EMPLOYEE BENEFIT MEC ENROLLMENT KIT

All benefits become effective the 1st of the month following your date of hire.

Administered by:
Regional Care Inc. (RCI) - 800.795.7772 or regionalcare.com

PPO Network:
PHCS/Multiplan - 888.342.7427 or multiplan.com

www.argbackoffice.com

ARG Health Benefit Plans

	MEC* Plus	MEC* Plus Advantage	MEC* Plus Advantage with Beazley Group Limited Indemnity (GLI**)
Preventive Care	MEC plans cover 100% of preventive care services under PPACA at no cost to the employee. A full list can be found by visiting www.healthcare.gov		
TelaDoc 24/7 (Multilingual)	Free (unlimited use) Telemedicine Services		
	PPO NETWORK SERVICES - PHCS		
Primary Care Visits	$0 Copay (Max 2 visits/year)	$20 Copay (max 3 visits per plan year)	$20 Copay (max 3 visits per plan year)
Specialist Office Visits	NOT COVERED	$50 Copay (max 3 visits per plan year)	$50 Copay (max 3 visits per plan year)
Urgent Care		$50 Copay (max 3 visits per plan year)	$50 Copay (max 3 visits per plan year)
Diagnostic X-ray and Lab		$50 Copay (in offices, max 5 services per plan year)	$50 Copay (in offices, max 5 services per plan year)
CT Scan/MRI (Outpatient only)		$200 Copay (max 1 CT Scan or 1 MRI per plan year)	$200 Copay (max 1 CT Scan or 1 MRI per plan year)
	PRESCRIPTION BENEFITS - WellDyne Rx		
Tier 1 – Low Cost	Discount Card Up to 75% Discount on FDA Approved Medications		$1 Copay
Tier 2 – Generics			10% Coinsurance
Tier 3 – Preferred			20% Coinsurance
Tier 4 – Non-Preferred			40% Coinsurance
Tier 5 – Generics & Preferred Specialty			10% Coinsurance (Plan pays 90% up to max of $150)
Tier 6 – Non-Preferred			20% Coinsurance (Plan pays 80% up to max of $250)
	HOSPITALIZATION BENEFITS - BEAZLEY		
Daily In-Hospital	NOT COVERED		$750 per day 30 days per plan year
Hospital Admission			$2,000 per admission 1 day per plan year
Inpatient Surgery			$1,000 benefit per day 1 day per plan year
Outpatient Major Surgery			$500 benefit per day 1 day per plan year
Anesthesia			$300 benefit per day 1 day per plan year
ER - Injury			$150 benefit per day 1 day per plan year
	MONTHLY COST – 4 Year Rate Cap		MONTHLY COST – 2 Year Rate Cap***
Employee Only	$ 82.85	$133.75	$133.75 + $ 63.69 = $197.44
Employee + Spouse	$132.59	$218.24	$218.24 + $130.57 = $348.81
Employee + Child(ren)	$123.17	$202.24	$202.24 + $114.53 = $316.77
Employee + Family	$176.82	$293.30	$293.30 + $190.26 = $483.56

*Apex MEC plans are PPACA compliant and provide non-insurance benefits

**Group Limited Indemnity is not major medical insurance. GLI does not satisfy any PPACA penalties

***Beazley GLI premium is illustrated in blue. GLI is underwritten by Beazley Insurance Company, Inc. 30 Batterson Park Road, Farmington, Connecticut, 06032. Beazley is rated A by A.M. Best. Beazley is licensed in all 50 states and the District of Columbia.

Your MEC plan is ACA Compliant

The list below summarizes some but not all services. Please reference the US Preventive Services Task Force website for the entire list. www.HealthCare.gov/center/regulations/prevention.html

Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Alcohol Misuse screening and counseling
3. Aspirin use for men ages 45-79 and women ages 55-79 to prevent CVD when prescribed by a physician
4. Blood Pressure screening
5. Cholesterol screening for adults
6. Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years
7. Depression screening
8. Type 2 Diabetes screening
9. Diet counseling
10. HIV screening
11. Obesity screening and counseling
12. Immunizations vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella)
13. Sexually Transmitted Infection (STI) prevention counseling
14. Tobacco Use screening and cessation interventions
15. Syphilis screening
16. Hepatitis B screening for non-pregnant adolescents and adults.
17. Lung Cancer screening-55-80 y/o who smoke 30 packs a year.
18. Fall Prevention –Physical therapy and vitamin D for 65 and older at risk for falling
19. Hepatitis C screening for high risk individuals and a onetime screening for HCV infection if born between 1945-1965.
20. Skin Cancer behavioral counseling for adults to age 24 with fair skin

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling and genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every year for women age 40+
5. Breast Cancer Chemo Prevention counseling for women
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
7. Cervical Cancer screening
8. Chlamydia Infection screening
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant when prescribed by a physician
12. Gestational diabetes screening
13. Gonorrhea screening
14. Hepatitis B screening for pregnant women
15. Human Immunodeficiency Virus (HIV) screening and counseling
16. Human Papillomavirus (HPV) DNA Test: HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening over age 60
18. Rh Incompatibility screening for all pregnant women and follow-up testing
19. Tobacco Use screening and interventions and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling
21. Syphilis screening
22. Well-woman visits to obtain recommended preventive services
23. Aspirin for Preeclampsiaprevention
24. Routine prenatal visits for pregnant women

Covered Preventive Services for Children

1. Alcohol and Drug Use assessments
2. Autism screening for children limited to two screenings up to 24 months
3. Behavioral assessments for children limited to 5 assessments to age 17
4. Blood Pressure screening
5. Cervical Dysplasia screening
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents age 12 and older
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children
10. Fluoride Chemo Prevention supplements for children without fluoride in their water source when prescribed by a physician
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents
17. Lead screening for children
18. Immunization vaccines for children from birth to age 18; doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hepatitis A & B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella, Haemophilus influenza type b
19. Iron supplements for children up to 12 months when prescribed by a physician
20. Medical History for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
21. Obesity screening and counseling
22. Oral Health risk assessment for young children up to age 10
23. Phenylketonuria (PKU) screening in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
25. Tuberculin testing for children
26. Vision screening for all children under the age of 5
27. Skin Cancer Behavioral Counseling –age 10-24 for exposure to sun
28. Tobacco intervention and counseling for children

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For **MEC Plus** start here!	For **MEC Plus Advantage** start here!	For **MEC Plus Advantage with Beazley GLI** start here!
Click "**Find a Provider**" in the top right corner 	Click "**Find a Provider**" in the top right corner 	Click "**Find a Provider**" in the top right corner 
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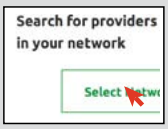
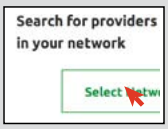
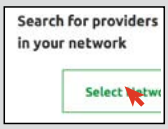
Click "**Select Network**" 	Click "**Select Network**" 	Click "**Select Network**" 
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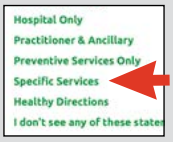
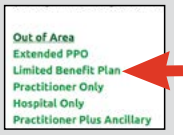
Click "**Preventive Services Only**" inside pop-up box 	Click "**Specific Services**" inside pop-up box 	Click "**Limited Benefit Plan**" inside pop-up box 
Enter type of provider (urgent care, primary care, etc...) in the search box 	Enter type of provider (urgent care, primary care, etc...) in the search box 	Enter type of provider (urgent care, primary care, etc...) in the search box 
Enter zip code and click the search icon 	Enter zip code and click the search icon 	Enter zip code and click the search icon 

For additional help:

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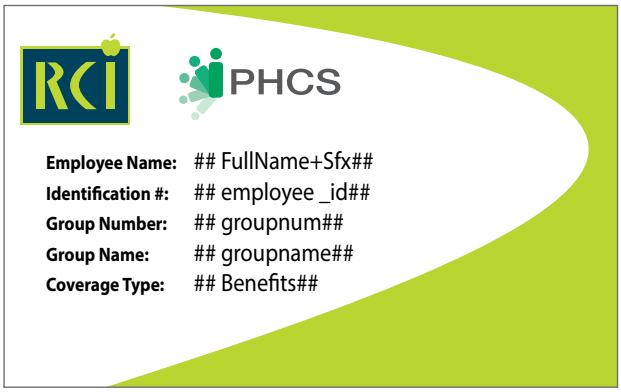
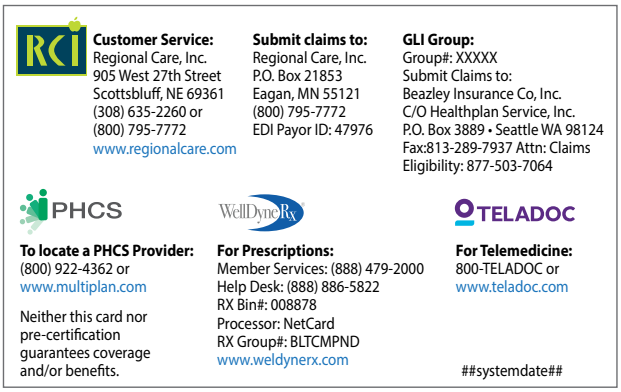


Front of card



Back of card

About Beazley GLI Plan

Group Limited Indemnity insurance pays fixed benefits when an insured incurs charges for services covered by the plan, such as inpatient hospitalization and ER visits for injury. Benefits for each covered medical service are paid at a specified amount per day to a maximum number of days per year.

No medical questions are required to qualify for coverage. Employees may opt for coverage for spouses and child(ren). NOTE: Group Limited Indemnity is not major medical insurance.

- Guaranteed issue
- A minimum of 5 enrolled employees is required to issue the Beazley GLI policy.
- See Beazley proposal for product details and benefit definitions

Group Limited Indemnity Benefit Summary Definitions
Hospital Confinement: For treatment in a hospital due to sickness or injury for 23 or more continuous hours (i.e., not less than a day)
Hospital Admission: Lump sum benefit for a hospital admission, due to sickness or injury
Inpatient Surgery: For inpatient surgery in a hospital due to sickness or injury
Outpatient Major Surgery: For outpatient surgery in hospital or freestanding surgery center, due to sickness or injury
Anesthesia: For general anesthesia administered by an anesthesiologist or Certified Registered Nurse Anesthetist
ER for Accidental Injury: For treatment in an ER due to injury, (treatment must occur within 72 hours of the accident)

The Beazley Group Limited Indemnity policy is offered under form number AHGLIMM001 102016 Ed. Coverage is not available in all states. Benefits may vary by state. Premium will vary based on the plan chosen. A waiting period for late entrants may apply. Pre-existing condition limitations may apply. This policy is renewable at the option of Beazley. Refer to the Master Policy and Certificate for all terms, conditions, exclusions and limitations. The GLI product is not available in NY, VT or HI. Insurance is underwritten by Beazley Insurance Company, Inc., 30 Batterson Park Road, Farmington, Connecticut, 06032. Beazley is rated A by A.M. Best. Beazley is licensed in all 50 states and the District of Columbia. For a current listing of product offerings and availability, visit http://www.beazley.com/accident&health. Beazley uses the services of a third party administrator.

EMPLOYEE

Apex Management Group MEC Enrollment Application

Apex Management Group

Enrollee Information (All information must be completed to ensure coverage)

Last Name	First Name	MI	
Date of Birth	Social Security #	Gender	Marital Status
Date of Hire	❑ Part Time ❑ Full Time	Height	Weight
Address Line 1	Address Line 2		
City	State	ZIP	Employer
Phone	Email		

Coverage & Change Request Information (You may be required to provide proof of the event)

Insurance Requested: ❑ New Enrollment ❑ Status Change

Coverage level: ❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee & Family

Plan name: ❑ MEC ❑ MEC Plus ❑ MEC Plus Advantage ❑ MEC Plus Advantage with Beazley **GLI**

If changing plans, indicate Qualifying Event: ❑ Marriage ❑ Divorce ❑ Adoption ❑ Returning to School Full-Time ❑ Court Order ❑ Other (specify): _____ Date of Qualifying Event _____

Are you currently actively at work and able to perform the duties of your occupation? ❑ Yes ❑ No

How many hours are you regularly working per week with your current employer? _____ Hours per week

Family Information (Only for those applying for coverage)

First Name & MI (Last if different than employee)	Social Security #	Gender	Height	Weight	Date of Birth
Spouse					
Child					
Child					
Child					

Employee Agreement (Signature required)

I authorize my employer to deduct the necessary contributions toward the benefits I have selected on a pre-tax basis from my pay. I understand that I cannot change the benefits I have selected or revoke this pay deduction authorization before the beginning of the next plan year unless that change or revocation is made on account of, and corresponds with, a change in status, a special enrollment event, or any other event that permits a mid-year change or revocation of elections under the terms of my employer's Section 125 cafeteria plan.

Employee Signature | Date

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee:

Waiver (Only complete this section if you are waiving all coverage)

I am declining coverage for (check all that apply): ❑Employee ❑Spouse ❑Child(ren)

I am declining coverage for the following reason(s): (Check all that apply and note that if you are declining coverage because you have other coverage, you must indicate that on this form. Failure to do so may result in you not being able to exercise special enrollment rights if you lose other coverage).

❑Covered by a spouse's or parent's group health plan ❑Individual medical plan ❑**Not Affordable**

❑COBRA/State Continuation ❑Government Plan (please specify plan name): _____

❑Other reason: _____

I understand that this waiver may be reported to IRS informing them I have declined the Employer-provided healthcare plan and this may result in fines and repayment of any federal subsidies when selecting insurance through a Health Care Exchange.

Authorization: As an employee, I hereby apply for, or waive (if indicted), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

Employee Signature | Date

EMPLOYEE BENEFIT ENROLLMENT KIT DENTAL, VISION, DISCOUNT PLANS, ID THEFT, AND LEGAL SERVICES

All benefits become effective the 1st of the month following your date of hire.

Dental and Vision Administered by:
Regional Care Inc. (RCI) - 800.795.7772 or regionalcare.com

www.argbackoffice.com

Vision Plan Overview - $20/$20 Copay

Frequency: 12:12:24 (Eye Exam, Lenses, Frames)

	Employee Only	Employee + One	Employee + Children	Employee + Family
Semi-Monthly (Twice/Month)	$4.10	$6.55	$6.69	$10.78

Benefit	VSP Network Providers subject to applicable copays[1]	Out-of-Network Providers subject to applicable copays[1]	
WellVision Exam	Covered-in-full after copay Routine retinal screening guaranteed pricing, not to exceed $39[2]	Reimbursed up to	$ 45
Contact Lens Exam – Fitting and Evaluation (when choosing contacts)	**Standard** and **premium fit**: covered-in-full after copay – 15% off[2] contact lens exam services; copay will never exceed $60	See elective contact lenses	
Single Vision Lenses	Covered-in-full after copay	Reimbursed up to	$ 30
Lined Bifocal Lenses	Covered-in-full after copay	Reimbursed up to	$ 50
Lined Trifocal Lenses	Covered-in-full after copay	Reimbursed up to	$ 65
Lenticular Lenses	Covered-in-full after copay	Reimbursed up to	$100
Frame	Covered-in-full after copay up to $130 allowance ($50 wholesale) 20% off[2] any amount exceeding retail allowance Members selecting featured frame brands including bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more will receive an extra $20 toward their frame allowance.[3]	Reimbursed up to	$ 70
Elective Contact Lenses	Covered up to $130 (instead of lenses and frames) Mail-in savings[5] on eligible contacts	Reimbursed up to (includes contact lens exam and materials)	$105[4]
Necessary Contact Lenses[6]	Covered-in-full after copay (instead of lenses and frames)	Reimbursed up to	$210

Benefit	Benefit Highlights	
Lens Enhancements	Standard Progressives Plastic	Covered-in-full
	Premium Progressives Plastic	$95-105 copay
	Custom Progressives Plastic	$150-175 copay
	Solid Tints & Dyes (Pink I&II)	Covered-in-full
	Solid Plastic Dye (except Pink I & II)	$15 copay
	Plastic Gradient Dye	$17 copay
	UV Protection	$16 copay
	Factory Applied Scratch-Resistant Coating	$17 copay
	Polycarbonate Lenses	Covered-in-full for dependent children $31 single vision or $35 multi-focal copay
	Standard Anti-Reflective Coating	$41 copay
	Photochromic Lenses Plastic	$70 single vision or $82 multi-focal copay
Primary EyeCare Plan℠	Supplemental coverage for non-surgical medical eye conditions, such as pink eye and other urgent eye care - $20 copay[7] per visit	
Low Vision	Supplemental testing covered every two years 75% of the cost for approved low vision aids, $1,000 maximum (less any amount paid for testing)	
Additional Glasses	20% off[2] additional complete pairs of prescription and non-prescription glasses (includes sunglasses)[8]	
Laser VisionCare Program	15% average discount or 5% off promotional price for PRK, LASIK, and Custom LASIK[9]	
Exclusions and Limitations[10]	There may be some materials and services with either limited or no coverage under this plan Please contact your VSP representative for more information	

[1] When covered-in-full services are obtained from a VSP network provider, the patient will have no out-of-pocket expense other than any applicable copays. Services and eyewear obtained through out-of-network providers are subject to the same copayments and limitations. Please refer to rate page.
[2] Based on applicable laws, benefits may vary by location.
[3] Reflects current promotion, evaluated annually. Promotion/featured frame brands are subject to change. In the event of a conflict between this information and your contract with VSP, the terms of the contract will prevail.
[4] If $100 allowance is purchased, out-of-network providers will reimburse up to $85.
[5] Rebates subject to change.
[6] Necessary contact lenses and fitting and evaluation are covered-in-full for members who have specific conditions for which contact lenses provide better visual correction.
[7] The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.
[8] Discounts valid through any VSP network provider within 12 months of the last covered eye exam.
[9] LaserVision Care discounts are only available from VSP-contracted facilities. Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member.
[10] Coverage shall be governed solely by the terms of your VSP contract.

Dental Plan Overview

	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Semi-Monthly (Twice/Month)	$22.25	$47.75	$46.50	$54.50

DEDUCTIBLE (Per Calendar Year, Per Person)	
Class B, C and D Services	$25
MAXIMUM BENEFIT AMOUNT (Per Person)	
Class B and C Services	$1,300 per Calendar Year
Class D Services	Not Covered
DENTAL PERCENTAGE PAYABLE	
Class A – Preventive	100% covered by the plan
Class B – Basic	70% after deductible
Class C – Major	50% after deductible
Class D - Orthodontia	Not Covered
Charges are limited to Usual and Customary Fees.	

Comprehensive Plan Design

Class A Services — Preventative Care |Routine oral exams. This includes the cleansing and scaling of teeth. Limit of 2 exams each Calendar Year. One bitewing x-ray series, one fluoride treatment for dependent children (under age 19), each Calendar Year. One full mouth x-ray every five (5) Calendar Years. Space maintainers for covered Dependent children (under age 19) to replace primary teeth. Sealants on the occlusal surface of a permanent posterior tooth for Dependent (under age 14) once per tooth in any 36 consecutive month period. Emergency palliative treatment for pain. *Some exclusions apply.

Class B Services — Basic | Dental x-rays not included in Class A. Oral surgery limited to removal of teeth, preparation of the mouth for dentures and removal of tooth generated cysts of less than 1/4 inch. Periodontics (gum treatments); endodontics (root canals); extractions (includes local anesthesia and routine post-operative care); recementing bridges, crowns or inlays; fillings (other than gold); general anesthetics, upon demonstration of Medical Necessity; antibiotic drugs. *Some exclusions apply.

Class C Services — Major | Gold restorations, including inlays, on-lays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold. Installation of crowns; installing precision attachments for removable dentures; installing partial, full or removable dentures to replace one or more natural teeth (includes all adjustments made during six (6) months following the installation). Addition of clasp or rest to existing partial removable dentures; initial installation of fixed bridgework to replace one or more natural teeth; repair of crowns, bridgework and removable dentures; rebasing or relining of removable dentures; dental implants. Replacing an existing removable partial or full denture of fixed bridgework; adding teeth to an existing removable partial denture or existing bridgework (to replace newly extracted natural teeth) — Applies if either 1) the existing denture or bridgework was installed at least five (5) years prior to its replacement and cannot currently be made serviceable, or 2) the existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within twelve (12) months from the date the temporary denture was installed. *Some exclusions apply.

Class D Services — Orthodontics (EXCLUDED) | Class D charges by a dentist or orthodontist for treatment, material and supplies in connection with orthodontic treatment furnished to dependent children (under age 19) when active appliance is first placed.

*Other exclusions may apply and will be explained in the Summary of Benefits in the Articles entitled "General Limitations and Exclusions."

Plan Guidelines

- Dependents are eligible to remain on the dental plan until age 26, regardless of status.
- Preventative services are covered at no cost to the member and the deductible does not have to be met to utilize this benefit.
- Aetna's negotiated rates make our dental network program very competitive.
- The dental network includes all 50 states. Of the nearly 210,000 available dental practice locations, over 157,000 are general dentists and more than 51,000 are specialists.

Network

- Utilizes the First Health network powered by the Aetna Dental Access network.
- In most instances, savings range from 15-50 percent on services.
- The network is available in all 50 states plus District of Columbia and Puerto Rico including 157,000 general dentists and 51,000 specialists.
- All offices are taking new patients.
- Go to www.aetna.com/docfind/custom/aetnadentalaccess/ to find a participating provider.

Discount Plan Package Options

SIGN UP ONLINE BY CLICKING **HERE**

BENEFITS Package 1	
Monthly Cost	$6.00*
Dental	✓
Vision	✓
Pharmacy & Vitamins	✓

BENEFITS Package 2	
Monthly Net Cost	$9.95
Dental	✓
Vision	✓
Pharmacy and Vitamins	✓
Health Advocate	✓
Lab Services	✓
MRI/CT	✓
Hearing Aids	✓

BENEFITS Package 3	
Monthly Net Cost	$12.00
Dental	✓
Vision	✓
Pharmacy and Vitamins	✓
Health Advocate	✓
Lab Services	✓
MRI/CT	✓
Durable Medical Equipment	✓
Hearing Aids	✓
Diabetic Supplies	✓
Pet Care	✓

optionsplus

BENEFITS Package 4

Three reasons to use Teladoc:

Teladoc gives you anytime access to U.S. board-certified doctors through the convenience of phone or video. **It's a low-cost way for treating cold and flu symptoms, bronchitis, respiratory infection, allergies and more!**

COLD & FLU

During cold and flu season, even the most careful person can get sick. Fortunately, you have Teladoc. Request a visit anytime you feel under the weather. With your consent, Teladoc is happy to provide information about your visit to your primary care physician.

ALLERGIES

Allergies leave you feeling drained and keep you from having a good night's sleep. Teladoc can quickly treat your allergy symptoms through phone or video.

PEDIATRIC CARE

Any parent knows their children don't get sick on a schedule. That's why Teladoc's pediatric network provides 24/7/365 access to physicians, even if you need a doctor in the middle of the night.

$7.50 Per Month

Visit MyMemberPortal.com

Phone: 855.847.3627

Disclosures: This plan is NOT insurance. The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act or Massachusetts M.G.L. c. 111M and 956 CMR 5.00. This discount card program contains a 30 day cancellation period. Member shall receive a reimbursement of all periodic membership fees if membership is canceled within the first 30 days after the effective date. Discount Medical Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 803475, Dallas, TX 75380-3475, 800-800-7616. Not available to FL, KS, UT, VT or WA residents.

Discount Benefit Descriptions

LAB SERVICES
Know your numbers! You have direct access to over 1,500 major clinical laboratories nationwide where you can save 10% to 80% on typical costs for lab work.

MRI/CT
A better image leads to a better diagnosis, better treatment and a better recovery. Save 40% to 75% on usual charges for MRI and CT Scans at thousands of credentialed radiology centers nationwide. You will be referred to a certified radiologist based on condition, preferences and location.

DURABLE MEDICAL EQUIPMENT
Caring for an aging or challenged parent or loved one can be difficult, and expensive. With Durable Medical Equipment, you can purchase discounted medical equipment. Not only will your supplies ship to you, but you'll also save 20% to 50% and an additional $5 on orders over $100!

HEARING AIDS
Want to save big on hearing aids? We hear you! You'll get a free initial screening and save 35% at retail locations nationwide. You will also receive a two-year supply of hearing aid batteries and two-year warranty, with a one-time replacement for loss or damage.

PET CARE
Keep your pets happy and healthy with discounts on everything from toys and treats to grooming and eats! You can save on boarding, doggie daycare, training, veterinary services and more.

DIABETIC SUPPLIES
Diabetes can be hard to manage–big savings on supplies can make life easier. Get 60% off average retail prices and free shipping on all packages, and an extra 15% off any single order item. You'll never run out of supplies or wait in long lines!

SIGN UP ONLINE BY
CLICKING **HERE**

Discount Benefit Descriptions Continued

DENTAL

Smile brighter with big savings on dental services including cleanings, X-rays, fillings, root canals and even orthodontics and specialty care such as periodontics.

- Choose from 195,000** dental practice locations nationwide with the Aetna Dental Access® Network (*as of May 2016)
- Savings: 15% to 50% per visit. (**Actual costs and savings vary by provider, service and geographical area.)

VISION

Your eyes are the windows to your health. Seeing is believing, save big on the following:

- 20% to 60% off prescription eyewear including most frames and specialty items such as tints,coatings and UV protection, plus 10% to 30% off eye exams.
- Participating chains include LensCrafters, Pearle Vision, Visionworks, JCPenny, Sears, Target and more.
- 40% to 50% off the national average cost of LASIK surgery.

PHARMACY AND VITAMINS

Don't pay full price - Save 10% to 85% on most prescriptions at over 60,000 pharmacies. Just present your card to save an average of 46% at locations nationwide (CVS, Walgreens, Target and more). With your vitamins discount, you can save an additional 10% off already low prices and low flat rate shipping on products for you, your family, and even your pets.

HEALTH ADVOCATE

Time is money. Your members get one-on-one support from professionals for medical or insurance related issues.

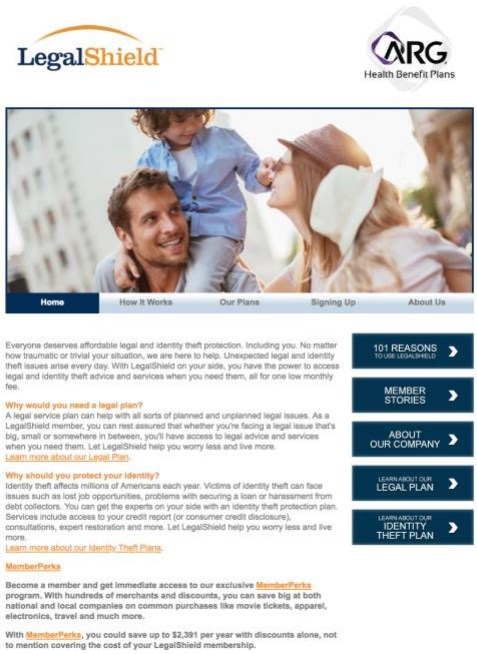
Have Questions About The Discount Plans?

Call member services and tell them you are employed by Agent HR Inc.

(800) 800-7616

Legal Shield Products

ARG is proud to offer our employees, and their families, access to best in class Legal Services (Legal Shield) and Identity Theft Protection (ID Shield) through Legal Shield. All benefits are portable and paid for on a per month basis.



(Above is the ARG Legal Shield Home Page)

How To Enroll

1. Go to (or click) on the following link: www.legalshield.com/info/agenthr
2. Explore the website to learn more about your options and the protection provided
3. Click on Signing Up Button
4. Complete all required fields
5. Download the Legal Shield App

Products Available

All products are offered at discounted groups rates as shown below:

	Single Rate	Family Rate
ID Shield	$8.95/month	$18.95/month
Legal Services	$18.95	

Have Questions About The Legal Shield Products?

Call or email member services and tell them you are employed by AgentHR Inc.

(866) 288-5229 || memberservices@legalshield.com

Vision Enrollment Form

Name of group (employer): **AgentHR, Inc.**

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Type of coverage selected:
☐ employee only
☐ employee and one dependent
☐ employee and children
☐ employee and family
☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

ARG Health Benefit Plans

Dental Plan Enrollment Form
Benefits Enrollment / Change of Status Form

1) Employer Name: AgentHR, Inc.

Employee Name (First, MI, Last)	Date of Birth:	Date of Hire:	Gender:	Social Security Number:

Mailing Address:	City	State:	Zip Code:

Email Address:	Home Phone:	Cell Phone:

2) Reason for Application

____ Open Enrollment
____ New Hire
____ Qualifying Event
____ COBRA

3) **Change of Status/Coverage**

_____ Change of Address _____ Divorce
_____ Marriage _____ Drop Dependent
_____ Birth of Child _____ Termination
Termination Date: _____

4) Effective Date: _____

5) Marital Status: ☐ Single / ☐ Married / ☐ Divorced

6) Enroll/Waive: ☐ Dental Plan ☐ Waive

7) Elect coverage for:
Employee Only: ☐ **Employee/Child(ren):** ☐ **Employee/Spouse:** ☐ **Employee/Family** ☐

Spouse's Name: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	Waive: ☐

Child 1: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	

Child 2: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	

Child 3: (First, MI, Last)	Date of Birth:	Gender: M / F	Social Security Number:	

Child 4: (First, MI, Last)	Date of Birth:	Gender: M/ F	Social Security Number:	

Regional Care, Inc. 905 West 27th Street, Scottsbluff, NE 69361 Phone: 800-795-7772

Please Sign here for enrolling or waiving coverage for yourself or dependents.
I acknowledge I have been given the right to apply for this coverage; however, I and/or my dependent(s), am/are electing to enroll or waive coverage. I acknowledge that I, and/or my dependent(s), may have to wait until the plans next anniversary date to be enrolled for dental coverage if waiving coverage.

Signature of Employee:_____ Date:_____