

HEALTHCARE OVERVIEW

ACTS, Inc.

**High Deductible Health Plan
Health Savings Account (HSA)**

Medical Provided by Blue Cross/Blue Shield Business Blue

High Deductible Health Plan	Network Providers	Out of Network
Deductible		
Single Coverage	\$2,600	\$2,600
Family Coverage	\$5,200*	\$5,200*
Coinsurance		
<i>After deductible, all covered expenses are paid follows:</i>		
Blue Cross pays:	100%	60%
Employee pays:	0%	40%
Maximum Out of Pocket		
Single Coverage	\$2,600	\$ 5,200
Family Coverage	\$5,200	\$10,400
Hospital Admission Copayment	\$0	\$0
Maternity	Yes	Yes
Routine Physical Exam		
<i>Limited to \$300 per person each benefit period</i>	100%	N/A
Routine Preventative Benefits		
<i>Annual Pap smear screening</i>		
<i>Two gynecological exams</i>	100%	N/A
<i>Prostate screening</i>		
Routine Mammography Screening		
<i>Annual screening for any female member age 40 or older</i>	100%	N/A
Chiropractic Benefits	Not Selected	
Lifetime Maximum	\$2,000,000	
Dental		
<i>See attached Humana benefits</i>		

* Please note that family coverage requires that the \$5,200 be met. Doctors visits and pharmacy are not covered except as noted above, but can be used to meet this deductible.

HEALTHCARE OVERVIEW
ACTS, Inc. & ACTS-SC, Inc.

MEDICAL (provided by Blue Cross Blue Shield of South Carolina) within Preferred Network:

- | | |
|----------------------------------|--|
| ✓ Deductible: | <i>Individual - \$2,000, family – three times</i> |
| ✓ Coinsurance: | <i>In-network – 70%, Out of network – 50%</i> |
| ✓ Out of Pocket: | <i>In-network - \$3,000, Out of network - \$6,000</i> |
| ✓ Physician Visit Copay: | <i>\$20*</i> |
| ✓ Specialist Visit Copay: | <i>\$40</i> |
| ✓ Maternity Coverage: | <i>Yes</i> |
| ✓ Prescription Card | <i>Co-Pay: Generic \$4, Preferred \$30, Non-Preferred \$60, Specialty prescriptions – 10% to a maximum of \$200 then 100% of allowable charges</i> |
| ✓ Mail Order Drug | <i>Co-Pay for 90-day supply
Generic 8, Preferred - \$70, Non-preferred - \$140</i> |
| ✓ Maximum Out of Pocket | <i>In-Network - \$3,000, Out of Network - \$6,000</i> |

Life Insurance: *Employee only - \$10,000*

Accidental Death & Dismemberment: *Employee only - \$10,000*

DENTAL (provided by HumanaDental)

- *No Preferred Network*
- *Preventive Services: 100%, No deductible*
- *Basic Services: 80%, After \$50.00 deductible*
- *Major Services: 50% After \$50.00 deductible*
- *Annual Maximum - \$1,000*

401(k) – *Through Principal Financial Group*

** OB-GYN, general and family practice physicians, internists, pediatricians, osteopaths are all now classified as Primary Care Physician.*

NOTE: THERE IS A 90-DAY WAITING PERIOD FOR ALL BENEFIT PLANS. (Benefits will become effective the first of the month, following 90 days of continuous employment.)

Eligibility: Must be a full time employee (minimum of 30 hours per week)

MEMBERSHIP APPLICATION

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, An independent licensee of the Blue Cross and Blue Shield Association • **COMPANION HEALTHCARE**, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina, An independent licensee of the Blue Cross and Blue Shield Association • **COMPANION LIFE INSURANCE COMPANY**, A wholly-owned subsidiary of Blue Cross and Blue Shield of South Carolina • **PREFERRED HEALTH SYSTEMS, INC.**, A subsidiary of Blue Cross and Blue Shield of South Carolina. Both are independent licensees of the Blue Cross and Blue Shield Association.

1. Please indicate reason for Application: New Subscriber(s) Coverage Change Cancel Miscellaneous
 COBRA: 18-mo. 29-mo. 36-mo. (Block 22 must be completed.) Life Coverage Yes No Transfer Within Your Group From _____
 Left Employment: No Conversion Wants Conversion or Medicare Complementary Info Deceased Name Change
 Department/Payroll Number Change Address Change Beneficiary Change Social Security Number Change From _____
 ID Card Request Add Dependents Return From Layoff/Medical Leave Physician Change Other _____

2. EFFECTIVE DATE OF ACTION REQUESTED: MONTH _____ DAY _____ YEAR _____ DATE OF HIRE: MONTH _____ DAY _____ YEAR _____ ELIGIBILITY DATE: MONTH _____ DAY _____ YEAR _____
 3. Type Contract: Preferred Blue Preferred Blue Select HMO Blue BLUE PLUS CHOICES Comprehensive Blue Choice CHC Other _____

IDENTIFICATION

4. Employee — Last Name First Initial Home Telephone No. 5. Social Security No.
 6. Mailing Address (Street or P.O. Box) (City) (State) (Zip Code) (County Code - see back)
 7. Name of Employer 8. Blue Cross Group Number 9. Dept. No. 10. Payroll No.

REASON FOR COVERAGE CHANGE

11. Check appropriate reason; give occurrence date in Block 13:
 A Birth or Adoption C Divorce F Attained Reduction Age
 B Death (Name: _____) D Marriage
 E Other - Explain: _____
 12. Name of spouse to be excluded from coverage if applicable
 13. Occurrence Date or Left Employment Date Mo. Day Yr.

TYPE MEMBERSHIP AND COVERAGE INFORMATION

14. Check type membership for each coverage desired. (Indicate life coverage desired, if applicable, in blocks 15 through 19.)
 a. HEALTH b. DENTAL c. REFUSAL OF HEALTH COVERAGE
 S - Single 01 Other insurance with BCBS of SC 10 Planned Administrators Inc.
 F - Family 02 Insurance with another company 11 Non-federally qualified HMO
 F - Employee/Children 03 US military coverage 12 Covered by Medicare
 8 - Employee/Spouse 04 Federally qualified HMO 13 Covered by CHAMPUS
 07 My spouse's coverage with this group 05 Other - Explain: _____
 09 Other third-party administrator
 If Sponsored Membership, give Sponsor's Social Security No. _____

16. Types and Amounts of Life Insurance Coverage Desired
 Life _____ Supplemental: Life _____
 AD&D _____ AD&D _____
 Dep. Life _____ Dep. Life _____
 STD _____
 LTD _____
 17. Earnings (Check One) Biweekly Monthly Annually
 \$ _____ (Amount) Hourly Weekly
 18. Life Class
 19. Full Name (Last Name, First, Init.): _____ Relationship _____
 Primary Beneficiary(ies): _____
 Contingent Beneficiary(ies): _____
 SEE INSTRUCTIONS ON BACK FOR MULTIPLE BENEFICIARY DESIGNATION

21. List All Family Members Covered or Affected By a Change For Contracts That Require Primary Care Physician Selection

Last Name	First	Initial	Sex	Birthdate Mo. Day Yr.	Primary Care Physician Name	Provider Number	Was This Your Regular Physician?
YOURSELF:							Yes No
Spouse							Yes No
Social Security No.							
Child							Yes No
Social Security No.							
Child							Yes No
Social Security No.							
Child							Yes No
Social Security No.							

OTHER INSURANCE INFORMATION

22. Do you or does any member of your family have other health, dental or drug coverage, Federal Employees' Program (FEP) or Medicare? YES NO
 If Yes: MEDICARE A Effective Date _____ MEDICARE B Effective Date _____
 A. Family Member's Name _____ and Social Security No. _____
 B. Name of Insurance Co. _____ Policy No. _____ Effective Date _____
 C. Family Member's Employer _____
 D. List Names of Covered Persons 1 _____ 2 _____ 3 _____ 4 _____
 E. Please circle each type of service covered by this policy: Hospital, Physician/Medical, Prescription Drugs, Dental, Vision

EMPLOYEE CERTIFICATION

23. Employee Certification - Read back for certification statement. Check box if health statement is attached.
 I HAVE READ AND UNDERSTAND EACH AND EVERY PART OF THIS ENROLLMENT APPLICATION.
 Date: _____ Signature: _____



SOUTH CAROLINA DENTAL EMPLOYEE APPLICATION / ENROLLMENT/CHANGE FORM

Group Number

Group Number input box

Dental plans insured by HumanaDental Insurance Company or Humana Insurance Company

Please print using black ink. Attach additional sheets if necessary; sign and date all attachments.

1 Employer Data - Complete with the name and location of the employer company offering benefits.

NAME OF EMPLOYER CITY STATE ZIP CODE

2 Employee Information - Welcome! Please indicate if you are a: [] New Applicant or [] Current Insured/Plan Subscriber

EMPLOYEE/LAST NAME FIRST NAME M.I. SEX SSN BIRTH DATE

EMPLOYEE STREET ADDRESS HOME PHONE () E-MAIL ADDRESS HOME WORK

CITY STATE ZIP DATE OF FULL-TIME EMPLOYMENT/REHIRE

3 Dependent Information - Please list any dependents to be covered.

Table with columns: NAME/RELATIONSHIP (WRITE LAST NAME IF DIFFERENT FROM EMPLOYEE), BIRTH DATE, SEX, NAME/RELATIONSHIP (WRITE LAST NAME IF DIFFERENT FROM EMPLOYEE), BIRTH DATE, SEX. Rows include SPOUSE and CHILD options.

4 Plan Selections

Dental Coverage: [] Employee [] Employee & Child(ren) [] Employee & Spouse [] Family

If you have been given a choice of plans please indicate: Dental Plan

5 Enrollment Questions

- 1. How many hours per week do you work for this employer? hrs/wk
2. Are you or any dependent now disabled or unable to perform normal activities? [] NO [] YES
3. Within the past 12 months, have you or your dependent(s) had any individual or other group DENTAL coverage? [] NO [] YES

6 Waiver - Refusal of Coverage

You must complete the section below only if you are waiving (declining) any of the coverage available to you through your employer. This is to acknowledge that I have been given opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer. I hereby waive insurance coverage for:

Myself: [] My Spouse: [] Dependent Children: []
I decline to apply for group coverage because of: [] Spousal coverage [] Other

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Humana Insurance Company or HumanaDental Insurance Company into waiving (declining) the above noted coverage. I understand that in the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) which may require additional limitations and waiting periods. I also understand that I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana Insurance Company or Humana. I understand that Humana Insurance Company and HumanaDental Insurance Company reserves the right to deny coverage with any future application for coverage. I freely and voluntarily waive the above noted coverage.

Date Employee Signature X

7 Agreement

I hereby acknowledge that I have read the above statements or that they have been read to me. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the company's other rights or requirements. I hereby agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice. An Enrollment Form should not be submitted more than 60 days prior to the effective date. This document will become a part of the certificate if coverage is approved.

Date Employee Signature X

ACTS of South Carolina, Inc.

Dental Health Care Plan Waiver

Employee Name: _____

Position _____

I hereby waive the right to all medical health care insurance benefits provided under ACTS health insurance plan. I understand the advantages of participating in the group medical health insurance, but I willingly decline enrollment due to the following reason:

- US Military Coverage
- My spouse's coverage under his/her group health insurance plan
- My spouse's coverage with this group
- Covered under my retirement plan
- Covered by Medicare
- Insurance with another company
- Other - explain

Employee Signature _____

Date: _____

Medical Health Care Plan Waiver

Employee Name: _____

Position _____

I hereby waive the right to all medical health care insurance benefits provided under ACTS health insurance plan. I understand the advantages of participating in the group medical health insurance, but I willingly decline enrollment due to the following reason:

- US Military Coverage
- My spouse's coverage under his/her group health insurance plan
- My spouse's coverage with this group
- Covered under my retirement plan
- Covered by Medicare
- Insurance with another company
- Other - explain

Employee Signature _____

Date: _____