

Group Name _____ Group ID (if applicable) _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE EMPLOYEE. Please read and initial with blue or black ink.

I acknowledge:

- _____ It is my responsibility to read the Benefit Plan Summary and either the Group Service Agreement or Member Handbook.
- _____ I acknowledge that I have received and read the Benefit Plan Summary for the benefit plan option in which I have chosen to enroll. I understand coverage varies by benefit plan option as summarized within the Benefit Plan Summary and detailed in the Group Service Agreement and Member Handbook.
- _____ I understand that the Benefit Plan Summary lists the co-payments, coinsurance and deductible levels that I am responsible to pay.

LIMITATIONS – I am aware and understand:

- _____ It is my responsibility to read the section titled “Exclusion and Limitations” of the Group Service Agreement. Benefit Exclusions and Limitations are fully described in my online Member Handbook.
- _____ Pre-existing Conditions: A twelve- (12) or eighteen- (18) month waiting period will apply for pre-existing conditions if I do not provide a Certificate of Creditable Coverage documenting sufficient prior coverage to eliminate the pre-existing condition waiting period. It is my responsibility to supply all letters of creditable coverage from previous health insurers to HCG in order to waive any pre-existing restrictions. Failure to do so may result in my claims being denied.
- _____ Only medications listed on my health plan’s formulary (prescription drug list) are covered. The formulary drugs are subject to a co-payment or coinsurance and may be subject to step therapy requirements, prior authorization, and annual limits. Most injectable medications are not covered on Healthstyles benefit plans. I understand that no exceptions will be made to the formulary.
- _____ Healthstyles benefit plans do NOT cover mental health, substance abuse or chiropractic services. Medications used to treat mental health conditions (such as depression, anxiety and ADD) are covered only if listed on my health plan’s formulary.
- _____ Maternity care is not a covered benefit on the Active Healthstyles benefit plan option.
- _____ If my provider refers me to, or uses the services of, a non-contracted provider or facility for non-emergent services, I am totally responsible for the cost of that care. These non-contracted non-emergent services could include reference labs, pathology labs, radiology centers, DME vendors, and suppliers. I understand that it is my responsibility to ask if the services are with a contracted provider and request that the services be provided by a contracted provider, or I may be responsible for the cost of the services even if they are a covered service under my Benefit plan option.
- _____ If I personally decide to use the service of a non-contracted provider or hospital for any non-emergent services without a referral, I am totally responsible for the cost of that care. This includes, but is not limited to, provider, hospital, reference labs, pathology labs, radiology centers, DME vendors, and suppliers.
- _____ All members are subject to a first-year, twelve (12) months of continuous coverage dollar cap of \$100,000 on medical benefits.

Group Name _____ Group ID (if applicable) _____

DEDUCTIBLES – I am aware and understand:

_____ All members are subject to an annual deductible and are responsible to read the section titled “Member Co-payments, Coinsurance and Deductibles” in the Group Service Agreement.

_____ All members are responsible to pay all co-payments, coinsurance and deductibles as listed on the Member’s benefit plan option Benefit Plan Summary. Services subject to the deductible are listed on the Benefit Plan Summary.

_____ Every January 1st the deductibles are set to zero and the Member must pay the full amount of the deductible before HCG pays for any services subject to the deductible. There is no carryover of accumulated deductible to the following calendar year regardless of the renewal date.

_____ Co-payments and coinsurance are my responsibility to pay and do not apply toward meeting my annual deductible.

_____ Co-payments and coinsurance are the member’s responsibility to access services, in addition to the deductible.

_____ The deductible for a family plan equals two (2) times the individual deductible regardless of family size.

This checklist includes a partial list of the limitations and exclusions. A complete list of limitations and exclusions is provided in the correlating Group Service Agreement and/or Member Handbook. Please retain a copy for your records.

<p>Business/Group Name (please print) _____</p> <p>Employee Name (please print) _____</p> <p>Employee Signature _____ Date _____</p>
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