the opportunity to purchase discount tickets year round. Tickets must be ordered prior to your trip and will be mailed directly to you. This means you will now have your tickets in-hand before you leave for your trip, saving you time when you arrive at your destination. These savings are not available to the general public, however you can order for friends and family.

There are two ways to order tickets and take advantage of these discounts:

1) Go to www.TicketsAtWork.com. Click on the “Login” Box at the top of the homepage. You will then be prompted to create a username and password, and enter the company code NHCBENEFITS. Once enrolled you will have unrestricted access to the savings!

2) Place your order over the phone by calling customer service at 800-331-6483. Orders may be placed over the phone Monday through Friday 9am – 6pm and Saturday 9am – 2pm Eastern Standard Time.

NHC employers and it’s affiliates make these services available to partners as a convenience, as well as a possible money saving opportunity. They should be used at each partner’s discretion.

Other Discounts

NHC does not negotiate or contract for discounts with local or nationwide businesses. However, some businesses may make discounts available to certain employers in their community. When you make a purchase, feel free to ask if the business offers discounts to employees of your employer, knowing that those discounts are always at the discretion of the business.

NHC and its affiliates, do not have business relationships with any of the discount providers. Neither does NHC endorse any of the providers, their events or their services.