2016

EMPLOYEE BENEFIT GUIDE

SURGERY PARTNERS

Surgery Partners' prescription drug coverage is considered Creditable Coverage under Medicare Part D. You can review the Medicare Part D Notice in the Important Notices section of this guide.

2016 EMPLOYEE BENEFITS

We're excited to announce the new benefit package for 2016! This past year has been an exciting one with the company merger and changes in many areas. We are utilizing a two-year strategy for employee benefit integration. This year we've combined the medical, dental, vision and life insurance for the combined company. Next year we will evaluate the 401(k), short term and long term disability insurance as well as the paid time off programs.

Medical - You now have two options for medical, both with BlueCross BlueShield of Tennessee. The first option is the Basic plan which includes traditional plan elements such as copays and deductible/coinsurance. The second option is a High Deductible Health Plan (HDHP.) With this plan, all medical expenses count toward your deductible but your premiums are lower than with the traditional plan. Enrollment in a HDHP allows you to enroll in a Health Savings Account, a pre-tax savings account that works like a medical IRA (more details on page 5.) If you are currently enrolled in medical, you will be defaulted to the Basic Plan for 2016 if you do not make an active election.

We have continued the low cost copay to utilize a Surgery Partners surgery center for your eligible outpatient surgical needs if you enroll in the Basic plan. The dependent tiers have an increased family deductible, however, your monthly employee contributions have been reduced to offset the savings the deductible increase provided.

Choices we all make for medical care drive the overall cost of the plan. We appreciate the way you choose high quality, low cost providers, including outpatient surgery centers, allowing us to maintain an affordable plan and keep the cost low for participants.

Dental - You will continue to have two options for dental, a base plan and buy up plan. The carrier for Dental this year will be Delta Dental. You have been mapped to the base or buy-up plan consistent with your current dental elections.

Vision – Vision coverage with Superior Vision includes the same benefit level you know with an expanded network, including Costco, Wal-Mart, LensCrafters, Pearle Vision, Target Optical and more! You'll also save money on this year's premiums compared to last year.

Life – You may elect additional life insurance this year up to 3x your annual salary (up to $300,000) without completing a health questionnaire. You may also elect additional coverage for your spouse or children. See page 8 for more information.

Employee benefits are an extremely important part of your compensation package. Surgery Partners, which includes participating subsidiaries, prides itself on providing our employees with a comprehensive and competitive benefit package. Please carefully review the options available to you. This is a summary overview and is not intended to explain the benefits in full. Surgery Partners reserves the right to alter the employee benefits plans as it deems necessary.

As a plan participant, you are entitled to a comprehensive description of your rights and obligations under the Surgery Partners group health plans. We have copies of the Summary Plan Descriptions (SPD), Summary Annual Reports (SAR), Summary of Benefits Coverage (SBC) and Summary of Material Modifications (SMM) on our employee intranet at www.portal.adp.com. In order to ensure that you fully understand the benefits available to you and your obligations as a plan participant, it is important that you familiarize yourself with the information contained within the plan documents. If you would like to receive a paper copy of any plan document, you may e-mail hr@surgerypartners.com or call 615-234-5920 and one will be provided to you free of charge.

HOW TO ENROLL

To change your elections, you will log onto www.portal.adp.com and select the link from the Home Page "2016 Open Enrollment". You can also go to the Benefits tab and select "Review / Change Benefits".

If you are NOT making any changes, your current elections, with the exception of the FSA plan, will continue for the next plan year. You only need to enroll online if you are making a change or would like to enroll in the FSA. Current enrollees in the FSA plan need to re-enroll annually if you wish to continue receiving this benefit.

To add a dependent, you must forward the marriage certificate, birth certificate, federal tax form, etc., identifying dependent status to your Regional HR Manager.

BENEFIT ELIGIBILITY

Full-Time employees working at least 30 hours per week are eligible for the benefits described in this benefit guide. Part-Time, PRN, Temporary or PT19 employees may participate in the 401(k) plan but are not eligible for other coverage unless determined to be eligible under the Affordable Care Act. Benefits begin on the 1st day of the month following date of hire.

Dependent Eligibility

- **Spouse** - The employee's current spouse as defined by state law. Please note that common law spouses must satisfy the legal definition in your state to be eligible for coverage. If you divorce, your former spouse is no longer eligible for coverage, except as a qualifying event under COBRA.
- **Children** - Adult children are eligible for coverage until their 26th birthday. There are no restrictions regarding financial support, residence, student status, marital status or employment. Adult children include son, daughter, step-child, adopted child or eligible foster child. NOTE: Grandchildren are not eligible dependents unless you are their legal guardian.

QUALIFIED LIFE EVENTS

Your premium for medical/Rx, dental, vision, and flexible spending plan elections are deducted from your pay check on a tax favorable basis (pre-tax). These pre-tax benefit contributions are yearly elections and may not be changed during the plan year unless you experience a qualifying life event.
Examples of a life event include:

- Marriage or divorce
- Birth or adoption of a child
- Death of your spouse or child
- Child is no longer eligible for coverage
- Significant change in the employee's or spouse's employment resulting in a loss of eligibility
- Changes made in conjunction with benefit elections made by a spouse during the spouse's annual enrollment period.

If you experience a qualifying life event, you have only 31 days to provide the necessary documentation and authorize the change consistent with your event. If you miss this window of opportunity, your next chance to change your benefit elections will be Open Enrollment. **Please note that newborn coverage is not automatic. You must enroll a newborn within 31 days of birth.**

MEDICAL PLANS – BlueCross BlueShield

Surgery Partners offers two medical plans with BlueCross BlueShield of TN. The following is a brief outline of the two plans, please refer to the Summary Plan Description for more details. You may also contact BCBST customer service with any questions or log on to www.bcbst.com. Enter Blue Network P, when searching for providers. Remember, Out-of-Network claims have a separate deductible and are paid at much lower levels.

Under either the Basic Plan or High Deductible Health Plan (HDHP), preventive care services received In-Network are paid at 100% with no deductible, copay or coinsurance. Coverage for some services may depend on age and/or risk guidelines. Claims must be submitted with a preventive procedure code to be covered at 100%. An outline of preventive care services is listed in your Summary Plan Description (SPD) under "Well Care Services."

BENEFIT	BASIC PLAN	HDHP
	In-Network	
Annual Deductible Individual Family	 $1,500 $4,500	 $2,500- employee only $5,000- family unit
Out-of-Pocket Maximum (Includes Deductible) Individual Family	 $5,000 $10,000	 $2,500 $5,000
Office Visits Primary Care Physician Specialist	 $35 copay $45 copay	 100% after deductible 100% after deductible
Inpatient Hospital	80% after deductible	100% after deductible
Outpatient Surgery	80% after deductible $200 Copay at Surgery Partners Facility	100% after deductible
Urgent Care	$75 copay	100% after deductible
Emergency Room	$200 copay	100% after deductible
Prescription Drugs *Retail* Generic Preferred Brand Non-Preferred Brand *Mail Order or 90 Day Retail* Generic Preferred Brand Non-Preferred Brand *Specialty* Available only through BCBST Specialty Pharmacy	 *30 day supply* $8 copay $40 copay $60 copay *90 day supply* $20 copay $100 copay $150 copay $125 copay	 *30 day supply* 100% after deductible 100% after deductible 100% after deductible *90 day supply* 100% after deductible 100% after deductible 100% after deductible 100% after deductible

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

- A High Deductible Health Plan (HDHP) operates differently from a traditional PPO plan.
- The family deductible is assigned per family unit (2 or more enrolled). All family member expenses are paid out of pocket until the family deductible has been satisfied.
- The plan pays 100% of expenses after you reach the deductible.
- An expense that would traditionally be a copay expense, such as prescriptions and office visits, are paid by you until the deductible is reached.
- Surgery Partners' HDHP is a qualified plan according to IRS standards, which means you have the ability to open a Health Savings Account.
- If you choose the HDHP, you cannot enroll in the regular Health Care FSA. You can, however, enroll in the Dependent Care FSA.

If you enroll in the HDHP, you may want to consider a Health Savings Account (HSA).

- Your contributions to an HSA are tax deductible up to $3,350 for individuals and $6,750 for families in 2016. Employees over the age of 55 can contribute an additional $1,000 each year. Distributions are tax-free if used for qualified medical expenses.
- If you choose to enroll in the company provided HSA, the contributions will be deducted from your paycheck pre-tax. If you participated in the Healthcare FSA in 2015 and have a balance in your account on January 1, 2016, you must wait to enroll in the HSA until after March 15, 2016.
- Money in your Health Savings Account is used to pay for out of pocket medical expenses for you and your family (like doctor visits and Rx).
- Unlike a flexible spending account, you do not have to use all the money in the account by the end of the year. The Health Savings Account is your account; the money you contribute stays in the account and is yours even if you leave employment.
- The Health Savings Account is administered by Discovery Benefits. There is a $2.25 administration fee per month. The fee is deducted from the balance of your account.
- Please be aware you cannot be covered under your spouse's traditional PPO plan and the Surgery Partners HDHP and still contribute to an HSA.
- *Note:* Per federal regulations, you cannot be enrolled in an HSA at the same time your spouse is enrolled in a Health Care FSA. Only one type of account, either HSA or FSA, is allowed per family. Federal law prohibits enrollment in an HSA if you are enrolled in Medicare or claimed as a dependent on another person's tax return. Also, the states of Alabama, California and New Jersey do not allow HSA contributions to be pre-tax for state income tax.

PRESCRIPTION PLAN OVERVIEW

Prescription coverage is included in the BCBST medical plans and is administered by Express Scripts. The prescription plan cannot be elected independently.

You must be enrolled in the basic medical plan in order to have Rx coverage with copays with Express Scripts. If enrolled in the High Deductible Health Plan (HDHP), you have prescription coverage with Express Scripts, but all prescription expenses (retail, mail or specialty) apply to the deductible; there are no copays. Present your BCBST ID card at any participating pharmacy to receive Express Scripts discounts at point of sale.

DENTAL PLAN - DELTA DENTAL

Surgery Partners offers two dental plans through Delta Dental. The Base Plan includes the PPO network; the Buy Up Plan includes both the PPO and Premier networks. The out-of-network covered percentage is the same for both the Base and Buy Up Plans. You may search for a provider in either network at www.deltadentaltn.com.

	BASE PLAN		BUY UP PLAN	
BENEFIT	**PPO NETWORK**	**OUT-OF-NETWORK***	**PPO NETWORK**	**PREMIER NETWORK**
Annual Deductible Single Family	 $50 $150	 $50 $150	 $50 $150	 $100 $300
Preventive Care Exams/ Cleanings Fluoride Treatment (to age 14) X-Rays Space Maintainers (to age 16)	100%	100%	100%	100%
Basic Services Restorative *(fillings, general anesthesia, simple extractions)* Periodontic Maintenance	80%	80%	90%	80%
Major Services Complex Restorations *(crowns, bridges, dentures)* Periodontic Therapy *(treatment of gums and bones supporting teeth)* Endodontic Therapy *(root canal)* Complex Oral Surgery	50%	50%	60%	50%
Orthodontia *(Children to age 19)*	50%	50%	50%	50%
Orthodontia Lifetime Maximum (*not included in annual maximum)*	$1,000	$1,000	$1,500	$1,500
Annual Maximum Benefit	$1,000	$1,000	$2,000	$2,000

*You may be responsible for charges exceeding the maximum plan allowance if you go to an out-of-network dentist.

VISION PLAN - SUPERIOR VISION

Superior Vision's Superior National Network offers a broad provider network of MDs, ODs, and national and regional optical retail chains such as Wal-Mart, Costco, LensCrafters, Sam's Club and Visionworks. You may download an ID card from www.superiorvision.com for your use.

BENEFIT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Eye Exam (every 12 months)	$10 copay	Up to $34
Frames (every 24 months)	$150 allowance; 20% off remaining balance	Up to $77
Lenses (every 12 months)		
Single	$20 copay	Up to $32
Bifocal	$20 copay	Up to $46
Trifocal	$20 copay	Up to $57
Lenticular	$20 copay	Up to $90
Contacts (every 12 months, in lieu of lenses)		
Evaluation and Fittings	$30 copay	Not covered
Elective	$150 allowance	Up to $100
Medically Necessary	100%	Up to $210

FLEXIBLE SPENDING ACCOUNTS

Healthcare Spending Account

The Healthcare Spending Account is a pre-tax savings account to be used for unreimbursed medical, prescription, dental, vision and other health expenses for you and your eligible dependents. The plan is administered by Discovery Benefits. You will receive a debit card to use as a convenient way to access the funds in your account. On occasion, you may be asked for additional documentation regarding a claim. Please provide this information to Discovery Benefits as quickly as possible in order to maintain the tax-free status on the claim amount.

The Healthcare FSA has a grace period for incurred expenses through 2 ½ months after the close of the plan year. Healthcare participants may incur eligible expenses and have them reimbursed from dollars remaining in their accounts through this time.

Dependent Care Spending Account

The Dependent Care Spending Account is a pre-tax savings account for elder care and childcare expenses. The child or elder care provider must declare the income on his/her tax return for Dependent Care services provided. You may use the Dependent Care Spending Account only to pay for dependent care that is required to allow you and your spouse to be gainfully employed. (Residential summer camp is excluded.) You must use the account for the care of an eligible dependent (nursing home care is excluded). **Certain Highly-Compensated individuals may have their election reduced based upon plan enrollment.**

ACCOUNT	USE FOR	CONTRIBUTION
Healthcare	Most medical, dental and vision care expenses (deductibles, co-insurance, eye exams, glasses, contacts, dental, orthodontia and prescribed over-the-counter medicines)	$2,550 annual maximum
Dependent Care	Dependent care expenses (daycare, after-school programs or elder care programs)	$5,000 annual maximum ***($2,500 if married filing separate tax return)***

If you participate in the Healthcare Flexible Spending Account, you will receive a VISA debit card that is valid for 3 years from issuance. If you enroll in the FSA the following year, the balance will be loaded on the same card.

Remember, if you participate in the High Deductible Health Plan (HDHP), you are not eligible to participate in the Healthcare Flexible Spending Account (FSA). You may participate in the Dependent Care Spending Account if desired. If you were a participant in the Healthcare FSA in 2015, you must wait to enroll in the HSA until all FSA funds from the 2015 plan year have been depleted or the grace period expires. Detailed information is also available at www.discoverybenefits.com.

BASIC LIFE AND AD&D INSURANCE

Basic Life and AD&D insurance is provided to you at no cost through Lincoln. If you are a Full-Time employee, you will receive 1 times your annual base pay with a minimum of $50,000 and a maximum of $500,000.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

You also have the option to elect additional life and AD&D insurance for yourself, your spouse and/or your child(ren) through Lincoln. You must elect coverage for yourself in order to elect coverage for your spouse and/or child(ren). **If you do not elect coverage during Open Enrollment, medical underwriting is required for the entire amount.**

COVERAGE	AVAILABLE LIMIT	GUARANTEED AMOUNT
Employee	$10,000 increments to a maximum of 5 times annual pay or $500,000; whichever is less	$300,000
Spouse	$5,000 increments up to 2 ½ times the employee's annual salary. Maximum benefit is $250,000 or 50% of employee amount; whichever is less	$50,000
Child(ren)	Increments of $2,000 to a maximum of $10,000 (Eligible child 14 days to 26th birthday)	$10,000

Basic and Supplemental coverage for employees and spouses reduces 35% upon attainment of age 70 and an additional 15% of the original amount at age 75. Coverage terminates upon retirement.

Special Medical Underwriting Rules – Applies to Employee and/or Spouse

If you elect an amount that requires medical underwriting, you will be required to complete an Evidence of Insurability form. The form will be submitted to Lincoln for consideration and you will be notified when the underwriting decision is made. Payroll deductions will not begin for "pended amounts" until coverage is approved.

DISABILITY INSURANCE

Short Term Disability

The Short Term Disability Plan with Lincoln can provide a continuation of a portion of your income if you become disabled and cannot work (employee physicians are not eligible for this benefit and California and Rhode Island employees receive a state mandated benefit). You are automatically enrolled in Short Term Disability benefits the first of the month following 6 months of employment at no cost to you. In the event you become disabled due to either illness or off-the-job injury and are unable to perform the duties of your job, STD benefits provide you coverage that supplements your lost wages. After 7 calendar days of your inability to work due to sickness or injury, the plan will reimburse you 66.7% of lost income up to $1,500 per week. The maximum benefit period is 26 weeks.

To initiate a short term disability claim, an eligible employee will call into the Lincoln Financial Group telephonic claims number at 800-423-2765. This number is also available on the Employee Intranet.

Long Term Disability

The Long Term Disability Plan with Lincoln can provide a continuation of a portion of your income if you become disabled and cannot work (employee physicians are not eligible for this benefit). You pay the full cost of coverage. If you become disabled and are unable to work for a period of 180 days, qualified employees will receive a benefit of 60% of your monthly earnings, up to the maximum of $15,000 a month. There are no rate changes this year. If you would like to calculate the cost or opt out of this plan, you will access this benefit on the employee portal. After your initial enrollment period as a new hire, enrollments beyond this time require a Statement of Health form to be approved by Lincoln. This form can be obtained from Human Resources.

401(k) PLAN

The 401(k) plan provided by Principal Financial Group assists our employees in further reaching their retirement savings goals. Surgery Partners provides a company match of 50% up to 4% of pay. For example, a participant deferring 4% of their pay will receive a 2% match. Someone deferring more than 4% still receives a 2% match. Employees become eligible for the match after one year of employment. Surgery Partners uses a five-year graded vesting schedule giving employees gradually increasing ownership of company matching contributions (20% after the first year, then 20% more each year until you are fully vested) as their length of employment increases, resulting in 100% vesting of match contributions after five years of service.

Enrollments and contribution changes can be made online at Principal's website www.principal.com any time after 30 days of employment. All employees are eligible, including Full-Time, Part-Time and Per Diem. Easy to follow instructions can be accessed on the Employee Intranet: www.adp.portal.adp.com. Employee contributions can be made as a percentage of pay or as a flat dollar amount up to the federal maximum of $18,000 each year. Catch-up contributions of $6,000 per year are available for those employees over or turning age 50 anytime within the plan year.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

All employees and their household family members above the age of 12 are eligible to utilize our Employee Assistance Program, EmployeeConnect, through Lincoln. You and your family members have telephonic assistance and face-to-face visits available depending on the situation. The benefit provides assistance with emotional, dependent care and care giving, marriage/family, legal and financial issues, lifestyle as well as fitness management resources.

To access, call EmployeeConnect at: 1-888-628-4824 or access their website for many helpful resources, tools and calculators at:

Website: www.GuidanceResources.com

User Name: LFGsupport
Password: LFGsupport1

RATES

Coverage	Bi-Weekly Contributions
BlueCross BlueShield of TN - Basic Plan	
Employee Only	$ 50.66
Employee + Spouse	$ 106.41
Employee + Child(ren)	$ 91.19
Family (Employee + Spouse + Child(ren)	$ 151.98
BlueCross BlueShield of TN - HDHP Plan	
Employee Only	$ 28.69
Employee + Spouse	$ 40.53
Employee + Child(ren)	$ 32.84
Family (Employee + Spouse + Child(ren)	$ 60.55
Delta Dental Base	
Employee Only	$ 6.48
Employee + Spouse	$ 13.35
Employee + Child(ren)	$ 17.30
Family (Employee + Spouse + Child(ren)	$ 26.80
Delta Dental Buy Up	
Employee Only	$ 11.73
Employee + Spouse	$ 23.24
Employee + Child(ren)	$ 28.86
Family (Employee + Spouse + Child(ren)	$ 44.53
Superior Vision	
Employee Only	$ 2.77
Employee + Spouse	$ 5.54
Employee + Child(ren)	$ 5.87
Family (Employee + Spouse + Child(ren)	$ 9.25

REFERENCES AND RESOURCES

Need additional information? Have a question about one of your benefits? Keep this workbook handy for a quick reference for all your benefit needs. Here are additional helpful resources.

PLAN	VENDOR	WEB ADDRESS	PHONE NUMBER
Medical - Policy #95216	BCBST	www.bcbst.com	800-565-9140
Prescription Drug Mail Order	Express Scripts	www.express-scripts.com	877-673-9165
Dental - Policy #5333	Delta Dental of TN	www.deltadentaltn.com	800-223-3104
Vision - Policy #	Superior Vision	www.superiorvision.com	800-507-3800
Flex Administration	Discovery Benefits	www.discoverybenefits.com	866-451-3399
COBRA Administration	Discovery Benefits	www.discoverybenefits.com	866-451-3399
Identity Theft Resources	Lincoln	www.lincoln4benefits.com or www.guidanceresources.com	855-891-3684
Travel Assistance ID # 322541	Lincoln	www.uhcglobal.com	800-527-0218
Will Preparation Discount Program	Lincoln	www.lincoln4benefits.com or www.guidanceresources.com	855-891-3684

IMPORTANT NOTICES

Medicare Part D Notice

Important Notice from Surgery Partners Inc.
About Your Prescription Drug Coverage and Medicare

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

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

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

2. Surgery Partners has determined that the prescription drug coverage offered by the Surgery Partners Inc. Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Surgery Partners coverage will be affected. An explanation of Surgery Partners' prescription drug coverage plan provisions and options is available at **www.portal.adp.com**.

If you do decide to join a Medicare drug plan and drop your current Surgery Partner coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact your medical carrier or your Regional HR Manager for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Surgery Partners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October, 2015
Name of Entity/Sender:	Surgery Partners
Contact--Position/Office:	Human Resources
Address:	40 Burton Hills Blvd., Suite 400, Nashville, TN 37215
Phone Number:	615-234-5920

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Notice of Surgery Partners Inc.
Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

> The effective date of this Notice of Surgery Partners Inc.'s Health Information Privacy Practices (the "Notice") is November 30, 2015.

Surgery Partners Inc.'s Health and Welfare Plan (the "Plan") provides health benefits to eligible employees of **Surgery Partners Inc.** (the "Company") and their eligible dependents as described in the Summary Plan Description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

> For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect for whom the Plan receives, creates or maintains Protected Health Information, including employees and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

> Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected Health Information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from other parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. With only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and processing of related health care data
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for Health Care Operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.
Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for Health Care Operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their Health Care Operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.
The Plan's use and disclosure of your PHI for Health Care Operations purposes may include uses and disclosures for the following additional purposes, among others.

- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their Health Care Operations activities similar to both categories listed above.
Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.
Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.
Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.
Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.
Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.
Workers' Compensation: The Plan may use and disclose your PHI when authorized and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation. The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

AUTHORIZATION TO USE OR DISCLOSE YOUR PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

THE PLAN MAY CONTACT YOU

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

> You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger

you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and Health Care Operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or Health Care Operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or Health Care Operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to the Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize or that occurred prior to April 14, **2003** are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not be longer than six years and may not include dates before April 14, **2003**. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request

more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

The Plan has designated Corporate Human Resources as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: 40 Burton Hills Blvd., Suite 400, Nashville, TN 37215 (615) 234-5900.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event.

Effective April 1, 2009, a special enrollment period provision was added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

Women's Cancer Rights Act Notice

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. Please contact your Business Office Manager or Administrator if you have any questions.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact hr@surgerypartners.com

.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Surgery Partners Inc.	47-3620923
5. Employer address	**6. Employer phone number**
40 Burton Hills Blvd., Suite 500	615-234-7904

7. City	8. State	9. ZIP code
Nashville	TN	37215

10. Who can we contact about employee health coverage at this job?	
Human Resources	
11. Phone number (if different from above)	**12. Email address**
	hr@surgerypartners.com

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees regularly scheduled to work 30 hours per week or more.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse- see definition in plan document; Children- eligible for medical coverage until 26th birthday.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Important Participant Notice Regarding Qualified Default Investment Alternative

SURGERY CENTER HOLDINGS, INC.
5501 W GRAY STREET
TAMPA, FL 33609-1007
(813) 569-6500
www.surgerypartners.com

You have the right to direct the investment of retirement plan contributions among the investment options offered under the retirement plan. Properly investing retirement contributions is important for planning your future retirement income. You should consider your investment direction decision carefully. This notice provides information regarding where contributions submitted to the retirement plan for your benefit will be directed in the absence of your investment election. You may direct the investment of the retirement funds by visiting www.principal.com.

Investment Option Default

If you have not provided complete, up-to-date direction as to how the account set up for you under the retirement plan is to be invested, the account will be invested under automatic rules. You need to understand these rules and make sure that you are comfortable with them or that you take action to direct the investment of the account according to your preferences. These rules state that, if we do not have complete investment directions from you, the retirement funds in the account and new contributions for which we do not have direction will be directed to the applicable Principal LifeTime portfolio (advised by Principal Management Corporation and sub-advised by Principal Global Investors). The applicable portfolio will be determined based on your current age and the definition of normal retirement date under the plan. Your directions must be received at the Corporate Center of Principal Life Insurance Company.

See the table below to identify the Principal LifeTime portfolio that will apply based on your current age and when you will reach the plan's normal retirement date. For information on how you may make an investment direction election, please see the "Right to Direct" section below.

Normal Retirement Date	**Principal LifeTime Portfolio**
2004 or earlier	Principal LifeTime Strategic Income Separate Account
Between 2005 and end of 2012	Principal LifeTime 2010 Separate Account
Between 2013 and end of 2017	Principal LifeTime 2015 Separate Account
Between 2018 and end of 2022	Principal LifeTime 2020 Separate Account
Between 2023 and end of 2027	Principal LifeTime 2025 Separate Account
Between 2028 and end of 2032	Principal LifeTime 2030 Separate Account
Between 2033 and end of 2037	Principal LifeTime 2035 Separate Account
Between 2038 and end of 2042	Principal LifeTime 2040 Separate Account
Between 2043 and end of 2047	Principal LifeTime 2045 Separate Account
Between 2048 and end of 2052	Principal LifeTime 2050 Separate Account
Between 2053 and end of 2057	Principal LifeTime 2055 Separate Account
2058 or later	Principal LifeTime 2060 Separate Account

Note: Neither the principal nor the underlying assets of the Principal LifeTime portfolios are guaranteed at any time, including the target date. Investment risk remains at all times.

To learn about the retirement plan's default investment option and related objectives, risk and return characteristics, and associated fees and expenses, please see the following description and attached investment information or Investment Option Summary included in the enrollment workbook for the Principal LifeTime portfolios that will apply.

Target Date portfolios are managed toward a particular target date, or the approximate date the investor is expected to start withdrawing money from the portfolio. As each target date portfolio approaches its target date, the investment mix becomes more conservative by increasing exposure to generally more conservative investments and reducing exposure to typically more aggressive investments. Neither the principal nor the underlying assets of target date portfolios are guaranteed at any time, including the target date. Investment risk remains at all times. Neither asset allocation nor diversification can assure a profit or protect against a loss in down markets. Be sure to see the relevant prospectus or offering document for full discussion of a target date investment option including determination of when the portfolio achieves its most conservative allocation.

Right to Direct

If you do not want retirement funds to be directed as indicated above, then you may elect to direct the retirement funds to investment options under the retirement plan by visiting The Principal Web site at www.principal.com and logging into the account or by calling 1-800-547-7754.

You may make changes to your investment direction as allowed under the retirement plan. This includes transferring any contributions from the applicable investment option default to another investment option. Transfers out of the investment option default are not subject to restrictions, fees or expenses[1] for a 90-day period, unless the fees and expenses are charged on an ongoing basis for the operation of the investment[2]. See the attached investment information for information regarding restrictions, fees or expenses after the 90-day period.

Additional Information

For additional information about the investment option default or other investment alternatives under the plan please visit www.principal.com or contact:

LAINIE KENNEDY, HUMAN RESOURCES MANAGER
40 BURTON HILLS BLVD
SUITE 500
NASHVILLE, TN 37215-6186
(615)234-5912
LKENNEDY@SURGERYPARTNERS.COM

[1] Includes surrender charges, liquidation or exchange fees, redemption fees and similar expenses charged in connection with the liquidation of, or transfer from, the investment option default.
[2] Includes investment management fees, distribution and/or service fees, "12b-1" fees, or legal, accounting, transfer agent and similar administrative expenses.