Headcount Management, Inc.

Health Insurance Plan

Headcount is proud to offer our employees health insurance. Our options include a choice of three major medical health plans which meet or exceed the Affordable Care Act's ("ACA") Affordability and Quality standards.

If you enroll on one of the major medical plans a pre-tax deduction of up to 9.56% of wages will be made from your paycheck to cover the "employee share" cost of the base plan (the Healthy Value 3500 Employee only plan). If you desire one of the richer benefit plans you will pay the full amount(s) listed in the chart provided in this packet. All plans,include vision and dental coverage.

Who is Eligible?:
Full-time hourly employees (those working an average of 30 hours or more per week): 1st of the month following 30 days of service.

If you are eligible for benefits, you also may enroll these members of your family:

- Your Spouse
- Your Domestic Partner
- Your Domestic Partner's children
- Biological children, adopted children and children legally placed for adoption through age 25
- Your Stepchildren, including your Spouse's biological children, adopted children and children legally placed with him or her for adoption through age 25

- Children in Legal Guardianship, including grandchildren, siblings, nieces or nephews for whom the court has granted you, your Spouse or Domestic Partner full and plenary Legal Guardianship for them and their estate through age 25
- Mentally or physically disabled children past the normal age limit, provided they meet the federal requirements

Next Steps:

If you are eligible for benefits:

1. Review and select a plan
2. Complete the health application attached below. Enroll any additional family members.
3. Finalize the Health application and email it to support@headcountmgmt.com and veronica.christian@medova.com.

HealthyChoice 1500 CP PPO

Lifestyle HEALTH PLANS — A World of Wellness

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
CARE PLAN DEDUCTIBLE (Achieved by completing requirements for Care Management Plan)	$1,500 Single / $3,000 Family	Not Applicable
2ND TIER DEDUCTIBLE (Applies for Non-participants in Care Management Plan & Wellness Program)	$2,500 Single / $5,000 Family	$5,000 Single / $10,000 Family
CO-INSURANCE	20%	50%
CO-INSURANCE MAXIMUM	$2,500 Single / $5,000 Family	$5,000 Single / $10,000 Family
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$4,000 Single / $8,000 Family (Assumes Care Plan Deductible)	$10,000 Single / $20,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	Unlimited
PHYSICIAN AND ANCILLARY SERVICES		
PREVENTIVE SERVICES	***Annual Primary Care visit with Care Management Plan is important to achieve Care Plan Deductible.***	
- Annual Primary Care Visit	100% Coverage	100% Coverage *
- Other ACA Preventive Services	100% Coverage	100% Coverage *
PHYSICIAN SERVICES	***Lab Services not included in office visit copay. Please utilize preferred lab vendor for 100% coverage.***	
- Primary Care Office Visit	$5 Copay, then 100%	Deductible / Co-insurance
- Specialist Office Visit	$50 Copay, then 100%	Deductible / Co-insurance
- Urgent Care / ER Professional Services	$50 Copay, then 100% to $2,500 per visit, then Deductible / Co-insurance	Deductible / Co-insurance
- Physician & Surgeon Professional Services	Deductible / Co-insurance	Deductible / Co-insurance
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance	Deductible / Co-insurance
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay through preferred vendor	Not Applicable
DIABETIC SUPPLIES	100% if preferred vendor, otherwise 50% cost through Rx Benefit	Deductible / Co-insurance
OUTPATIENT LAB SERVICES	100% if preferred vendor, otherwise Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging.***	
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT REHAB & THERAPY		
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required prior to scheduling. Care coordination required to maximize benefits.***	
- Physician Office / Freestanding Surgery Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
ALLERGY TREATMENT	$25 Copay, then 100% to $100 per visit	Deductible / Co-insurance
CHIROPRACTIC & ALTERNATIVE MEDICINE SERVICES		
- Chiropractic Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
- Alternative Medicine Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
MENTAL HEALTH AND SUBSTANCE ABUSE		
- In-office Therapy (Physician / Licensed Therapist)	$50 Copay, then 100%	Deductible / Co-insurance
DURABLE MEDICAL EQUIPMENT	Deductible / Co-insurance	Deductible / Co-insurance
FACILITY BASED SERVICES		
EMERGENCY SERVICES	***ER Copay waived if admitted***	***ER Copay waived if admitted***
- Hospital ER (Facility Charge Only)	$1,000 Copay, then Deductible / Co-insurance	$1,000 Copay, then Deductible / Co-insurance
- Ambulance	$500 Copay, then Deductible / Co-insurance	$500 Copay, then Deductible / Co-insurance
- Air Ambulance	$2,500 Copay, then Deductible / Co-insurance	$2,500 Copay, then Deductible / Co-insurance
LAB SERVICES	***(If provided at a facility-based setting.)***	
- Hospital Outpatient	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging. Subject to plan maximum based on specific imaging service.***	
- Hospital Outpatient	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT REHAB & THERAPY	***Applicable to services provided at a hospital-based facility.***	
- Hospital Outpatient	$50 Copay, then Deductible / Co-insurance	$50 Copay, then Deductible / Co-insurance
CHEMOTHERAPY, RADIATION THERAPY & OUTPATIENT DIALYSIS	***Pre-certification required. RX medication subject to care coordination review. Dialysis Services subject to plan allowance.***	
- Chemotherapy & Radiation Therapy Services	$100 Copay per visit, then Deductible / Co-insurance	$100 Copay per visit, then Deductible / Co-insurance
- Dialysis Services	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required. Copay may be waived based on medical necessity approval. Benefit subject to a plan maximum based on specific procedure. Plan allowance provided at time of pre-certification.***	
- Hospital Outpatient	$1,000 Copay per visit, then Deductible / Co-insurance	$1,000 Copay per visit, then Deductible / Co-insurance
INPATIENT HOSPITALIZATION	***All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hours. Hospital location approval subject to care coordination and selection of value-based facility. Inpatient hospitalization includes medical, surgical, mental health, and substance abuse services.***	
- Inpatient Facility Services (Value-based)	$250 Copay, then Deductible / Co-insurance [2]	Not Applicable
- Inpatient Facility Services (All Others)	$1,500 Copay, then Deductible / Co-insurance [2]	$1,500 Copay, then Deductible / Co-insurance [2]
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible / Co-insurance	Deductible / Co-insurance
PRESCRIPTION DRUG BENEFITS	**REFER TO PREFERRED FORMULARY AND SUMMARY PLAN DOCUMENT (SPD)**	
- Generic	$15 Copay	No Benefits Payable
- Brand / Non-Preferred Brand / Specialty	$50 Copay / $100 Copay / 50% [3]	No Benefits Payable
- Mail Order (Preferred Vendor) - Generic / Brand	$5 Copay / $80 Copay (90-day supply)	No Benefits Payable
- International Mail Order (Preferred Vendor) - Brand	$0 Copay (voluntary participation)	No Benefits Payable

IMPORTANT NOTES:

[1] Then, Deductible / Co-insurance. [2] Per admission. All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins.

[3] Subject to Step Therapy methodology - refer to Preferred Formulary for details. * Usual & customary allowable applies.

This outline is intended as a brief overview of the actual plan and representative benefit levels. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

Healthy100 2500 CP PAN

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
CARE PLAN DEDUCTIBLE (Achieved by completing requirements for Care Management Plan)	$2,500 Single / $5,000 Family	Not Applicable
2ND TIER DEDUCTIBLE (Applies for Non-participants in Care Management Plan & Wellness Program)	$3,500 Single / $7,000 Family	$7,000 Single / $14,000 Family
CO-INSURANCE	0%	50%
CO-INSURANCE MAXIMUM	No Co-insurance Responsibility	$2,500 Single / $5,000 Family
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$2,500 Single / $5,000 Family (Assumes Care Plan Deductible)	$9,500 Single / $19,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	Unlimited
PHYSICIAN AND ANCILLARY SERVICES		
PREVENTIVE SERVICES	***Annual Primary Care visit with Care Management Plan is important to achieve Care Plan Deductible.***	
- Annual Primary Care Visit	100% Coverage	100% Coverage *
- Other ACA Preventive Services	100% Coverage	100% Coverage *
PHYSICIAN SERVICES	***Lab Services not included in office visit copay. Please utilize preferred lab vendor for 100% coverage.***	
- Primary Care Office Visit	$5 Copay, then 100%	Deductible / Co-insurance
- Specialist Office Visit	$50 Copay, then 100%	Deductible / Co-insurance
- Urgent Care / ER Professional Services	$50 Copay, then 100% to $2,500 per visit, then Deductible / Co-insurance	Deductible / Co-insurance
- Physician & Surgeon Professional Services	Deductible / Co-insurance	Deductible / Co-insurance
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance	Deductible / Co-insurance
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay through preferred vendor	Not Applicable
DIABETIC SUPPLIES	100% if preferred vendor, otherwise 50% cost through Rx Benefit	Deductible / Co-insurance
OUTPATIENT LAB SERVICES	100% if preferred vendor, otherwise Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging.***	
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT REHAB & THERAPY		
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required prior to scheduling. Care coordination required to maximize benefits.***	
- Physician Office / Freestanding Surgery Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
ALLERGY TREATMENT	$25 Copay, then 100% to $100 per visit	Deductible / Co-insurance
CHIROPRACTIC & ALTERNATIVE MEDICINE SERVICES		
- Chiropractic Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
- Alternative Medicine Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
MENTAL HEALTH AND SUBSTANCE ABUSE		
- In-office Therapy (Physician / Licensed Therapist)	$50 Copay, then 100%	Deductible / Co-insurance
DURABLE MEDICAL EQUIPMENT	Deductible / Co-insurance	Deductible / Co-insurance
FACILITY BASED SERVICES	**All FACILITY BASED BENEFITS SUBJECT TO VALUE BASED REPRICING**	
EMERGENCY SERVICES	***ER Copay waived if admitted***	
- Hospital ER (Facility Charge Only)	$1,000 Copay, then Deductible / Co-insurance	
- Ambulance	$500 Copay, then Deductible / Co-insurance	
- Air Ambulance	$2,500 Copay, then Deductible / Co-insurance	
LAB SERVICES	***(If provided at a facility-based setting.)***	
- Hospital Outpatient	Deductible / Co-insurance	
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging. Subject to plan maximum based on specific imaging service.***	
- Hospital Outpatient	Deductible / Co-insurance	
OUTPATIENT REHAB & THERAPY	***Applicable to services provided at a hospital-based facility.***	
- Hospital Outpatient	$50 Copay, then Deductible / Co-insurance	
CHEMOTHERAPY, RADIATION THERAPY & OUTPATIENT DIALYSIS	***Pre-certification required. RX medication subject to care coordination review. Dialysis Services subject to plan allowance.***	
- Chemotherapy & Radiation Therapy Services	$100 Copay per visit, then Deductible / Co-insurance	
- Dialysis Services	Deductible / Co-insurance	
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required. Copay may be waived based on medical necessity approval. Benefit subject to a plan maximum based on specific procedure. Plan allowance provided at time of pre-certification.***	
- Hospital Outpatient	$1,000 Copay per visit, then Deductible / Co-insurance	
INPATIENT HOSPITALIZATION	***All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hours. Hospital location approval subject to care coordination and selection of value-based facility. Inpatient hospitalization includes medical, surgical, mental health, and substance abuse services.***	
- Inpatient Facility Services (Value-based)	$250 Copay, then Deductible / Co-insurance [2]	
- Inpatient Facility Services (All Others)	$1,500 Copay, then Deductible / Co-insurance [2]	
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible / Co-insurance	
PRESCRIPTION DRUG BENEFITS	**REFER TO PREFERRED FORMULARY AND SUMMARY PLAN DOCUMENT (SPD)**	
- Generic	$15 Copay	No Benefits Payable
- Brand / Non-Preferred Brand / Specialty	$50 Copay / $100 Copay / 50% [3]	No Benefits Payable
- Mail Order (Preferred Vendor) - Generic / Brand	$5 Copay / $80 Copay (90-day supply)	No Benefits Payable
- International Mail Order (Preferred Vendor) - Brand	$0 Copay (voluntary participation)	No Benefits Payable

IMPORTANT NOTES:

[1] Then, Deductible / Co-insurance. [2] Per admission. All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins.

[3] Subject to Step Therapy methodology - refer to Preferred Formulary for details. * Usual & customary allowable applies.

This outline is intended as a brief overview of the actual plan and representative benefit levels. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request an SPD from Lifestyle Health Plans. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

HealthyValue 3500 CP PPO

Lifestyle HEALTH PLANS — A World of Wellness

PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK
CARE PLAN DEDUCTIBLE (Achieved by completing requirements for Care Management Plan)	$3,500 Single / $7,000 Family	Not Applicable
2ND TIER DEDUCTIBLE (Applies for Non-participants in Care Management Plan & Wellness Program)	$4,500 Single / $9,000 Family	$9,000 Single / $18,000 Family
CO-INSURANCE	50%	70%
CO-INSURANCE MAXIMUM	$2,500 Single / $5,000 Family	$5,000 Single / $10,000 Family
OUT-OF-POCKET LIMIT (Deductible + Co-Insurance Max) (OOP Limit does not include copays and Rx copays)	$6,000 Single / $12,000 Family (Assumes Care Plan Deductible)	$14,000 Single / $28,000 Family
ACA MAXIMUM OUT-OF-POCKET	$8,550 Single / $17,100 Family	Unlimited
PHYSICIAN AND ANCILLARY SERVICES		
PREVENTIVE SERVICES	***Annual Primary Care visit with Care Management Plan is important to achieve Care Plan Deductible.***	
- Annual Primary Care Visit	100% Coverage	100% Coverage *
- Other ACA Preventive Services	100% Coverage	100% Coverage *
PHYSICIAN SERVICES	***Lab Services not included in office visit copay. Please utilize preferred lab vendor for 100% coverage.***	
- Primary Care Office Visit	$5 Copay, then 100%	Deductible / Co-insurance
- Specialist Office Visit	$50 Copay, then 100%	Deductible / Co-insurance
- Urgent Care / ER Professional Services	$50 Copay, then 100% to $2,500 per visit, then Deductible / Co-insurance	Deductible / Co-insurance
- Physician & Surgeon Professional Services	Deductible / Co-insurance	Deductible / Co-insurance
- Anesthesia Services (Physician / CRNA)	Deductible / Co-insurance	Deductible / Co-insurance
TELEPHONIC PHYSICIAN CONSULTATIONS	$0 Copay through preferred vendor	Not Applicable
DIABETIC SUPPLIES	100% if preferred vendor, otherwise 50% cost through Rx Benefit	Deductible / Co-insurance
OUTPATIENT LAB SERVICES	100% if preferred vendor, otherwise Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging.***	
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT REHAB & THERAPY		
- Physician Office / Freestanding Imaging Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required prior to scheduling. Care coordination required to maximize benefits.***	
- Physician Office / Freestanding Surgery Ctr.	Deductible / Co-insurance	Deductible / Co-insurance
ALLERGY TREATMENT	$25 Copay, then 100% to $100 per visit	Deductible / Co-insurance
CHIROPRACTIC & ALTERNATIVE MEDICINE SERVICES		
- Chiropractic Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
- Alternative Medicine Services	$50 Copay, then 100% to $200 per visit [1]	Deductible / Co-insurance
MENTAL HEALTH AND SUBSTANCE ABUSE		
- In-office Therapy (Physician / Licensed Therapist)	$50 Copay, then 100%	Deductible / Co-insurance
DURABLE MEDICAL EQUIPMENT	Deductible / Co-insurance	Deductible / Co-insurance
FACILITY BASED SERVICES		
EMERGENCY SERVICES	***ER Copay waived if admitted***	***ER Copay waived if admitted***
- Hospital ER (Facility Charge Only)	$1,000 Copay, then Deductible / Co-insurance	$1,000 Copay, then Deductible / Co-insurance
- Ambulance	$500 Copay, then Deductible / Co-insurance	$500 Copay, then Deductible / Co-insurance
- Air Ambulance	$2,500 Copay, then Deductible / Co-insurance	$2,500 Copay, then Deductible / Co-insurance
LAB SERVICES	***(If provided at a facility-based setting.)***	
- Hospital Outpatient	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT RADIOLOGY & IMAGING	***Pre-certification required prior to scheduling for MRI, CT, PET and Nuclear Imaging. Subject to plan maximum based on specific imaging service.***	
- Hospital Outpatient	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT REHAB & THERAPY	***Applicable to services provided at a hospital-based facility.***	
- Hospital Outpatient	$50 Copay, then Deductible / Co-insurance	$50 Copay, then Deductible / Co-insurance
CHEMOTHERAPY, RADIATION THERAPY & OUTPATIENT DIALYSIS	***Pre-certification required. RX medication subject to care coordination review. Dialysis Services subject to plan allowance.***	
- Chemotherapy & Radiation Therapy Services	$100 Copay per visit, then Deductible / Co-insurance	$100 Copay per visit, then Deductible / Co-insurance
- Dialysis Services	Deductible / Co-insurance	Deductible / Co-insurance
OUTPATIENT SURGICAL PROCEDURES	***Pre-certification required. Copay may be waived based on medical necessity approval. Benefit subject to a plan maximum based on specific procedure. Plan allowance provided at time of pre-certification.***	
- Hospital Outpatient	$1,000 Copay per visit, then Deductible / Co-insurance	$1,000 Copay per visit, then Deductible / Co-insurance
INPATIENT HOSPITALIZATION	***All non-emergency confinements must be pre-certified. Report emergency confinements within 48 hours. Hospital location approval subject to care coordination and selection of value-based facility. Inpatient hospitalization includes medical, surgical, mental health, and substance abuse services.***	
- Inpatient Facility Services (Value-based)	$250 Copay, then Deductible / Co-insurance [2]	Not Applicable
- Inpatient Facility Services (All Others)	$1,500 Copay, then Deductible / Co-insurance [2]	$1,500 Copay, then Deductible / Co-insurance [2]
HOME HEALTH, SKILLED NURSING & HOSPICE CARE	Deductible / Co-insurance	Deductible / Co-insurance
PRESCRIPTION DRUG BENEFITS	**REFER TO PREFERRED FORMULARY AND SUMMARY PLAN DOCUMENT (SPD)**	
- Generic	$15 Copay	No Benefits Payable
- Brand / Non-Preferred Brand / Specialty	$50 Copay / $100 Copay / 50% [3]	No Benefits Payable
- Mail Order (Preferred Vendor) - Generic / Brand	$5 Copay / $80 Copay (90-day supply)	No Benefits Payable
- International Mail Order (Preferred Vendor) - Brand	$0 Copay (voluntary participation)	No Benefits Payable

IMPORTANT NOTES:

[1] Then, Deductible / Co-insurance. [2] Per admission. All non-emergency confinements must be pre-certified and emergency confinements must be reported within 48 hours of when confinement begins.

[3] Subject to Step Therapy methodology - refer to Preferred Formulary for details. * Usual & customary allowable applies.

This outline is intended as a brief overview of the actual plan and representative benefit levels. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services. Please refer to your Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. If there is any inconsistency between this outline and the SPD, the SPD shall govern. You may request a SPD from Lifestyle Health Plans. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non coverage of services.

LIFESTYLE DENTAL PLANS

Your Answer to Dental Coverage

Lifestyle Dental Plans are specifically designed to complement our wellness-inspired group health benefits program. Lifestyle Dental is your starting point for great group dental benefits, integrated into a program focused on prevention, lifestyle change, and health improvement. In fact, dental care and routine dental exams often assist with the early detection of serious diseases or conditions.

Dental coverage is important - without it, many employees may never visit the dentist at all. Our Dental Plans are designed to offer all that you will need in terms of prevention, basic and major dental procedures, as well as orthodontia. Dental benefits do not need to be complicated and our program is designed with some straightforward, cost-competitive plan designs - in the same wellness-inspired spirit of our medical & vision programs.

Lifestyle Dental Plans / MetLife Dental Plan Options

MetLife | Dental

Option 1 / DentalCare 1000

	In Network[1,2]	Out of Network[2,3]
PREVENTATIVE (Cleanings, exams)	100%	100%
BASIC SERVICES (Composite fillings, x-rays, sealants)	80%	80%
MAJOR SERVICESMAJOR SERVICES (Endodontics, periodontics, oral surgery, crowns, bridges, dentures, implants)	50%	50%
ANNUAL MAXIMUM	$1,000	$1,000
DEDUCTIBLE (No Deductible for Preventative)	$50 per person $150 per family	$50 per person $150 per family
ORTHODONTICS (Child only, covered to age 19) (Lifetime Maximum)	50% $1,000	50% $1,000

Dental insurance provided by Metropolitan Life Insurance Company New York, NY.
Administered by Medova healthcare Financial Group, LLC.

1. Plan benefits for in network covered services are based on a percentage of the Negotiated Fee — the fee that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
2. "In Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out of Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
3. Plan benefits for out of network services are based on a percentage of the Reasonable and Customary (R&C) charge. The R&C charge is based on the lowest of (i) the dentist's actual charge; (ii) the dentist's usual charge for the same or similar services; or (iii) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. Out of network reimbursement is 90th Percentile, R&C.

VER10012020

Lifestyle Dental / MetLife Dental Allocations & Limitations

MetLife | Dental

Type A - Preventative Services (No deductible for type A Services)	
Examinations	2 times in 12 months
Examinations - Problem Focused	Combine with Examination limit
Prophylaxis: Cleanings	2 times in 12 months
Fluoride	1 times in 12 months for dependent child(ren) under age 19
Bitewing X-Rays	

Type B - Basic Services	
Sealants	1 per molar in 60 months for a child under age 16
Space Maintainers	1 per lifetime for child(ren) under age 14
Full Mouth X-Ray	1 time every 60 months
A Malgam Fillings	1 replacement per surface in 24 months
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Ray	
Resin Composite Fillings	
(Includes coverage for composite fillings on molars)	
General Services	

Type C - Major Services	
Consultations	1 times in 12 months
Root Canal	1 per tooth per lifetime
Periodontal Maintenance	4 Perio treatments in 1 calendar year, includes 2 cleanings (total combination of 4)
Periodontal Surgery	1 per quadrant in any 60 month period
Scaling & Root Planning	1 per quadrant in any 60 month period
Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 10 calendar years
Crown Buildups / Post Core	1 per tooth in 10 calendar years
Repairs	1 in 12 months
Recementations	1 in 12 months
Dentures	1 in 10 calendar years
Immediate Temporary Dentures - Complete/Partials	1 replacement in 12 months
Dentures - Rebases/Relines	1 in 36 months
Denture Adjustments	1 in 12 months
Fixed Bridges	1 in 10 calendar years
Inlays/Onlays/Crowns	1 replacement per tooth in 10 calendar years
Implant Services	1 per tooth in 10 years
Implant Repairs	1 per tooth in 10 years
Implant Supported Prosthetic	1 per tooth in 10 calendar years
Tissue Conditioning	1 in 36 months
Occlusal Adjustments	1 in 12 months
General Anesthesia	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
A Pexification & Recalcification	
Periodontal Surgery - Soft & Connective Tissue Grafts	
Periodontics - Non Surgical	
Oral Surgery: Surgical Extractions	
Oral Surgery: Simple Extractions	
Other Oral Surgery	

Lifestyle DENTAL

LIFESTYLE VISION PLANS

Your Answer to Vision Coverage

Lifestyle Vision Plans has teamed up with MetLife Vision to provide you with competitive vision plans specifically designed to complement our wellness-inspired group health benefits program. We all know that vision care and routine vision exams can assist with the early detection of serious diseases or conditions. Lifestyle Vision is your answer to vision coverage, integrated into a program focused on prevention, lifestyle change, and health improvement.

Our Vision Plans are designed to offer all that you and your family will need in terms of annual eye exams, lenses, frames, and contact lenses. Lifestyle Vision offers you two cost-competitive plan designs with both In-network and Non-network benefits - in the same wellness-inspired spirit of our medical and dental programs.

Lifestyle Vision Plans / MetLife Vision Plan Options

Eye Examinations

MetLife | Vision

Option 1 / VisionCare 130

Plan Benefits	In Network Coverage	Out of Network Reimbursement
Comprehensive Exam of Visual functions and prescription of corrective eyewear	$10 copay	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the the eye, Particularly the retina, to look for possible changes.	Up to $39 copay	Applied to the exam allowance

Materials / Eyewear (Either Glasses or Contacts)

MetLife | Vision

Option 1 / VisionCare 130

Plan Benefits	In Network Coverage	Out of Network Reimbursement
Standard Corrective Lenses		
Single Vision	$10 copay	$30 Allowance
Lined Bifocal	$10 copay	$50 Allowance
Lined trifocal	$10 copay	$65 Allowance
Lenticular	$10 copay	$100 Allowance
Standard Lens Options		
Ultraviolet coating	Covered in Full	Applied to the allowance for the applicable corrective lens
Polycarbonate (Child up to age 18)	Coverage in Full	
Additional Lens Enhancements		
Progressive Standard	Up to $55 copay	
Progressive Premium	Premium: Up to $95-$105 copay Custom: Up to $150-$175 copay	
Polycarbonate (Adult)	Single Vision: Up to $31 copay Multifocal: Up to $35 copay	
Scratch-resistant coating (variable by type)	Up to $17-$33 copay	
Tints (variable by type)	Single Vision: Up to $17-$34 copay Multifocal: Up to $17-$44 copay	
Anit-reflective coating (variable by type)	Up to $41-$85 copay	
Frame Allowance (You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations, except Costco)	$130 Allowance	$70 Allowance
Costco	$70 Allowance	
Contact Lenses		
Contact fitting and evaluation	Standard or Premium Fit: Covered in full with a maximum $60 copay	Applied to contact lens Allowance
Elective Lenses	$130 Allowance	$105 Allowance
Necessary	Covered in full after eyewear copay	$210 Allowance
Frequency		
Plan Benefits		
Examination	1 per 12 months	1 per 12 months
Standard Corrective Lenses	1 per 12 months	1 per 12 months
Frames	1 per 24 months	1 per 24 months
Contact Lenses	1 per 12 months	1 per 12 months

Either glasses or contacts allowed per frequency

Lifestyle +++ wellness

PROGRAM OVERVIEW

Welcome to Lifestyle Wellness!

It is the mission of Lifestyle Wellness to assist you in fostering and maintaining a healthy lifestyle! We seek to accomplish this through two solutions. **MyLifestyle** is a program where each member establishes a care management plan with their primary care physician and Lifestyle Wellness helps you to stay on track. **Rewards+** is a program which offers a variety of individual and group activities to participate in throughout the year. Both programs offer incentives that work together to reduce the out of pocket healthcare costs for the member.

This overview will help get you started on *all you need to know* about Lifestyle Wellness!

MyLifestyle PROGRAM

For your individualized program, everything gets started within *the first 3 months* of being effective with Lifestyle Health Plans. All you need to do is get your **annual lab work** done and visit with your primary care doctor for your **annual wellness exam**. At this visit, have your doctor use the **MyLifestyle Personalized Care Management Plan Form*** to develop a care management plan to follow throughout the plan year!

PROGRAM YEAR 1

First 3 Months:

In your first 3 months, you will be able to earn a $1000 deductible credit for your *first year* by completing your **lab work, annual wellness exam** and enrollment in your **Care Management Plan**:

Lifestyle ACTIVITIES	POINTS
Lab Work	250 MyLifestyle Points
Annual Exam	250 MyLifestyle Points
Enrollment in Care Management Plan	500 MyLifestyle Points
Care Management Plan Compliance	250 MyLifestyle Points *(per quarter)*

Remaining Program Year Months:

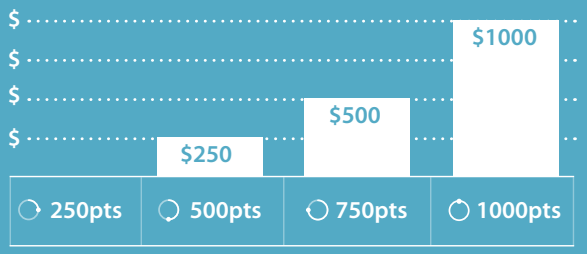
After your first 3 months, you will be able to earn MyLifestyle Points that will determine your deductible credit next year. Points available during this timeframe consist of compliance in your Care Management Plan (250 MyLifestyle Points per quarter). The Annual Wellness Exam is a prerequisite to Care Management Compliance. However, the Care Management Plan Compliance is the only activity available for points after the first 3 months in MyLifestyle.

PROGRAM YEAR 2+

In Program Year two and beyond, you will be able to complete your Annual Wellness Exam for 250 MyLifestyle Points in the first 3 months. Coaching Compliance is also offered in Program Year two and beyond for MyLifestyle Points (250 MyLifestyle Points per quarter).

*You cannot earn points for enrolling in your **Enrollment in Care Management Plan** in years 2+.*

MyLifestyle POINT CONVERSION



250pts = **$0** *Deductible Credit*
500pts = **$250** *Deductible Credit*
750pts = **$500** *Deductible Credit*
1000pts = **$1000** *Deductible Credit*

TIMELINE BY MONTH

MyLifestyle Points
Rewards+ Points
Deductible Credit Earned

PROGRAM YEAR 1

First 3 Month Activities
MyLifestyle Points earned for **first** program year

After first 3 months MyLifestyle Points reset. Begin earning Rewards+ Points.
Points earned for the **following** program year

PROGRAM YEAR 2

Points reset & begin earning points for following program year.

Lifestyle +++ wellness

*** The MyLifestyle Care Management Plan Form** can be found on your wellness portal. Instructions to login to your portal are on the back page.

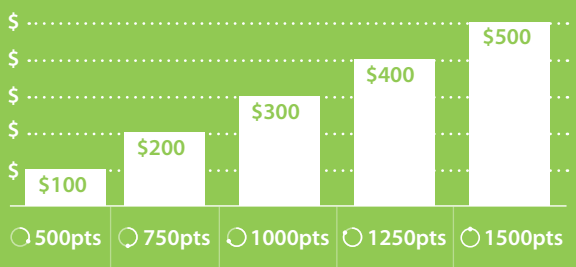
Rewards+ PROGRAM

The Rewards+ program will allow you build a bank of **Rewards+ Points** each year by participating in the wellness program. After completing your MyLifestyle Plan within the first 3 months, you'll be able to start earning **Rewards+ Points** through the Ways to Earn Rewards chart below. Every year, you are working towards your *next year's* deductible credit with your current **Rewards+ Point** accumulation.

PROGRAM YEAR 2+

As you earn points in Rewards+, these **Rewards+ Points** will accumulate and can grow to a 'bank' of points that will be able to convert to deductible credit for your next program year. You can use your **Rewards+ Point**s to work together with your MyLifestyle Points to get you the full deductible credit each year. A deductible credit between MyLifestyle and Rewards+ programs combined *cannot exceed $1,000.*

Rewards+ POINT CONVERSION



500pts = **$100** *Deductible Credit*
750pts = **$200** *Deductible Credit*
1000pts = **$300** *Deductible Credit*
1250pts = **$400** *Deductible Credit*
1500pts = **$500** *Deductible Credit*

WAYS TO EARN Rewards+ POINTS

Rewards+ ACTIVITIES	Rewards+ POINTS
Annual Preventive Exams	
Dental Exam	100
Vision Exam	100
Flu Shot	50
Challenges	
Individual	50
Employer (Limit 2 per PY)	250
Action Plans	
Wellness Center Action Plans	200
Tobacco Coaching	
Initial Enrollment	100
Coaching Compliance	100
Healthy Actions	
Gym Attendance	400 max/per year
Self-Reported Exercise	400 max/per year

DEDUCTIBLE Credits

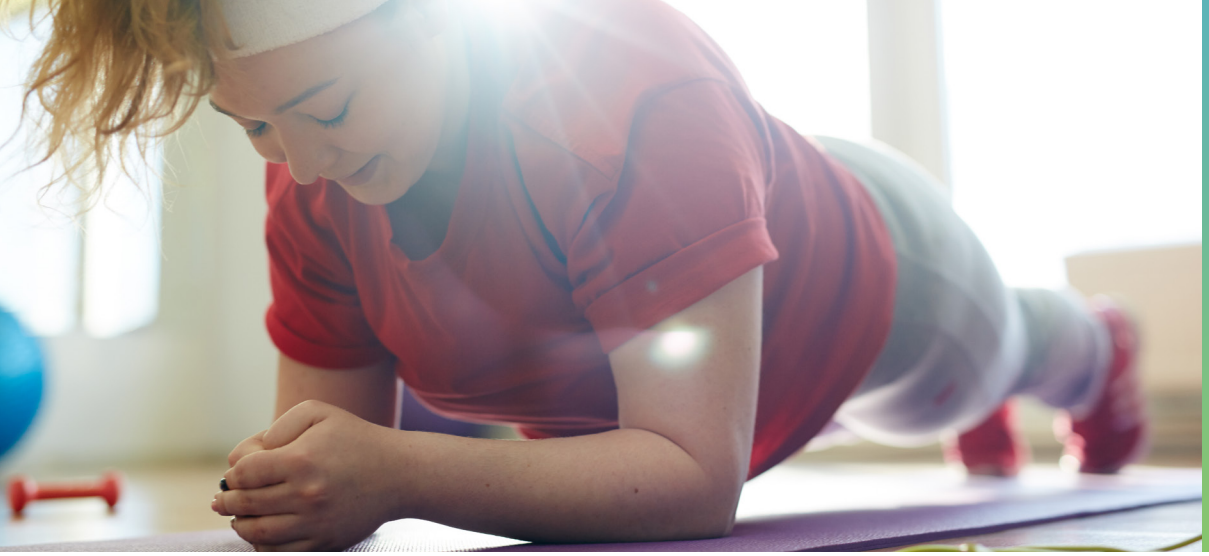
Your **MyLifestyle** & **Rewards+** points each convert into their own deductible credits for the following program year.*

The ***maximum*** deductible credit you can earn between both programs is $1,000.

**The first 3 months are unique. Please see more details on page 2.*

ROLLOVER

Since MyLifestyle and Rewards+ program deductible credits cannot exceed *$1,000 combined*, unused **Rewards+ Points** that accumulate in the Rewards+ bank, will carry forward into the next year. The maximum amount of points a member can carry over into the next year is **1,000 Rewards+ Points**.



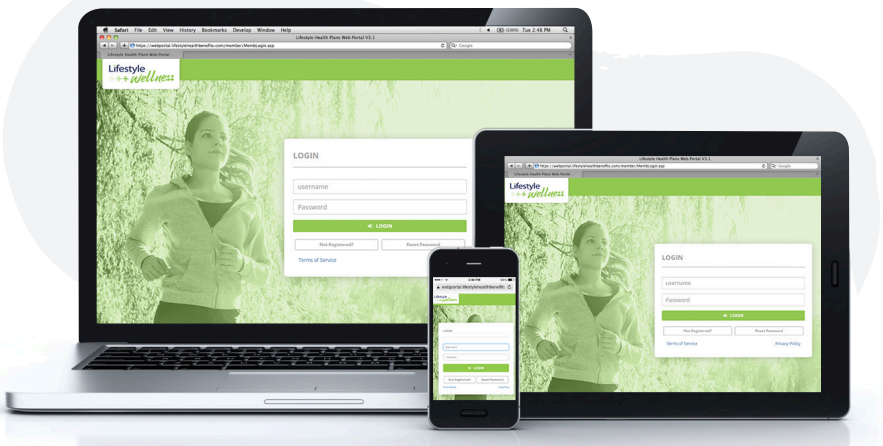
STEPS IN THE JOURNEY

1. Register your account on the Wellness portal
2. Get your labs done at a preferred lab within the first three months
3. Get your annual wellness exam done within the first three months
4. Enroll in a compliance program designed around your physician's advice for your health
5. After the first three months, log in every quarter to give feedback and verify your compliance to earn MyLifestyle points
6. After the first three months, begin engaging in healthy activities through the Rewards+ program

GETTING REGISTERED

Register and Login

1. Go to **www.lifestylewellnessprogram.com**.
2. Select the Wellness Center tab at the top right of the Home Page.
3. Click **"Not Registered?"** under the Sign In options.
4. Read and accept the Terms of Service & Privacy Policy before continuing.
5. Fill in your information to check your eligibility.
6. Then, fill in the rest of your account information to create your profile.
7. Once your account has been created, **log in with your new credentials.**



QUESTIONS? *Call Today!*

866-827-6607 Option 1
or email us at *wellness@medova.com*

Lifestyle +++ wellness

V102920

Headcount Management, Inc.

Weekly Employee Contribution Amount

Enrollment Option- Age	Healthy Choice 1500	Healthy 100	Healthy Value 3500
Employee Only: 0-39	$ 94.83	$ 92.04	$ 79.19
Employee Only 40-49	$ 106.69	$ 103.55	$ 89.10
Employee Only 50-59	$ 125.80	$ 122.10	$ 105.06
Employee Only 60+	$ 148.43	$ 144.06	$ 123.95
Employee/Spouse: 0-39	$ 149.17	$ 144.78	$ 124.57
Employee/Spouse: 40-49	$ 173.11	$ 168.02	$ 144.56
Employee/Spouse: 50-59	$ 212.66	$ 206.40	$ 177.59
Employee/Spouse: 60+	$ 266.48	$ 258.64	$ 222.54
Employee/Child: 0-39	$ 148.50	$ 144.14	$ 124.01
Employee/Child: 40-49	$ 172.45	$ 167.38	$ 144.01
Employee/Child: 50-59	$ 211.99	$ 205.76	$ 177.03
Employee/Child: 60+	$ 265.82	$ 258.00	$ 221.98
Family Coverage: 0-39	$ 242.25	$ 235.12	$ 202.29
Family Coverage: 40-49	$ 266.19	$ 258.36	$ 222.32
Family Coverage: 50-59	$ 305.74	$ 296.74	$ 255.32
Family Coverage: 60+	$ 359.56	$ 348.99	$ 300.26

*Please review and pick the coverage of your choice. The next step is to fill out the Health insurance application below.

IMPORTANT: Please send your completed Health Insurance form to both Headcount and Medova in order to be enrolled. Please email completed forms to the following two emails: support@headcountmgmt.com and veronica.christian@medova.com.

2021 Employee Health Application Enrollment for Employer's Group Medical Plan

SECTION 1: EMPLOYER INFORMATION

Employer Name: Headcount Management Inc			
Street Address:	**City:**	**State:**	**Zip:**

SECTION 2: EMPLOYEE INFORMATION

Employee Full Name (Last name – First name – Middle name)	**Hire Date** (Required in Enrolling)	**Birth Date (mm/dd/yyyy)**	
Street Address	**City**	**State**	**Zip**
Employee Social Security # (Required in Enrolling)	**Gender** ☐ Male ☐ Female	**Tobacco Use** ☐ Yes ☐ No	
Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed			
Home Phone	**Cell Phone**	**Email Address**	
Job Title	**Hours Worked Per Week** (Required in Enrolling)		
Spouse's Employer	**Spouse's Business Phone**		

SECTION 3: OTHER INSURANCE COVERAGE

Are you, your spouse or dependents currently on COBRA?	☐ Yes	☐ No
Do you, your spouse or dependents have other health insurance coverage that will continue in addition to this coverage?	☐ Yes	☐ No
If Yes, name of Carrier:		

Policy Holder's Name:	**Policy #**	**Effective Date**
Name(s) of Covered Dependents:		

Section 4: DEPENDENT INFORMATION (Required for all participating dependents. Attach additional sheets if necessary)

First Name Last Name	Relationship	SSN # (Required if Enrolling)	DOB (mm/dd/yyyy)	Age	Gender	Tobacco Use
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No
	☐ Spouse ☐ Child				☐ M ☐ F	☐ Yes ☐ No

SECTION 5: HEALTH PLAN PARTICIPATION

- **MEDICAL**

☐ I elect coverage
☐ I decline coverage

Coverage Level (Choose)
☐ Employee Only
☐ Employee / Spouse
☐ Employee / Children
☐ Family

Plan Design Selected
☐ HealthyChoice 1000
☐ HealthyChoice 2500
☐ HealthyConsumer 6500

Reason for Decline:
☐ Spouse's Employer's Plan ☐ Individual Plan ☐ Medicare ☐ Medicaid
☐ VA Eligibility ☐ I (we) have no other coverage at this time ☐ Other:

SECTION 6: HEALTH INFORMATION (Please furnish us with the height and weight for you and your spouse)

Self: Height ____ feet _____ inches; Weight _____ lbs. **Spouse: Height ____ feet _____ inches; Weight _____ lbs.**

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

1. **Have you or any of your dependent(s) been diagnosed or treated for, or has hospitalization or surgery not yet performed been recommended for, any of the following conditions in the past five (5) years? If so, the Plan requires you to disclose these conditions solely for underwriting purposes (and you can properly disclose by checking "Yes" for each of the conditions for which you and/or your dependents have previously received diagnosis, treatment or a recommendation for hospitalization or surgery not yet performed). Although neither you nor your dependents will be denied coverage because of any previous treatment, diagnosis or recommendation for hospitalization or surgery not yet performed for any condition, if you fail to disclose any previous treatment, diagnosis, recommendation of hospitalization or surgery not yet performed for a condition listed below, the Plan will not cover any medical expenses, diagnosis, treatment, services, supplies, surgeries or hospitalizations for that undisclosed condition related or attributable, to the coverage sought as part of this application.** ***NOTE: You are required to disclose any updates to these health questions that may arise prior to the effective date of your coverage.***

A	Cardiac Disorder	☐ Yes	☐ No	I	Alcohol / Drug Abuse	☐ Yes	☐ No
B	Cancer / Tumor (any form)	☐ Yes	☐ No	J	Mental / Nervous Disorder	☐ Yes	☐ No
C	Diabetes (If yes, see A1C note below)	☐ Yes	☐ No	K	Neuromuscular Disorder	☐ Yes	☐ No
D	Kidney Disorder	☐ Yes	☐ No	L	Stomach / Gastrointestinal	☐ Yes	☐ No
E	Respiratory Disorder	☐ Yes	☐ No	M	Arthritis, Back, Bone, Joint Disorder	☐ Yes	☐ No
F	Liver Disorder	☐ Yes	☐ No	N	Seizures, Convulsions, Epilepsy	☐ Yes	☐ No
G	High Blood Pressure	☐ Yes	☐ No	O	Any Other Medical Condition (not listed above)	☐ Yes	☐ No
H	AIDS / HIV / Immune System Disorder	☐ Yes	☐ No				

2. **Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed, rated or otherwise modified?** ☐ Yes ☐ No

3. **Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, surgery, or hospitalization?** ☐ Yes ☐ No

* **If Yes, please provide information on who and for what conditions in space provided below**

4. **In the past 24 months, have you or any of your dependent(s) had more than $5,000 in medical expenses?** ☐ Yes ☐ No

* **If Yes, please provide information on who and for what medical conditions in space provided below**

5. **Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed?** ☐ Yes ☐ No

* **If Yes, please provide information below**

6. **Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant?** ☐ Yes ☐ No

* **If Yes, please provide due date and detail in space provided below**

7. **Are you or any of your dependent(s) disabled?** ☐ Yes ☐ No

* **If Yes, please provide information below for each disabled family member**

8. **In the past 12 months, have you or any of your dependent(s) been taking any medications, prescriptions or injections?** ☐ Yes ☐ No

* **If Yes, please provide detail in the Prescriptions / Medications section on the next page (Box 10)**

IMPORTANT: If you answer "Yes" to any of the questions on page 2, please provide detail in space provided on the next page.

If you answer "Yes" to Question 1.C Diabetes, please indicate the most recent A1C reading for each Diabetic Member" and include the date of that reading in the space below under "Remaining Symptoms or Problems".

9.	Question Number	Family Member	Disease / Disability / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

10. Prescriptions / Medications – List any medications, prescriptions, or injections taken in the last 12 months

Family Member Name	Medication / Rx / Injection	Dosage	Medical Condition	Currently Taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

SECTION 7: AGREEMENTS, AUTHORIZATION & ATTESTATION

Agreements

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its home office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Application that may arise prior to the effective date of my coverage.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Medical Authorization

I hereby authorize my health plan, healthcare provider, and their applicable business associates to disclose my Protected Health Information ("PHI") to Medova Healthcare Financial Group, LLC and Medova's respective carriers. I authorize Medova Healthcare and Medova's respective carriers to assist me in obtaining health care services, payment information, or account resolution. Medova Healthcare and Medova's respective carriers will not use this information for any purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, and patient advocacy services. PHI includes the following: enrollment, claims, payment, or managed-care information.

Unless otherwise revoked in writing, this authorization will commence on the date indicated below and will expire twenty-four months from the date below. I understand that:

- Information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 C.F.R. Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and the Privacy Act of 1974 (5 U.S.C. § 552a).
- I may revoke the authorization at any time by giving written notice of the revocation to Medova Healthcare Financial Group, LLC at 8300 E. Thorn Drive, Suite 300, Wichita, KS 67226. Revocation of this authorization will not affect any action that Medova Healthcare, Medova's respective carriers, or any duly authorized representatives, have taken reliance on this authorization before my written notice of revocation was received.
- Medova Healthcare Financial Group LLC provides administrative and informational services for our respective carriers only and does not provide health insurance or medical services, nor does either recommend or endorse any treatment.

Acknowledgement & Attestation

In the event that I enroll in the Plan under Medova's Lifestyle Health Plan product, I understand that the aforementioned authorization will remain in force as it relates to the normal functions and duties of Medova in conducting its administrative, care coordination, member services, and population health duties and responsibilities. I also hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and schedule of benefits and contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obtain a copy of these documents from my employer directly. Upon request, a customer service representative can explain my benefit coverage options.

Employee Signature: _____ **Date:** _____

SECTION 8: CONSENT TO ELECTRONIC DISCLOSURE OF PLAN MATERIALS

Under the Employee Retirement Income Security Act of 1974 (ERISA) and related regulations, employee consent must be given in order to receive electronic copies of employee benefits materials in certain situations. Unless I "OPT OUT," as described below, I hereby consent to receive:

(i) an electronic version of the Summary Plan Documents, Summary of Benefits and Coverage, HIPAA Portability Notice, HIPAA Privacy Notice, and other DOL, HHS, or IRS required participant notices and summaries; and

(ii) an electronic version of my claims information, including explanation of benefits (EOBs).

I understand and acknowledge that the Plan materials listed above will be available to me (and any dependents enrolled in the Plan) on the online web portal to which I will need to establish electronic access and, further, that I will receive electronic notice at the email address provided by me (or any enrolled dependent, as applicable) whenever such Plan materials become available via the online web portal.

I acknowledge, further, that I have access to email at the address provided by me, as well as access to the Internet and the ability and the necessary equipment and software to view, read, and print documents in the Adobe Portable Document Format (.pdf).

I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this authorization at any time (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to all other disclosures listed above).

I understand that I will have the opportunity to "OPT OUT" of receiving the communications described above in electronic form. (*Note, if you do not have access to email, do not have access to the Internet, or do not have the programs necessary to view .pdf files, you should "opt out" of electronic disclosure when given the opportunity to do so.*)

I have read and understand all of the above conditions, acknowledgements, and declarations and attest to the above statements.

Employee Signature: _____ **Date:** _____

SECTION 9: EMPLOYEE AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize the above-referenced Plan and any entities that provide services to such Plan to disclose certain protected health information about me to Medova Healthcare Financial Group, LLC ("***Medova***").

The Plan or any entities providing services to it are hereby authorized to disclose to Medova any protected health information from my medical records as is requested by Medova solely for the purpose of cost analysis, pricing, and/or underwriting.

I understand that this request does not apply to: (1) certain health information that is not held in the records of the Plan or any entities providing services to it; (2) psychotherapy notes (i.e., notes documenting or analyzing the contents of a conversation during a counseling session that are maintained separate from the rest of my medical record); (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed to Medova to assist me in obtaining health care services. Medova will not use this information for any purposes other than cost analysis, pricing and/or underwriting.

This authorization will expire two (2) years after the date of its execution, unless expressly revoked by me at an earlier time.

- I understand that the Plan or any entities providing services to it may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.
- I understand that I may revoke this authorization at any time by delivering a revocation in writing to Medova Healthcare Financial Group, LLC at 8300 E. Thorn Drive, Suite 300, Wichita, KS 67226. If I revoke this authorization, it will have no effect on actions already taken by the Plan or Medova in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the employee listed on this authorization.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

EMPLOYEE OR EMPLOYEE'S REPRESENTATIVE ENTITLED TO RECEIVE A SIGNED COPY OF THIS AUTHORIZATION UPON REQUEST