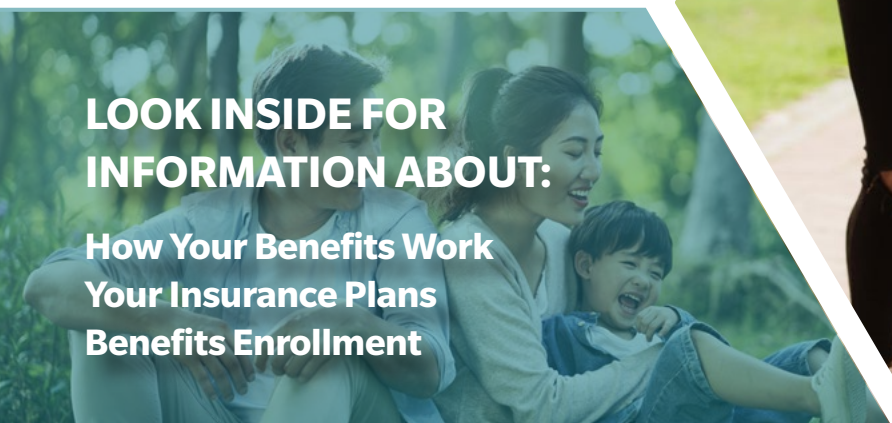
MANAGEMENT REGISTRY INC.

Benefits Enrollment Guide

2022 PLAN YEAR



LOOK INSIDE FOR INFORMATION ABOUT:

How Your Benefits Work
Your Insurance Plans
Benefits Enrollment

Table of Contents

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.

See the Medicare Part D Notice on page 28.

Dear Employee:

We are committed to providing employees with a comprehensive and market competitive benefits program. Our ongoing goal first and foremost is to maintain an employee benefits program that delivers high quality healthcare at an affordable price, both to you and to the company. Your benefits are a significant and valuable part of your compensation and we believe it is important for you to see the value in the benefits we offer.

The Benefits Guide has been designed to assist you in determining the coverage levels that will provide you and your family with the protection that gives you peace of mind. You will find explanations for each type of coverage, suggestions on how to effectively use your benefits, and examples to help you determine your benefit and payroll deductions.

If your Spouse has group medical coverage available through his or her employer (outside of Malone), he or she is not eligible for coverage on Malone's plan. If Malone's medical plan is the only source for benefits, your Spouse can be covered under Malone's plan. However, you will be required to complete a Spousal Eligibility Affidavit (Separate Form) and return it to Human Resources.

Once your enrollment is complete, you may print a summary of your benefit elections for your records.

Thank you for your participation.

Human Resources

If You're a New Employee

You and your eligible family members can participate in the benefits package 7 days after you complete your enrollment.

Who Can Enroll?

You are eligible to participate in the benefit plans if you are a regular full-time active employee, and are scheduled to work 30 hours or more per week.

Eligible dependents include:

- Your legal spouse (Common Law Spouses and Domestic Partners are not eligible for coverage).
- Your natural children, stepchildren, children for whom you assume legal guardianship, legally adopted children or children placed for adoption up to age 26
- Dependent children age 26 or older incapable of self-support due to mental or physical disability incurred prior to age 26. You will be required to provide documentation.

Some Information You Will Need to Enroll Online

In order to make the enrollment process as smooth as possible, it will help if you have the following information:

- Your name, date of birth and Social Security Number.
- The name(s), date(s) of birth and Social Security Number(s) of your spouse and dependent children up to age 26 (if you plan to cover them on the plans).
- Your current address. This will also ensure that your ID cards and other important benefit information are sent to the correct address.
- The full name and relationship of your beneficiary. If you want to leave your life insurance benefits to any child(ren) under age 18, including your own child(ren), you must set up a trust or designate a guardian to hold and manage the money. By law, children under age 18 cannot control assets, so if you do not establish a trust or designate a guardian, the court will name a guardian, either a person or financial institution, for your life insurance benefits.

Qualifying Events

You may change your benefits coverage within 31 days of a qualifying event. Some examples of qualifying events are:

- To add dependents: marriage, birth, placement for adoption, legal custody of a child, dependent loses benefit eligibility at his/her work, or a dependent's Open Enrollment.
- To remove a dependent: divorce, death of the dependent, loss of dependent status, or dependent gains eligibility for benefits at his/her job.
- If you have a Qualifying Life Event, please contact your Human Resources representative within 30 days of the event. You will be required to provide Human Resources with documentation of the event.

About Payroll Deductions

Your premiums for Medical, Dental, Vision, Flexible Spending Account elections, Hospital and Accident plans will be deducted on a pre-tax basis because they are covered under Section 125 of the Internal Revenue Service Code. This means that once you elect to enroll in any of these plans, you will not be allowed to drop or change your election until the company's next Open Enrollment unless you have a qualifying event. Your Telemedicine, Voluntary Life, Voluntary Short Term Disability, Critical Illness, Identity Theft, Legal Plan and Pet Insurance premiums will be deducted on an after-tax basis.

Section 125 Tax Savings

Section 125 of the Internal Revenue Code allows an employer to let employees pay their share of the cost of medical benefits under the employer's plan with income that is never taxed. This is done simply by allowing you to reduce your taxable income by the amount you pay for eligible benefits. Considering federal income taxes, state income taxes (where applicable), and social security, most employees would be in at least a 24% marginal tax bracket. Some employees will have higher tax rates, such as families with two incomes.

The Gross Cost shown on the chart below is an example of the amounts someone enrolled in the Employee Only options for Medical, Dental, and Vision will have deducted from pay. Withholding for taxes will be reduced by the taxes that would have been paid if this amount were counted as income - this saves the employee $14.13 per paycheck, equaling over $725 per year.

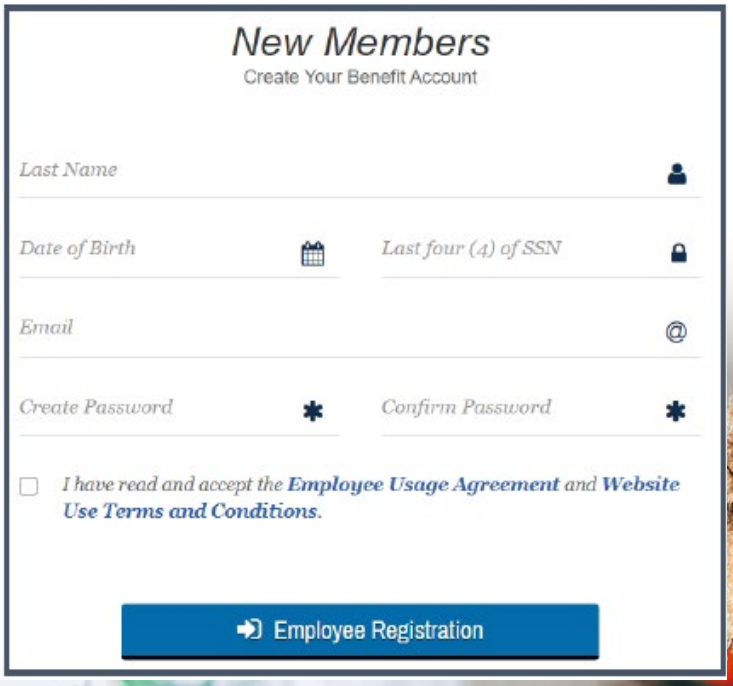
Example Tax Savings for Employee Only Coverage				
	Employee Medical Cost	Employee Dental Cost	Employee Vision Cost	Employee Total Cost
Gross Cost (Payroll Deduction)	$43.12	$13.44	$1.72	$58.28
Less Estimated Tax Savings	$10.35	$3.23	$0.41	$13.99
Net Cost	$32.77	$10.21	$1.31	$44.29

2022 Enrollment Process

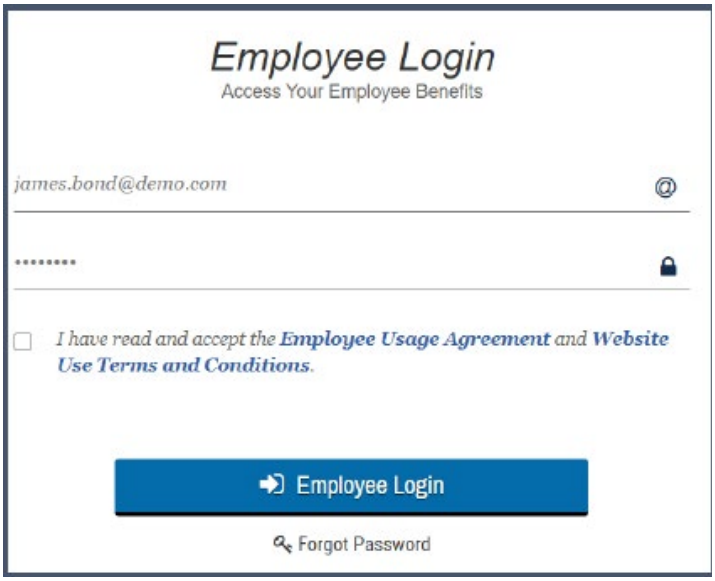
Welcome to your employee benefits supersite! Please visit https://www.mybensite.com/malonesolutions/ to complete your benefits enrollment as well as to access all of the following:

- Benefit summaries
- Side by side comparisons
- Insurance carrier information
- Member service information
- Provider search directories
- Forms and plan documents

The first time you visit the site, use the “New Members” box to enter your last name, date of birth, and last 4 digits of your Social Security Number. You will then enter your email address (this is required and is used as your username to log in) and create a password to complete your registration.



After you have registered, use the “Employee Login” section to log in by entering your email address and password, then check the box to agree to website terms and conditions.



Whether you are enrolling for the first time, making changes due to a qualifying event, or completing your annual open enrollment, visit https://www.mybensite.com/malonesolutions/.

Medical Coverage (Anthem BlueCross BlueShield)

Open Access POS Plan

The Open Access POS plan does not require a member to choose a primary care physician or to obtain referrals for specialty care. Members must use an Open Access POS In-Network provider in order to receive In-Network benefits.

This plan does allow you to seek care from a provider who is not in the network. If you make this choice, you will pay a larger portion of expenses out of your pocket, and the benefits may be subject to reduction based on what is reasonable and customary for your area, which could result in a greater out of pocket expense for you.

Some of the covered services require only a copay. Other covered services require the member to meet a deductible and then pay a percentage of the covered expenses. When you reach the annual Out-of-Pocket maximum, the plan pays most remaining covered expenses at 100%. In accordance with healthcare reform, all member cost share amounts apply to the Out-of-Pocket annual maximum. This includes office visit copays, prescription drug copays, and coinsurance.

You can access the provider directory online at www.anthem.com (see instructions on next page). For help locating an In-Network provider or to check the status of your provider, you may also call 1-855-397-9267.

The Prescription Drug Program

The medical plan includes the Essential Prescription Drug List that outlines the most commonly prescribed medications for certain conditions and divides them into tiers. Your costs may change depending on a medication's tier placement. For more information, please visit http://www.anthem.com/pharmacyinformation/ and click on Essential Drug List 4-Tier (searchable).

Spouse Coverage

Malone does not cover Spouses with access to group medical coverage.

If your Spouse has group medical coverage available through his or her employer (outside of Malone), he or she is not eligible for coverage on Malone's plan. If Malone's medical plan is the only source for benefits, your Spouse can be covered under Malone's plan. However, you will be required to complete a Spouse Eligibility Affidavit (Separate Form) and email it to HR@malonesolutions.com.

Important Notice: If false information is provided, it will be regarded as a violation of your ethical responsibility as a Malone employee, and will lead to disciplinary action, up to and including termination of employment. In addition, an employee who is found to have provided false information will be held responsible for premiums that Malone paid.

Looking for a doctor?

Finding one online is fast and easy.

Use Anthem BlueCross BlueShield's online Find a Doctor tool to look for doctors, hospitals, pharmacies, labs and other health care providers in your network. Check if your favorite doctor is in the network, or look for one near you.

Locating an In-Network Medical Provider

- Go to www.anthem.com.
- Click on the "Find a Doctor/Find Care" link near the top right of the page.
- You may search as a Member or Guest. If you search as a Guest, click on "Guests," and answer the questions on the page.
  - Under, "What type of plan do you want to search with?" select "Medical (Employer Sponsored)."
  - Under "Select a plan/network" select "Blue Open Access POS (Select Network)" for providers in Georgia, or "National PPO (BlueCard PPO)" for providers outside of Georgia.
- Click "Continue."
- In the box with the magnifying glass, enter the type of provider specialty or facility, or enter the name of the specific provider or facility you are looking for. You may need to enter the city, county, or zip code for your search.
- A drop down list will populate with options you can select from, or you can click "View All" at the top right of the list to see all options on a new page.

Medical Coverage (Anthem BlueCross BlueShield)

Please go online to https://www.mybensite.com/malonesolutions/ and view the Summaries of Benefits and Coverage (SBCs).

Anthem BlueCross BlueShield Medical Summary of Benefits		
	Copay Plan	
	In-Network	Out-of-Network
Annual Deductible		
Individual	$500	$1,500
Family	$1,500	$4,500
Out-of-Pocket Maximums *(includes deductibles and all copays)*		
Individual	$5,000	$10,000
Family	$15,000	$30,000
Coinsurance	80%	60%
Lifetime Maximum	Unlimited	Unlimited
Office Visit Copays		
PCP	$25	60% after deductible
Specialist	$50	60% after deductible
LiveHealth Online (Virtual PCP Visits)	$0 copay for the first 12 visits, then a $25 copay	60% after deductible
Psychiatrist/Therapist Visits	$25 copay	60% after deductible
Preventive Services		
Well Child Exams	100% *(no copay)*	60% after deductible
Routine Adult Physicals	100% *(no copay)*	60% after deductible
Routine Pap Tests	100% *(no copay)*	60% after deductible
Routine Colonoscopy	100% *(no copay)*	60% after deductible
Routine Mammogram	100% *(no copay)*	60% after deductible
Inpatient Hospital	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Urgent Care	$60 copay	60% after deductible
Emergency Room *(waived if admitted)*	$300 copay, then 100%	$300 copay, then 100%
Prescription Drugs		
Retail *(30-day supply)*		
Tier 1	$10 copay	
Tier 2	$30 copay	
Tier 3	$50 copay	
Tier 4	20% up to a $300 maximum per drug	
Retail Maintenance *(90-day supply)*	3 x copay	
Maintenance Drugs		
Mail Order *(90-day supply)*	2 x copay	
Weekly Payroll Deductions		
Employee Only	$43.12	
Employee + Spouse	$141.00	
Employee + Child(ren)	$120.69	
Family	$261.70	

LiveHealth Online (Anthem BlueCross BlueShield)

All employees and family members who are enrolled in the medical plan will have convenient online access to a board certified PCP doctor, a board-certified psychiatrist or a licensed therapist. There is no cost to you for the first 12 PCP doctor visits, then it's a $25 copay per visit. There is a $25 copay per visit for psychiatrist or therapist visits.

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed. It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.
- **Visit a licensed therapist in four days or less.** Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call 1-888-548-3432 seven days a week.
- **Consult a board-certified psychiatrist within two weeks.** If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call 1-888-548-3432 seven days a week.

Download the app now!

Start a conversation now.

Just enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

apple.com

play.google.com/store

Anthem BlueCross BlueShield Preventive Care Services

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life. When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care – what's the difference?

Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

You may refer to www.anthem.com, click "Individual and Family" at the top left hand side of the web page, then click on "Preventive Health" in the middle of the page to find out what preventive care services are appropriate for your age group. You can also ask your doctor what's right for you, based on your age and health condition(s).

Diabetes Program (Essential Drug List)

This program lowers the cost you pay for diabetes drugs. You can get the prescriptions and supplies on this list at no cost to you. That makes it easier for you to get the drugs you need to manage your diabetes and stay healthy.

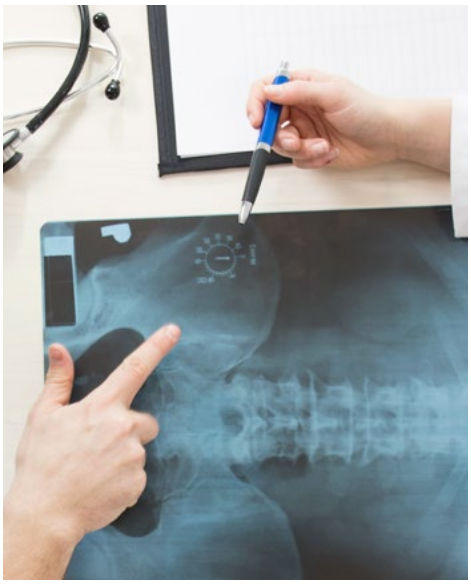
The drug list includes brand and non-brand (generic) products, so you can choose from a range of quality drugs. Most brand-name drugs that have a generic equivalent available are not covered under this benefit.

If you and your doctor agree that a covered drug is a good treatment option, you will need a new prescription. Then, you can fill the prescription at a retail pharmacy or through home delivery.

Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips by Lifescan & Roche will be covered by this benefit.

Health and Wellness Programs

Whether you're suffering from asthma, expecting a baby, or just fighting a cold, the Anthem BlueCross BlueShield health and wellness programs can help. They even include toll-free access to a nurse any time, any day.



Condition Care (1-800-638-4754)

If you have a long-term health problem, ConditionCare is for you. It's a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. When you join the program, you'll receive tools and resources to take charge of your health, including:

- 24/7 phone access to a nurse care manager for questions and up-to-date information about your condition
- A health review and follow-up calls if you need them
- Tips on prevention and lifestyle choices to help you improve your quality of life

Future Moms (1-800-828-5891)

Future Moms can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you're pregnant. You'll get:

- 24/7 phone access to a nurse coach you can talk to about your pregnancy and your health
- The Mayo Clinic Guide to a Healthy Pregnancy book that shows changes you can expect for you and your baby over the next nine months
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks
- Visit with a lactation consultant online at no cost to you. Sign up now for livehealthonline.com, create an account and select Future Moms with Breast Feeding Support. Schedule your appointment at any time.

24/7 NurseLine (1-888-724-2583)

You can call any time to talk to a registered nurse about your health concerns. You can get answers to questions, whether you're sick or not. Need health care right away? A nurse can help you decide where to go if your doctor isn't available. Going to the right place can save you time and money. And you can access better care, too.

Sydney Health Mobile App

Access these services through the Sydney Health mobile app

Total Health, Total You gives you the tools to help you engage with your health, work on lifestyle changes, and connect with specialized health professionals, no matter where you are. To access your Total Health, Total You benefits, use the Sydney Health mobile app:

- View your health plan details
- Access your digital ID card
- Find local doctors
- Participate in wellness activities

You can also call or chat with a Health Guide, who can answer your health care questions and make sure you are making the most of your benefits.

If you need extra support, a Health Guide can connect you to a team of health professionals, such as nurses, social workers, dietitians, respiratory therapists, pharmacists, exercise physiologists, and health coaches.

Access to your care can be as simple as picking up your smartphone

Have peace of mind

Clearly see what your plan covers, how much services cost, and where you have spent your health care dollars

Find doctors who are right for you

Search for high-quality doctors and specialists near you, in your network, and rated by real patients.

Take care of your health

Access a Health Guide or find well-being programs that can help you track your fitness and nutrition, all in one place.

GoodRx

What happens if my insurance doesn't cover a prescription or I can't afford it due to a high deductible?

You can use a GoodRx discount instead of your prescription insurance if the cost is lower.

What is GoodRx?

GoodRx is a powerful free mobile app and website that can help you save money by locating the lowest prescription prices at your local pharmacies. Use the price comparison tool on your mobile app or at goodrx.com to save up to 80% on virtually all FDA-approved drugs – brand-name and generic. GoodRx gathers prices, coupons and savings tips for prescriptions at virtually every U.S. pharmacy to help you fight against high drug prices. It can be used for your pet medications as well!

Does it cost anything to use GoodRx?

No, it's 100% free and works for every member of your family. Simply use the GoodRx website or mobile app to search for your prescriptions and then use the free coupons at your local pharmacy to save. You can find savings of 80% or more on your prescriptions. Because prices vary wildly between pharmacies, you will need to search for your prescription on GoodRx for an exact price.

Is GoodRx insurance?

No. GoodRx is not a type of health plan or insurance. GoodRx is a service that will help you find lower drug prices. You can use GoodRx instead of your insurance when it offers a lower price than your insurance plan. If you purchase prescriptions using GoodRx instead of through your insurance plan, the cost will not apply to your deductible or out-of-pocket amounts. It may make more financial sense to use your insurance to satisfy your deductible and out-of-pocket amounts depending on what your insurance plan pays and what the GoodRx discount is.

What if the Pharmacist will not allow me to use GoodRx?

If you choose to use a GoodRx coupon, it's important to ask the pharmacist not to run your prescription through your insurance. Ask that the pharmacist use the coupon to process the transaction as cash instead. If your pharmacist has any trouble using the discount instead of your insurance, please give GoodRx a call at 1-855-268-2822 (between the hours of 9a.m. and 8p.m. EST).

Telemedicine (HealthiestYou)

If you are enrolled in the Medical Plan you have access to LiveHealth Online, a similar plan to HealthiestYou.

This benefit offers 24/7 access to its proprietary nationwide network of U.S. licensed physicians for telephone medical consultations. Physicians provide specific answers to medical questions and give advice regarding non-emergency, routine medical conditions. Physicians discuss symptoms, recommend treatment options, diagnose common conditions and send an e-script to your choice of pharmacy when appropriate. You can connect via telephone free of charge, with a network of physicians for informational or diagnostic consultation.

Featured highlights include:

- $0 copay
- Coverage is provided for all family members
- Never wait for an appointment or sit in the doctor's office
- Access to a physician from anywhere via telephone 24/7
- Save money by avoiding unnecessary doctor's office or ER visits
- Prescriptions sent via e-script to your choice of pharmacy
- HIPAA compliant and confidential

When to Call HealthiestYou

- When your physician is not available
- For non-emergency medical conditions or questions
- After normal business hours, nights, and weekends
- For requesting prescriptions or refills

Be sure to download the HealthiestYou App today!

Download on the App Store | ANDROID APP ON Google play

PRESCRIPTION SAVINGS
Geo-based prescription search engine can save you up to 85% on your prescription.

SHOP & PRICE PROCEDURES
Mobile app puts you in the driver's seat by providing a vehicle to search and price procedures in your direct area.

LOCATE PROVIDERS
Mobile app will lead you through the process to search for a doctor, dentist, or other provider.

HEALTH MANAGEMENT CONTENT
Let HealthiestYou guide you to improved health and happiness with relevant health content delivered at the time of need.

SYNC YOUR MEDICAL BENEFITS
Mobile app provides you the option to enroll to view your medical plan deductible in real time. Research in-network and out- of-network providers for medical, dental, vision, and specialists.

HealthiestYou will mail a welcome packet to your home that will include directions on setting up physician access, medical history and downloading the mobile app. You will also receive a HealthiestYou card in the mail which is simply a benefit reminder card – it is not needed to use the service.

HealthiestYou Weekly Payroll Deduction	$1.38

** Not available in Arkansas or Idaho.*

Voluntary Dental PPO Plan (Anthem BlueCross BlueShield)

Voluntary Dental PPO Plan

Dental benefits are available to you and your eligible family members to cover routine care such as exams, x-rays and cleanings, as well as fillings, dentures, bridgework and periodontal care. Orthodontia is also available for adults and children.

Malone's dental plan benefits have been designed to allow employees and their dependents to use the dental provider of their choice, regardless of their network status. If you choose to see an out-of-network provider your out-of-pocket costs may be higher. You can access a provider directory online at www.anthem.com (plan network-Dental Complete) or for help locating a network provider, call 1-877-604-2158.

Locating an In-Network Dental Provider

- Go to www.anthem.com.
- Click on the "Find a Doctor/Find Care" link near the top right of the page.
- You may search as Member or a Guest. If you search as a Guest, click on "Guests," and answer the questions on the page.
  - Under, "What type of plan do you want to search with?" select "Dental".
  - Under "Select a plan/network" select Dental Complete.
- Click "Continue".
- In the box with the magnifying glass, enter the type of provider specialty or facility, or enter the name of the specific provider or facility you are looking for. You may need to enter the city, county, or zip code for your search.
- A drop down list will populate with options you can select from, or you can click "View All" at the top right of the list to see all options on a new page.

Dental Plan Summary of Benefit	Basic Plan	Premium Plan
Calendar Year Deductible*	$25 Individual / $75 Family	$25 Individual / $75 Family
Calendar Year Maximum	$1,500	$2,500
Preventive Services • Routine Oral Exams • Routine Cleanings (two per year) • Topical Applications of Fluoride • Space Maintainers • Dental X-Rays • Sealants	Plan pays 100% *(no deductible)*	Plan pays 100% *(no deductible)*
Basic Services* • Fillings • Oral Surgery • Simple Extractions • Periodontal Maintenance	Plan pays 80% *(deductible applies)*	Plan pays 100% *(deductible applies)*
Major Services* • Inlays and Onlays • Implants • Crowns and Bridges • Re-cement Crowns and Bridges • Dentures • Repair of Fixed Bridge • Endodontics • Periodontic Surgery	Plan pays 50% *(deductible applies)*	Plan pays 80% *(deductible applies)*
Orthodontic Services *For adults and children*	Plan pays 50% *(no deductible)*	Plan pays 50% *(no deductible)*
Orthodontic Lifetime Maximum	$2,000	$3,000

** There is a maximum of three deductibles per family.*

Dental Weekly Payroll Deductions	Basic Plan	Premium Plan
Employee	$9.35	$13.44
Employee + Spouse	$26.19	$39.71
Employee + Child(ren)	$26.19	$39.71
Family	$26.19	$39.71

Voluntary Vision (Anthem BlueCross BlueShield)

It is important to preserve your eye health and receive regular eye exams. Did you know that diabetes, heart disease, high blood pressure, and high cholesterol are all diseases that an eye care specialist can detect from an eye exam?

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters, Target Optical, JC Penney Optical, Sears Optical and Pearle Vision locations. Members may call Blue View Vision at 1-866-723-0515 with questions about vision benefits or provider network status.

Out-of-Network Services

Members may choose to receive care outside the Blue View Vision network. Members receive an allowance toward services and pay the balance. Members pay in full at the time of service and then file a claim for reimbursement.

Locating an In-Network Vision Provider

- Go to www.anthem.com.
- Click on the "Find a Doctor/Find Care" link near the top right of the page.
- You may search as Member or a Guest. If you search as a Guest, click on "Guests," and answer the questions on the page.
  - Under, "What type of plan do you want to search with?" select "Vision".
  - Under "Select a plan/network" select Blue View Vision.
- Click "Continue".
- In the box with the magnifying glass, enter the type of provider specialty or facility, or enter the name of the specific provider or facility you are looking for. You may need to enter the city, county, or zip code for your search.
- A drop down list will populate with options you can select from, or you can click "View All" at the top right of the list to see all options on a new page.

Anthem BCBS Vision Summary of Benefits		
	Anthem BCBS Vision Network	**Out-of-Network**
Exam	Plan pays 100% after a $10 copay	Plan pays up to $30 reimbursement
Lenses (One Pair)		
Single Vision	Plan pays 100% after a $10 copay	Plan pays up to $25 reimbursement
Bifocal	Plan pays 100% after a $10 copay	Plan pays up to $40 reimbursement
Trifocal	Plan pays 100% after a $10 copay	Plan pays up to $55 reimbursement
Eyeglass Lens Upgrades	Member Cost	Discounts on lens upgrades are not available out-of-network
UV Coating	$15	
Tint *(Solid and Gradient)*	$15	
Standard Polycarbonate *(adults/children under age 19)*	$40/$0	
Transitions lenses *(adults/children under age 19)*	$75/$0	
Progressive Lenses		
Standard	$65	
Premium Tier 1	$85	
Premium Tier 2	$95	
Premium Tier 3	$110	
Standard Anti-Reflective Coating	$45	
Premium Tier 1 Anti-Reflective	$57	
Premium Tier 2 Anti-Reflective	$68	
Other Add-ons and Services	20% off retail price	
Contact Lenses *(in lieu of lenses and frames, contact lens allowance must be used at the time of initial service)*	Plan pays up to $150, then 15% off remaining balance (conventional)	Plan pays up to $105 reimbursement
Contact Fit & Follow Up Exams		
Standard	Member cost up to $55	Discounts not available out-of-network
Premium (Allowance)	10% off retail price	
Medically Necessary	Covered in full	Plan pays up to $210 reimbursement
Frames	Plan pays up to $150, then 20% discount; Member pays remainder	Plan pays up to $45 reimbursement
Frequencies (months)		
Exam / Lenses / Frames	Once every calendar year	

Vision Weekly Payroll Deductions	
Employee	$1.72
Employee + Spouse	$3.41
Employee + Child(ren)	$3.08
Family	$4.77

Voluntary Life (Mutual of Omaha)

Voluntary Life Insurance provides extra protection for your family in the event of your untimely death.

You can enroll in the Voluntary Life plan up to the guarantee issue amounts (see below) for yourself, your spouse and your children without completing a health questionnaire. You will be required to complete a health questionnaire for yourself and your dependents for all life amounts over the guarantee issue amounts.

Employees:

- Increments of $10,000 up to a maximum of $500,000, not to exceed 10 times annual earnings.
- Guaranteed issue amount for New Hires is $200,000.
- Life Insurance reduces by 35% at age 65, and an additional 15% at age 70. Benefits terminate at retirement.

Spouse:

- Increments of $5,000 to a maximum of $100,000, not to exceed 100% of the employee's coverage.
- Guarantee issue amount is $50,000.
- Spouse life amounts reduce based on employee's age.

Dependent Children:

- Age 15 Days to age 26 years. You may elect dependent coverage of $5,000 to a maximum of $10,000, not to exceed 100% of the employee's coverage.
- Guarantee issue amount is $10,000.
- Once child coverage is elected, the amount of insurance covers each of your dependent eligible children for the one premium price.

Note: This policy requires the employee to be actively at work on the first day of coverage. Dependents cannot be hospital confined and must be able to perform all of the usual duties of a person who is at the same age and gender who is in good health in order for coverage to be effective.

Sample Voluntary Life Weekly Payroll Deductions

Please note: Spouse premiums are calculated based on the employee's age.

Employee Voluntary Life Weekly Payroll Deductions					
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**
Under 25	$0.12	$0.23	$0.35	$0.46	$0.58
25-29	$0.14	$0.28	$0.42	$0.55	$0.69
30-34	$0.16	$0.32	$0.48	$0.65	$0.81
35-39	$0.18	$0.37	$0.55	$0.74	$0.92
40-44	$0.32	$0.65	$0.97	$1.29	$1.62
45-49	$0.51	$1.02	$1.52	$2.03	$2.54
50-54	$0.88	$1.75	$2.63	$3.51	$4.38
55-59	$1.48	$2.95	$4.43	$5.91	$7.38
60-64	$2.05	$4.11	$6.16	$8.22	$10.27
65-69	$3.60	$7.20	$10.80	$14.40	$18.00
70-74	$6.74	$13.48	$20.22	$26.95	$33.69
75+	$6.74	$13.48	$20.22	$26.95	$33.69

Spouse Voluntary Life Weekly Payroll Deductions (Spouse rates are based on employee age)					
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**
Under 25	$0.06	$0.12	$0.17	$0.23	$0.29
25-29	$0.07	$0.14	$0.21	$0.28	$0.35
30-34	$0.08	$0.16	$0.24	$0.32	$0.40
35-39	$0.09	$0.18	$0.28	$0.37	$0.46
40-44	$0.16	$0.32	$0.48	$0.65	$0.81
45-49	$0.25	$0.51	$0.76	$1.02	$1.27
50-54	$0.44	$0.88	$1.32	$1.75	$2.19
55-59	$0.74	$1.48	$2.22	$2.95	$3.69
60-64	$1.03	$2.05	$3.08	$4.11	$5.13
65-69	$1.80	$3.60	$5.40	$7.20	$9.00
70-74	$3.37	$6.74	$10.11	$13.48	$16.85
75+	$3.37	$6.74	$10.11	$13.48	$16.85

Child Coverage	
$5,000 (per child)	$0.10 per weekly payroll deduction
$10,000 (per child)	$0.21 per weekly payroll deduction

Disability (Mutual of Omaha)

Voluntary Short Term Disability (STD)

Short Term Disability provides a weekly benefit to replace a portion of your income in the event you are disabled. If you have an injury or sickness and have received medical care or advice, or had drugs prescribed or taken in the 3 months prior to the day you become covered under this plan, benefits will not be paid for this condition until you have been covered for 6 continuous months.

Short Term Disability Summary of Benefits	
Benefit Amount	60% of Base Weekly Earnings
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	24 Weeks
Benefits Begin	15th Day for Accident; 15th Day for Illness

STD Rate Calculated by Age	
Age	**Rate**
< 30	$0.58
30-39	$0.55
40-49	$0.56
50-59	$0.79
60+	$1.43

Calculating your Weekly Premium for Short Term Disability

Your Coverage:

$_____ x 0.60 = _____ x _____ ÷ 10 x 12 / 52 = $_____

(Your Weekly Base Earnings) — *(Your Weekly Benefit to a maximum of $1,000)* — *(See rates by age in chart)* — *Weekly Premium*

Employee Assistance Program – EAP (Mutual of Omaha)

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

EAP Benefits

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week.
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Five face-to-face sessions with a counselor per calendar year
  - Face-to-face visits can also be used toward legal consultations
  - California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.
- Legal assistance and financial services
  - Online will preparation
  - Legal library and online forms
  - Telephonic financial consultation
- Resources for:
  - Financial tools and resources
  - Substance abuse and other addictions
  - Dependent and elder care assistance and referral services
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap

Flexible Spending Accounts (iSolved, formerly Infinisource)

What is a Flexible Spending Account (FSA)?

Flexible Spending Accounts (FSA) allow you to pay health care and dependent care expenses with pre-tax dollars. This reduces your taxable wages by the amounts you contribute to your health care and/or dependent care accounts. Funds are deducted through payroll before taxes are withheld. Amounts elected are divided by the number of pay periods remaining in the plan year (January 1 – December 31). You must re-enroll each year.

There are 2 separate Flexible Spending Accounts:

- **Dependent Care FSA:** Any employee with children in day care knows that a sizable amount of the family's income is used for this expense. The same is true for those who must provide day care for a disabled spouse or parent. You may elect to contribute a maximum of $5,000 if you are single or if you are married and filing a joint tax return. If you are married and filing separate returns, you may elect to contribute a maximum of $2,500 for the calendar year.
- **Health Care FSA:** Our health care plan is a valuable benefit that provides coverage for many medical, dental, and vision expenses. Yet we all spend money every year for deductibles, copayments, and other out-of-pocket expenses our health plan doesn't pay. You may elect to contribute a maximum of $2,750 for the calendar year. The Healthcare FSA will reimburse your expenses as they occur, up to your elected contribution.

Carry Over up to $500 of your Health Care funds

You have until the end of the plan year (December 31, 2022), to use your FSA Health Care funds. You can carry over up to $500 in unused Health Care funds into the next plan year. Any unused funds greater than the carryover limit ($500) are forfeited after the last day of the plan year provided you make an election to participate again. You will have until March 31, 2023 to submit claims for expenses incurred between January 1, 2022 and December 31, 2022.

If you carry over funds into Plan Year 2023 (January 1, 2023 through December 31, 2023), you can still contribute up to $2,750 for that plan year.

Run-out Period

This is the time period after the close of the plan year when you can still file Dependent Care and Health Care FSA claims from the previous plan year. You have until March 31, 2023 to submit claims for Plan Year 2022 expenses incurred between January 1, 2022 and December 31, 2022.

A Flexible Spending Account Example

Jay and his wife, Candy, earn a combined annual income of $75,000. They have two small children whom they claim as dependents on their income tax return. Jay contributed $2,750 to the Health Care Reimbursement Account and $5,000 to the Dependent Care Reimbursement Account. **This example is for illustrative purposes only. Actual savings will vary based on your individual tax situation. Please consult a tax professional for more information.*

Jay's Expenses	With FSA	Without FSA
Combined annual income	$75,000	$75,000
Health Care Reimbursement Account contributions	- $2,750	$0
Dependent Care Reimbursement Account contributions	- $5,000	$0
Taxable Income	$67,250	$75,000
Estimated Federal and Social Security taxes	- $13,450	- $15,000
Health care and dependent care expenses	$0	- $7,750
Your spendable income	$53,800	$52,250
Money saved with reimbursement accounts	**$1,550**	

Flexible Spending Accounts (iSolved, formerly Infinisource)

What Expenses are Eligible?

- Go to fsastore.com/FSA-Eligibility-List.aspx to search eligible products and services.
- Dependent care expenses must be for children in daycare through age 12 and adult family members who need daily care so that the adult(s) that claim(s) the dependents on a federal tax income return can work.
- They are not eligible for reimbursement from any other source.
- You have retained documentation from the provider of the services or supplies which shows the amount of each expense and the date it was incurred.

Accessing Your Flexible Spending Account is Easy!

The Benefits Card is a swipe card (similar to a credit card) used to pay for eligible expenses. If you have a Health Care FSA, you can charge up to the amount you have elected. You will also have the ability to use the Benefits Card to pay for eligible Dependent Care expenses as long as the provider accepts credit/debit cards and the funds are available in your account.

Use the iFlex App

You have your phone with you all the time. Why not use the iFlex App to review your account information, take a photo of the receipt and submit the claim right away?

The iFlex App connects you with the details:

- Quickly check available balances 24/7
- Access account details
- View charts summarizing account(s)
- Click to call or email Customer Service

Provides additional time-saving options (if supported or applicable to your accounts)

- View claims requiring receipts
- Submit medical FSA claims
- Take a picture of a receipt to submit for a claim
- Report a lost or stolen debit card

Follow these steps to download the iFlex App:

1. Visit the iTunes App Store or the Android Market to download the iFlex by Infinisource app on your iPhone, iPad or Android.
2. Once installed, enter the Username and Password to log into your account at www.isolvedbenefitservices.com/login.

Voluntary Aflac Products – Accident and Hospital Indemnity Insurance

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations of the plan.

Aflac Accident Insurance (24-Hour Coverage)

After a covered accident, you may have expenses you've never thought about before. Can your finances handle them? It's reassuring to know that an Aflac Accident insurance plan can be there for you through the many stages of care—from the initial emergency treatment or hospitalization, to follow-up treatments or physical therapy.

In addition, your regular bills, such as the mortgage or rent, car payments, and utility bills, don't stop when you're injured after a covered accident. Aflac Accident insurance plan benefits are paid directly to you (unless you choose otherwise), so you can use them to help with your normal bills as well as unexpected out-of-pocket costs.

Plan Details:

- Hospital Admission Benefit: $900
- Hospital Confinement Benefit (per day): $225
- Hospital Intensive Care (per day): $300
- ER/Urgent Care Visit: $150
- Wellness Benefit: $25 up to $75
- Accidental Death: $50,000

Weekly Payroll deductions	
Employee	$3.50
Employee + Spouse	$5.94
Employee + Child(ren)	$7.83
Family	$10.26

Aflac Hospital Indemnity Insurance

You might think of the hospital as a place to go if you have an accident, but the truth is that the majority of hospital stays are due to sickness. Just a few days in the hospital for illness can be costly. Cash benefits from the Aflac Hospital Indemnity Insurance plan may offer a measure of financial protection when you're hospitalized due to a covered accident or covered sickness.

Plan Details:

- Hospital Admission Benefit (once per occurrence): $1,000
- Hospital Confinement Benefit (per day): $150
- Hospital Intensive Care Benefit (per day): $150

Weekly Payroll deductions	
Employee	$5.10
Employee + Spouse	$9.32
Employee + Child(ren)	$7.60
Family	$11.81

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsted in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situsted in New York, coverage is underwritten by American Family Life Assurance Company of New York.

If the coverage outlined in this summary will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Voluntary Aflac Products – Critical Illness Insurance

The Aflac Critical Illness insurance plan can help with the treatment costs of covered critical illnesses, such as cancer, a heart attack, or a stroke. More importantly, the plan helps you focus on recuperation instead of the distraction and stress over the costs of medical and personal bills. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Plan Details:

- Pays a lump sum benefit for a covered critical illness—cancer, heart attack, stroke, major organ transplant, end-stage renal failure, Alzheimer's disease, Parkinson's Disease, ALS, MS, and benign brain tumor.
- Pays a benefit for a recurrence of the same critical illness if separated by at least 6 consecutive months. If the recurrence is cancer, you must have been treatment-free from cancer for at least 12 months. (Note: Cancer that has spread, even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment-free for at least 12 months.)
- Pays a benefit for an additional occurrence of a different critical illness if separated by at least 6 months. See weekly rate tables below.

Non-Tobacco Employee Weekly Premiums		
Age	**$20,000**	**$30,000**
18-29	$2.27	$3.23
30-39	$3.48	$5.05
40-49	$6.47	$9.53
50-59	$12.29	$18.26
60+	$23.23	$34.67

Non-Tobacco Spouse Weekly Premiums		
Age	**$10,000**	**$15,000**
18-29	$1.31	$1.79
30-39	$1.92	$2.70
40-49	$3.41	$4.94
50-59	$6.32	$9.30
60+	$11.79	$17.51

Tobacco Employee Weekly Premiums		
Age	**$20,000**	**$30,000**
18-29	$3.05	$4.40
30-39	$5.24	$7.69
40-49	$9.98	$14.79
50-59	$19.62	$29.26
60+	$36.06	$53.91

Tobacco Spouse Weekly Premiums		
Age	**$10,000**	**$15,000**
18-29	$1.70	$2.38
30-39	$2.80	$4.02
40-49	$5.16	$7.57
50-59	$9.99	$14.81
60+	$18.20	$27.13

Voluntary Legal Plan / Identity Theft

You've thought about it for years—do you finally want to complete your Will? Or do you want a lawyer to write a letter on your behalf? Or review a document for you before you sign? Are you interested in having a legal plan for your small business, or in guarding yourself against identity theft? We have a plan for you.

For Individuals and Families:

LEGAL PLAN – Talk to a lawyer. No high hourly costs.

- Family plan covers member, spouse and dependents
- Standard Will preparation
- Legal advice/consultation/ representation
- Letters/phone calls on your behalf
- Legal document review
- Moving traffic violations
- IRS audit protection
- Trial defense
- 24/7 emergency assistance
- Mobile app
- 25% preferred member discount

Legal Plan and Identity Theft Weekly Payroll Deductions	
Individual IDShield	$1.95 weekly
Family IDShield	$3.68 weekly
Family Legal Plan	$4.83 weekly
Legal Plan + Individual IDShield	$6.78 weekly
Legal Plan + Family IDShield	$7.82 weekly

IDSHIELD℠ – Coverage that will help protect against, and resolve, identity theft issues

- Family plan covers member, spouse and up to eight minor dependents under the age of 18
- Individual plan covers member only
- Consultation/Advice
  - Identity theft advisor
  - Credit report review
  - Lost wallet protection
- Notifications
  - Data breach notifications
  - Identity alert system
- Access
  - Mobile app
  - Monday through Friday 7 a.m.–7 p.m. CT
  - 24/7/365 emergency access to an IDShield℠ Licensed Private Investigator for covered situations
- Monitoring
  - Black Market web surveillance
  - Credit monitoring
  - Minor identity protection
  - Social media monitoring
- Identity Restoration
  - Licensed private investigators
  - $5 Million Service guarantee

For more information prior to enrollment, please contact Whitney Young at hello@wittybydesign.com or 502-354-7842.

Voluntary Pet Insurance (PetsBest Pet Insurance)

Just like human healthcare, the cost of veterinary care available to pets is continuing to rise. We have health insurance, car insurance, home-owner's insurance and more to protect ourselves financially against the unexpected, why wouldn't we have pet insurance to protect ourselves and our pets as well? PetsBest pet health insurance is available as a payroll deduction. The plans are customizable and priced based on the coverage requested, breed, and age of the pet. Dependent on the plan selected, pet insurance covers injuries and illness and even offers an optional wellness rider benefit.

Plan Options:

- Best Benefit Plans – covers both injuries and illness
- Accident Only Plans – covers accidental injuries only
- Optional Wellness Rider – can be added to Best Benefit Plan

Prices vary depending on location, age and breed of pet. Average monthly premium cost is $25-$65.

For additional information or to enroll in pet insurance, please contact PetsBest directly at www.petsbest.com/MALONE or call 1-888-984-8700 and reference MALONE.

Important Legal Notices

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services are subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in Malone's medical, dental, or vision plans within 31 days after your other coverage ends.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/
State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medica l/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

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

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

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

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

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs- and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/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

Management Registry, Inc. Welfare Benefit Plan Notice of 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.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Management Registry, Inc. Welfare Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on January 1, 2022.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Management Registry, Inc. requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Management Registry, Inc. for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Management Registry, Inc. Welfare Benefit Plan Notice of 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.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Human Resources
Management Registry, Inc.
1868 Campus Place
Louisville, KY 40299
502-456-2380

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Medicare Part D Notice: Prescription Drug Coverage and Medicare *COPAY PLAN*

This notice has information about your current prescription drug coverage with Management Registry, Inc. and 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.

Please note: If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

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

- 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.
- Management Registry, Inc. has determined that the prescription drug coverage administered by Anthem BlueCross BlueShield 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 through 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 Management Registry, Inc. coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Management Registry, Inc. 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 Management Registry, Inc. 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: 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 Management Registry, Inc. 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 Human Resources - Phone # 502-456-2380

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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 Management Registry, Inc.		4. Employer Identification Number (EIN) 61-0863236	
5. Employer address 1868 Campus Place		6. Employer phone number 502-456-2380	
7. City Louisville	8. State Kentucky	9. ZIP code 40299	
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@malonesolutions.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:

    Employees who work an average of 30 hours per week for a 12-month measurement period

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Spouse and dependent children up to age 26

  - ☐ We do not offer coverage.

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

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

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

Contact Information

Medical and Rx

Anthem BlueCross BlueShield
HSA Plan Customer Service: 1-877-812-9777
Copay Plan Customer Service: 1-855-397-9267
LiveHealth Online: livehealthonline.com
ConditionCare: 1-800-638-4754
Future Moms: 1-800-828-5891
24/7 NurseLine: 1-888-724-2583
Website: www.bcbsga.com
For network providers outside of GA: National PPO (BlueCard PPO)
For network providers in GA: Blue Open Access POS (Select)

Good Rx
Customer Service: 1-855-268-2822
Website: goodrx.com

Dental

Anthem BlueCross BlueShield
Customer Service: 1-877-604-2158
Website: www.anthem.com
Plan Network: Dental Complete

Vision

Anthem BlueCross BlueShield
Customer Service: 1-866-723-0515
Website: www.anthem.com
Plan Network: Blue View Vision

Flexible Spending Accounts

iSolved, formerly Infinisource
Customer Service: 1-866-370-3040
Email: fsa@infinisource.com
Website: www.infinisource.com

Member Claims Advocate

Dee Hoats: 706 576 3541
Toll Free: (800)226-4518
Email: mmajslbenefitclaims@marshmma.com

Life and Disability

Mutual of Omaha
Life Claims: 1-800-775-8805
Disability Claims: 1-800-877-5176
Website: www.mutualofomaha.com

Employee Assistance Program

Mutual of Omaha
Member Services: 1-800-316-2796
Website: https://www.mutualofomaha.com/eap

Pet Insurance

PetsBest
Phone: 1-888-984-8700
Website: www.petsbest.com/MALONE

Telemedicine

HealthiestYou
Connect with a Doctor: 1-866-703-1259
Customer Service: 1-855-894-9627
Website: www.healthiestyou.com
Setup Online Account: member.healthiestyou.com

Voluntary Benefits

Aflac
Customer Service: 1-800-433-3036
Website: www.aflacgroupinsurance.com

Legal Shield and Identity Theft

Contact: Whitney Young
Phone: 502-354-7842
Email: hello@wittybydesign.com
Customer Service: 1-800-654-7757

Malone Benefits HR Department

- **Malone HR benefits Contact**
  General Emails Use:
  HR@malonesolutions.com
- **Chris Elmore**
  Chris.Elmore@malonesolutions.com
  502-813-8638
- **Lauren Malone Frerman**
  Lauren.Malone@malonesolutions.com
  502-242-3174
- **Glenda Armes**
  Glenda.Armes@malonesolutions.com
  502-242-3175

Please return to Attn: Human Resources at HR@malonesolutions.com

MALONE
the workforce resource

2022 MANAGEMENT REGISTRY, INC. SPOUSAL ELIGIBILITY AFFIDAVIT

This form must be completed within 31 days of the date the person named as spouse gains or loses eligibility for medical coverage AND ANNUALLY following the close of Annual Enrollment. This form is not used for the election of medical benefits, but only to support eligibility for spouse medical benefits.

Employee Name_____ **EE#**_____ **Phone #** _____

Spouse Name_____ **Spouse Phone #**_____

Section A: To be completed by the EMPLOYEE:

I am completing this form for ☐ Annual Enrollment for 2022; OR ☐ a Gain or Loss of Coverage effective_____.

☐ My spouse is unemployed and not covered under any other employer-sponsored medical coverage (including any retiree medical coverage). Note: A letter confirming termination of group medical coverage will be required from the spouse's employer if the change is outside Annual Enrollment.

☐ My spouse is eligible for medical coverage through his/her employer or former employer (i.e. retiree medical coverage). The spouse must elect his/her employer sponsored medical coverage and NOT be covered under Management Registry, Inc.'s plan.

☐ My spouse is employed but is not offered medical coverage through his/her employer. If you check this box, please complete section below:

Spouse's Employer/Company Name:_____

Spouse's Employer's Address:_____

Human Resource Contact's Name:_____ Title:_____ Phone#_____

_____ Initial I certify that the spouse named above is my current and legal spouse.

_____ Initial I understand that any misrepresentation in the information I have provided in support of this affidavit will permit Management Registry, Inc. to terminate the spouse coverage and seek any other legal remedies available including possible prosecution for insurance fraud and/or the collection of the cost of benefits paid on behalf of my spouse.

_____ Initial I understand that providing false information may result in disciplinary action, up to and including, immediate termination of employment.

_____ Initial I understand that I am responsible for reporting any loss or gain in my spouse's eligibility for medical coverage within 31 days to Management Registry, Inc. and for submitting an updated Spousal Eligibility Affidavit.

_____ Initial I understand that it is my responsibility to review my paystubs and verify that any deductions are correct. If the deductions are incorrect, it is my responsibility to immediately notify the Management Registry, Inc.

Employee Signature_____ Date _____

Section B: To be completed by the SPOUSE:

_____ Initial I understand that any misrepresentation in the information concerning my eligibility for medical coverage provided in support of this affidavit will permit Management Registry, Inc. to terminate my coverage and seek any other legal remedies available including possible prosecution for insurance fraud and the collection of the cost of benefits paid on my behalf.

_____ Initial I understand that I am responsible for reporting a change in my employer(s) to Management Registry, Inc. by submitting within 31 days an updated Spousal Eligibility Affidavit that indicates the date of the gain or loss of eligibility for medical coverage.

_____ Initial I authorize the release of my medical plan coverage information and authorize its use in reviewing the application for Management Registry, Inc. medical coverage.

Spouse Signature_____ Date _____

This guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.