Quest

ASSET MANAGEMENT, INC.

NEW HIRE CHECKLIST-FULL TIME EMPLOYEE

1. New Employee Information Sheet
2. W4
3. I9-Manager/Regional complete and sign Section 2
4. Copies of ID's
5. Direct Deposit Form
6. TAA Employment Application
7. Zenith Network Workers Compensation Acknowledgment-Signed
8. Completed Benefits Enrollment Form
9. Signed Job Description (all pages)
10. Signed Employee Handbook Acknowledgment
11. Signed Resident Screening Policy & Procedures (for office personnel only)
12. Signed Petty Cash Agreement (Managers only)
13. Signed Manager's worksheet (Managers only)
14. Drug Test Results

NEW HIRE CHECKLIST-PART TIME EMPLOYEES

1. New Employee Information Sheet
2. W4
3. I9-Manager/Regional complete and sign Section 2
4. Copies of ID's
5. Direct Deposit Form
6. TAA Employment Application
7. Zenith Network Workers Compensation Acknowledgment-Signed
8. Signed Job Description (all pages)
9. Signed Employee Handbook Acknowledgment
10. Signed Resident Screening Policy & Procedures (for office personnel only)
11. Drug Test Results

****Please check that all items are completely filled out and signed in the appropriate places

Quest

ASSET MANAGEMENT, INC.

*********THIS SECTION TO BE COMPLETED BY MANAGER/REGIONAL SUPERVISOR		
Property Name:		____ Part Time ____ Full Time
Rate of Pay:	$ _____ Per Hour / Annually	____ Paid Hourly ____ Salary
Job Title:		Date of Hire:

Employee Information

*********THIS SECTION TO BE COMPLETED BY EMPLOYEE		
Full Name:	First:	Last:
Address:		Apt #
City:		State/Zip:
Phone Number:		Birth Date:
Social Security No.		Email:
Emergency Contact	Name: Relationship:	Phone #

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4.

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $

b **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $

c **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

a Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $

b Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $

b **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $

c **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $

e **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

a Enter your total income . . . . . **8a** $

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until _____ (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Quest

ASSET MANAGEMENT, INC.

RESIDENT SCREENING REPORT POLICY & ACKNOWLEDGEMENT

In order to remain in compliance with our screening vendor contract and credit reporting laws, please carefully read the policies outlined below. For the purpose of this acknowledgement, the term **"Resident Screening Report"** is defined as a credit, criminal or background report obtained directly by Tenant Tracker, Inc. Responsibility will originate with the employee that generated the **Resident Screening Report**, which is traceable via the tracking number at the top of each Resident Screening Report. Other or multiple employees may be held responsible if evidence exists that one or more of the policies below were not followed.

- Any part of a **Resident Screening Report** that is no longer needed must be shredded onsite or by a certified shredding company. If your property doesn't have a working shredder or a certified shredding company then please contact your supervisor directly. Not having a shredder or secure shredding box is not an excuse for improperly disposing of a **Resident Screening Report**.
- All files containing a **Resident Screening Report** must be secured behind **two (2) locks** when you leave at the end of the day. For example, the clubroom entry door counts as one lock and tenant files should be locked in another office or filing cabinet too (totaling two locks). Leaving applicant or resident files stacked on an office desk that is either not locked or outside the manager's locked office at the end of the day doesn't comply with the two lock rule.
- Under no circumstance should a **Resident Screening Report** be copied and/or provided to an applicant or resident.
- Under no circumstance should the specific content of a **Resident Screening Report** be shown or discussed with an applicant or resident. Only generic details can be discussed. For example, an applicant was denied for **Assault**. In this example, you'd explain that the applicant was denied based on a prior **conviction** of "**Assault**" and therefore denied occupancy based on our Resident Selection Criteria, yet NOT share any specific details contained within the report including but not limited to date of offense, reporting city/county, conviction type [example: misdemeanor, felony], etc..
- Under no circumstance should a **Resident Screening Report** or a partial **Resident Screen Report** be e-mailed to anyone, including but not limited to anyone at Tenant Tracker or an employee with a @questami.com e-mail address. For move-ins or transfers, a **Resident Screening Report** should not be e-mailed to corporate compliance, however, a printed copy of page one [of the **Resident Screen Report**] will remain in each move-in / transfer tenant file.
- If an applicant is denied by Quest compliance or management then the applicant must contact Tenant Tracker, Inc. directly to obtain a copy of their screening report and/or dispute the information on their report, if applicable. *The Applicant Denial & Notification Policy* and applicant denial letter can always be found under the "**Leasing Forms**" section of the Quest forms website. The denial letter was designed so that you can type information directly into the form itself within Adobe Acrobat. By signing below, you acknowledge that you have read the *Applicant Denial & Notification Policy*, the applicant denial letter and understand it.

EMPLOYEE ACKNOWLEDGEMENT:

Please contact your supervisor directly if you have any questions related to the above screening policies. By signing below, I acknowledge receipt of the screening report policies outlined above. I also understand that any violation of the policies above could result in immediate termination and involvement in a lawsuit related to the mishandling or distribution of screening report information. I also understand that I could be personally held liable for criminal and civil damages under the Fair Credit Reporting Act for the improper disposal or dissemination of information contained with any **Resident Screening Report**.

Accepted and agreed to this _____ day of _____, 20 _____.

_____ _____

Employee Signature Representative of Company

Quest Asset Management, Inc.

Employee Authorization Agreement for Automatic Direct Deposits

If you are setting up a new account(s):

1. The account must be established and active at your bank before you request direct deposit.
2. Confirm the bank accepts direct deposits and verify the transit routing and account numbers.
3. For Savings accounts, you MUST confirm the transit routing number with your bank.
4. Notify the bank that you are going to set up direct deposit through payroll.

If you are changing an existing account(s), check the box(es) that apply and complete the appropriate items.

☐ Add account ☐ Change account distribution ☐ Cancel account

ACCOUNT 1: A. Bank Name:_____

B. Bank Transit Routing Number: **C.** Bank Account Number:

☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. ☐ Checking ☐ Savings **E.** ☐ Percent _____% ☐ Fixed Amount $_____ ☐ Remainder

---

☐ Add account ☐ Change account distribution ☐ Cancel account

ACCOUNT 2: A. Bank Name:_____

B. Bank Transit Routing Number: **C.** Bank Account Number:

☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. ☐ Checking ☐ Savings **E.** ☐ Percent _____% ☐ Fixed Amount $_____ ☐ Remainder

---

☐ Add account ☐ Change account distribution ☐ Cancel account

ACCOUNT 3: A. Bank Name:_____

B. Bank Transit Routing Number: **C.** Bank Account Number:

☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. ☐ Checking ☐ Savings **E.** ☐ Percent _____% ☐ Fixed Amount $_____ ☐ Remainder

---

☐ Add account ☐ Change account distribution ☐ Cancel account

ACCOUNT 4: A. Bank Name:_____

B. Bank Transit Routing Number: **C.** Bank Account Number:

☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. ☐ Checking ☐ Savings **E.** ☐ Percent _____% ☐ Fixed Amount $_____ ☐ Remainder

---

- I authorize my employer and the bank(s) listed above to deposit my net pay or portion thereof as indicated into my account each payday.
- If funds to which I am not entitled are deposited into my account, I authorize my employer to direct the bank to return said funds to my employer.
- I understand that my deposit may not be credited to my account until 5:00 PM on the pay date indicated on the check voucher.
- I understand that new direct deposit accounts may take up to two payroll cycles to become active.

Employee Name (Print): _____ Employee Signature: _____

Social Security #(Required): _____ Date: _____

Rev. 8/2023

TEXAS APARTMENT ASSOCIATION
M E M B E R

Employment Application

Prospective employer: _____

Worksite location: _____

Position applying for: _____

Application date: _____

As an employer, we appreciate your taking the time to complete this application. It is important that all questions be answered completely and accurately. In filling out this form, if there is insufficient space to complete the answer, please continue on a separate piece of paper. We are an Equal Opportunity Employer, and we comply with applicable federal, state and local laws, regulations and ordinances which prohibit discrimination against qualified applicants and employees. We prohibit any form of workplace harassment. Please print or write neatly.

PERSONAL INFORMATION

Full name _____
(Please use complete names rather than initials. Show any nicknames in parentheses.)

Have you ever used another name for work, school or business? ❒ yes ❒ no If yes, please state name(s), dates, and circumstances:

_____ Are you at least age 18? ❒ yes ❒ no

Present residence address _____
Street Address City State Zip

Permanent address (if any) _____
Street Address or P.O. Box City State Zip

Present work phone (_____) _____ Home phone (_____) _____

Have you been employed by us before? ❒ yes ❒ no If yes, Dates _____ Location _____ Supervisor's name _____

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) _____

Do you have relatives in our line of business in Texas? ❒ yes ❒ no. If yes, please list them and their employers _____

_____ Do you have any relatives currently in our employ? ❒ yes ❒ no. If yes,

please list them _____ Date you are available to begin work _____

Is your availability for work limited to any specific times? ❒ yes ❒ no. If yes, please indicate which hours and days of the week you are unavailable _____

Are you willing to work flexible hours, which could include nights, weekends and/or overtime? _____

Do you plan to engage in other work while in our employ? ❒ yes ❒ no. If yes, please describe the work, as well as the hours and days of the week involved _____

Are you willing to travel? ❒ yes ❒ no. If yes, how much? _____

Are you willing to relocate? ❒ yes ❒ no. If yes, what geographical preference? _____

What languages (including English) do you speak, read or write proficiently?

Language	*Speak*	*Read*	*Write*
English	❒	❒	❒
_____	❒	❒	❒
_____	❒	❒	❒

Have you served in the United States Armed Services? ❒ yes ❒ no. If yes, please state branch and dates of service _____

Nature of duty or training _____

Highest rank held _____ Rank at time of discharge _____

How were you referred to us? ❒ Advertisement ❒ Friend ❒ Relative ❒ Walk-in ❒ Agency ❒ Other _____

Notify in case of emergency: Name _____ Relationship _____

Address _____ Work phone (_____) _____ Home phone (_____) _____

Do you engage in the current illegal use of drugs (for example: marijuana, cocaine, heroin, crack, speed, LSD, etc.)? ❒ yes ❒ no.

Are you willing to be tested for the current illegal use of drugs? ❒ yes ❒ no.

CONTINUED ON NEXT PAGE

EDUCATION

	Name and location of school	Circle grade or # of years completed	Did you graduate?	Degree(s) received or Subject(s) studied
Grade school	_____	1 2 3 4 5 6 7 8	☐ yes ☐ no	_____
High school	_____	9 10 11 12	☐ yes ☐ no	_____
College	_____	1 2 3 4 5 6	☐ yes ☐ no	_____
Trade, business or vocational school	_____	1 2 3 4	☐ yes ☐ no	_____

Academic honors or awards received _____

LICENSES, CERTIFICATIONS AND DEBARMENT Do you have any professional or vocational licenses (real estate, plumbing, electrician, air conditioning, pest control applicator, etc.) or certifications (such as CAM, CAMT, CAPS, NALP, CAS or CPM) that relate to the job for which you are applying? ☐ yes ☐ no. If yes, please describe all licenses and certificates below.

Type of license or certification	From what city, state agency, or organization	Date issued (if applicable)	License number
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a professional or vocational license or certification (if any) denied, revoked, or suspended? ☐ yes ☐ no. If yes, please explain

_____

_____

Have you ever been debarred, excluded or suspended from participation in any program involving payment or reimbursement for services sponsored, conducted or funded by the Federal Government? ☐ yes ☐ no.

Are you presently subject to any proceeding that might result in such debarment, exclusion or suspension? ☐ yes ☐ no.

OTHER QUALIFICATIONS Please state any other information about your personal qualities, work skills, or other abilities which would assist us in considering you (including strengths, weaknesses, goals, etc.) _____

_____

_____

_____

_____

_____

_____

_____

REFERENCES (Do not include relatives or previous employers)

Name	City and State	Phone	Occupation	Years known
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of present landlord _____ City _____ Phone _____

Name of previous landlord _____ City _____ Phone _____

Name of next previous landlord _____ City _____ Phone _____

(Limit response to landlords within previous 24 months)

CONTINUED ON NEXT PAGE

EMPLOYMENT HISTORY

We routinely contact an applicant's current and previous employers for reference checks. Are you currently employed? ❒ yes ❒ no. May we contact your current employer at this time? ❒ yes ❒ no. If no, please explain ________

____

(Permission to contact your current employer for a reference check will be required before hiring.)

Please attach a copy of any employment recommendation letters which relate to the position for which you are applying.

Please provide below your complete work history (full-time and part-time) for the preceding five employers or past 10 years, whichever is greater. Explain all gaps in employment during this period in the next section. Use additional sheets if necessary to provide complete information.

Current or last employer

Name ______________________________ Phone (_______) ______________

Address ____________________________ From ____________ To ____________

Position and duties ____

Salary (beginning) $ __________ (ending) $ __________ Supervisor's name ______________

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) ____

Next previous employer

Name ______________________________ Phone (_______) ______________

Address ____________________________ From ____________ To ____________

Position and duties ____

Salary (beginning) $ __________ (ending) $ __________ Supervisor's name ______________

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) ____

Next previous employer

Name ______________________________ Phone (_______) ______________

Address ____________________________ From ____________ To ____________

Position and duties ____

Salary (beginning) $ __________ (ending) $ __________ Supervisor's name ______________

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) ____

Next previous employer

Name ______________________________ Phone (_______) ______________

Address ____________________________ From ____________ To ____________

Position and duties ____

Salary (beginning) $ __________ (ending) $ __________ Supervisor's name ______________

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) ____

CONTINUED ON NEXT PAGE

EMPLOYMENT HISTORY, continued

Next previous employer

Name _____ Phone (_____) _____

Address _____ From _____ To _____

Position and duties _____

Salary (beginning) $ _____ (ending) $ _____ Supervisor's name _____

Reason for leaving ❒ Resigned with notice ❒ Quit without notice ❒ Asked to resign ❒ Terminated ❒ Laid off

❒ Other (Be specific) _____

Other employment history information

Please explain all periods of unemployment between the above jobs _____

_____

_____

Have you ever been terminated from employment or asked to resign by any employer other than those listed above? ❒ yes ❒ no. If yes, please provide employer(s), location, date and explanation _____

_____

_____

DRIVING RECORD **Answer the following questions only if you are applying for a position which involves driving on the job.** Can you safely drive a vehicle? ❒ yes ❒ no. Do you have a valid, unexpired driver's license? ❒ yes ❒ no. If yes, please state your current driver's license number _____ Expiration date _____

Issuing state _____

Has your driver's license been revoked, suspended or denied during the past five years? ❒ yes ❒ no.

If yes, please explain _____

List all traffic violations (other than parking tickets) for which you pled guilty, were convicted or pled no contest/nolo contendere during the past five years.

Year	Nature of violation	Location (city and state)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLEGAL USE OF DRUGS AND MEDICAL EXAM/QUESTIONNAIRE The position you are applying for requires reliable attendance and dependable performance during the contemplated work hours. You may be asked to submit to testing for the current illegal use of drugs before or after any offer of employment is made to you. If you receive a conditional offer of employment, you may be asked to take a medical examination or complete a medical questionnaire.

CRIMINAL HISTORY INFORMATION If you are among the final candidates being considered for a position or if you receive a conditional offer of employment, you may be asked to complete a form with questions about any past criminal history, and the Employer may request your authorization to conduct a crimnal background check on you. If you refuse to answer or falsely answer any of the criminal history questions, you will not be further considered for employment.

CONTINUED ON BACK SIDE

NOTE TO APPLICANT: Complete the next two pages *after* completing the first four pages of the Employment Application.

CERTIFICATION AND AUTHORIZATION BY EMPLOYMENT APPLICANT

Employer's Name _____ Date _____

Applicant's Full Name _____

(Please use complete names rather than initials. Show any nicknames in parentheses.)

For purposes of this certification and authorization, the term "application" includes this employment application form and any supplemental questionnaire, exhibit, resumé, biographical sheet, or other documents submitted by Applicant.

I certify that all information provided on this application and in any resumés and exhibits submitted to the Employer is true, correct, and complete. I have accounted for all of my work experience, training, and other information requested on this application. I have not withheld any fact or circumstance which is requested by this application.

I understand that any false, misleading, or incomplete information on this application or resumés and exhibits will result in rejection of my application or termination of my employment whenever discovered.

I understand that I may be asked to take job-related written tests and skill tests (if applicable) for the position for which I am applying. If I refuse to be tested, I understand that I will not be further considered for employment.

I understand that I may be required to produce my driver's license or other identification card to verify my identity.

If I am considered for employment, I authorize the Employer and agencies or companies of the Employer's choice to investigate or to make any inquiry about any information contained in this application, including, without limitation:

1. Obtain verification of any information provided by me in this employment application and in any supplemental questionnaire, exhibit, resumé, or biographical sheet submitted by me;
2. Obtain information regarding my work habits, skills, and conduct from my past and present employers, as well as listed or developed references or institutions;
3. Obtain information from all law enforcement and other governmental agencies, military authorities, and private companies concerning my conduct, including traffic and criminal violations;
4. Obtain information from educational institutions concerning my educational record, conduct, and skills; and
5. Obtain records of my employment, including income history and other information reported by employer(s) to any state employment security agency (e.g., Texas Workforce Commission). Work history information may be used only for purposes of my prospective employment or for the employment purposes of promotion, reassignment or retention while I am an employee. Authority to obtain such work history information expires 365 days from the date of this application.

I agree to furnish additional information as may be requested. I authorize the Employer to use any information obtained during the investigation for all matters relating to my suitability for initial or continued employment.

Applicant's Initials: _____

(Certification and Authorization continued on the next page)

CONTINUED ON NEXT PAGE

I further authorize all institutions, agencies, companies, or persons referred to above, to give the Employer and/or its agents all information requested. I release the Employer, its agents and all other parties from any claims, liabilities, and damages resulting from obtaining or furnishing such information. A copy of this authorization and release shall be as valid as the original.

I understand that before or after receiving any offer of employment, I may be asked to submit to testing for the current illegal use of drugs by a firm that is chosen and paid by the Employer. I understand that the reason for such testing is that the Employer endeavors to operate its business in a safe manner for all employees, customers, tenants, visitors, and/or guests. The results of such testing will be communicated to the Employer or its agents. If I refuse to be tested, or if I produce a positive test result for the current illegal use of drugs, I understand that any job offer will be withdrawn and that I will not be further considered for employment. I understand that I will be asked to sign a separate authorization form prior to any testing for the current illegal use of drugs.

If I receive a conditional offer of employment, I understand that I may be asked to submit to a medical examination performed by a medical practitioner who is chosen and paid for by the Employer. I further understand that I may be asked to complete a medical questionnaire or answer medical inquiries proposed by the Employer. The results of such examinations and/or questions will be communicated to the Employer or its agents. If I refuse to submit to a post-job offer medical examination or respond to medical questions, I understand that I will not be further considered for employment. I understand that if I receive a conditional offer of employment, I may be asked to sign a separate form authorizing a medical examination.

If I am among the final candidates for a position or if I receive a conditional offer of employment, I understand that I may be asked to complete a form with questions about my past criminal history and that the Employer may request my authorization to conduct a criminal background check on me. If I refuse to answer or falsely answer any of the criminal history questions, I understand I will not be further considered for employment. I also understand that any past criminal history could possibly disqualify me for employment.

I understand that I will be provided a separate notice and authorization form to sign if the Employer elects to obtain consumer reports, including but not limited to criminal, income, credit or work history reports, for employment purposes under the federal Fair Credit Reporting Act.

If I am employed, I understand that I will be asked to sign a federal I-9 form and to provide documents verifying my identity and right to work in the U.S.A.

If I am employed, I acknowledge that I must comply with the Employer's rules, procedures, and policies as modified from time to time, including any drug-free workplace policies. I understand that the job for which I am applying requires reliable attendance and dependable performance during the contemplated working hours. I further understand that if I am employed, I may be required to work various shifts and schedules as directed by my supervisor. I understand that any employment is subject to change in wages, conditions, benefits, and operating policies. I understand that any employment will be for an indefinite period and can be terminated at any time by the Employer or myself, without notice and without cause.

I understand that this application does not constitute an offer of employment or an employment contract.

_____	_____
Applicant's Signature	Applicant's Printed Name
_____	_____
Street Address	City/State/Zip Code
_____	_____
Driver's License No. (or alternative identification)	State Issuing Driver's License (or alternative identification

(NOTE TO EMPLOYER: This employment application form is for use only in Texas and only by Texas Apartment Association members. Use by non-TAA members is a violation of federal copyright laws. Use in other states is at the user's risk since this form may or may not comply with special laws or requirements, if any, of other states. Employers are advised to retain completed applications of unsuccessful applicants for at least 12 months.)

Employment Screening

Disclosure Statement

FOR: _____
(EMPLOYER NAME)

I hereby acknowledge that in connection with my employment, or application for employment, that Employer may procure, or cause to be procured, a consumer report on me as part of the process considering my status or candidacy as an emplyee. In the event that information from a report is utilized in whole or in part in making an adverse decision with regard to my employment or application, I have been advised that Employer will provide me with a copy of the consumer report on me, as allowed by law, and a written description of my rights under the law.

_____ _____
Signature of Applicant Date

Copy of report provided to applicant/employee on: _____
DATE

Copy of report provided by: _____
Signature of Employer Representative

NCTC DISCLOSURE STATEMENT: COPY TO BE PROVIDED TO APPLICANT PRIOR TO REQUSTING A REPORT FROM NCTC.

Zenith Health Care Network
HCN License Number: 13041730

Zenith®
Health Care Network

Zenith Health Care Network

Employee Notice of Network Requirements

Your employer provides medical services for work related injuries through the certified Zenith Health Care Network (ZHCN). The ZHCN includes doctors, hospitals and other medical providers in 231 counties which is called the ZHCN Service Area.

If you are injured at work you must check to see if you live in the ZHCN Service Area. If you do live in the ZHCN Service Area, you must receive all health care for your injury through the ZHCN.

The information in this notice will explain the ZHCN Service Area and will help you get medical care through the ZHCN. If you have any questions, you can ask your employer, or call 1-800-841-3987.

Claims Administrator
Your claims administrator is:
Zenith Insurance Company

Contact for Complaints:
Zenith Insurance Company
ATTN: Provider Relations

Mailing Address:
21255 Califa Street
Woodland Hills, CA 91367

Email for Complaints:
txnetwork@thezenith.com

Access to Health Care Services
When requested, the ZHCN must arrange for medical services in a timely manner, taking into consideration your circumstances and medical condition. This includes referrals to specialists. In any circumstance, services must be arranged no later than 21 days after the date of the request.

ZHCN Service Area
A map of the ZHCN Service Area is attached.

If you live in the ZHCN Service Area, you must pick your Treating Doctor from the ZHCN Provider Directory. Your Treating Doctor will treat you. Your Treating Doctor may refer you to another health care provider for other medical treatment.

If you think you do not live in the ZHCN Service Area you may contact your claims examiner. You have to request a review in writing. If you request a review, you have to provide proof to show that you do not live in the ZHCN Service Area. Your request for review should be sent to your claims administrator.

Your claims administrator will review your request and within seven (7) days of receipt of your request will make a decision and give you written notice. If you do not agree with the decision, you may file a complaint. Complaints should be filed with the Department of Insurance (See Complaints section for more information).

While your request is under review, you may seek all medical care within the network. To do this, you should select a ZHCN Treating Doctor. All health care for your work injury will be set up with your Treating Doctor.

If it is determined that you live in the ZHCN Service Area, you may have to pay for health care if it is from a provider that is not in the ZHCN.

How to Get Health Care through the ZHCN
Tell your supervisor or manager immediately if you are injured at work.

You should pick your Treating Doctor from the ZHCN Provider Directory. You may need a referral to a specialist or other health care provider. Your ZHCN Treating Doctor must make all referrals. If you need emergency care, you do not have to go through your ZHCN Treating Doctor.

ZHCN providers will only treat and bill your employer's workers' compensation insurer or claims administrator for services related to a compensable work injury. ZHCN providers will not bill you.

You may want to get health care from providers who are not in the ZHCN. To do this, you must first get approval from your claims administrator. If you do not get approval to use providers who are not in the ZHCN, you may have to pay for those services yourself.

The exceptions to this rule are:

- Emergency Care
- If you do not live within the ZHCN Service Area
- Out-of-network care that your claims administrator pre-authorized
- Your HMO Primary Treating Physician is your Treating Doctor

Emergency Care
If you are injured at any time - and you think it is a medical or mental health emergency - call 911 or go to the nearest medical facility offering emergency care services.

You may be injured while you are outside of the ZHCN Service Area. If this happens and you think it is a medical or mental health emergency, go to the nearest medical facility offering emergency care services or call 911.

You should contact your claims administrator as soon as possible to report your injury.

Texas Law defines the term "medical emergency" as an acute medical condition that occurs suddenly. Symptoms are severe and include severe pain. A patient's health, bodily function or function of any organ or body part could be in serious jeopardy without immediate medical care. The Texas Law also defines the term "mental health emergency". It is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

Non- Emergency Care
If you are hurt at work, and it is not an emergency, pick a Treating Doctor from the Provider Directory. The Provider Directory is available on your claims administrator's website. You may also call your claims administrator for help choosing a Treating Doctor. Your claims administrator is listed above.

You should call your Treating Doctor to set up an appointment. Your claims administrator can also help you set up an appointment.

You may be injured while you are outside the Service Area. If this happens and you need non-emergency health care please call your claims administrator. Your claims administrator will help you locate a medical provider.

After-Hours Care
You may need after-hours medical care. If this happens, call your claims administrator. Your claims administrator will help you find a provider or facility. You may also visit your claims administrator's website to select a provider from the online directory. You should contact your employer to report your injury as soon as possible.

If you have a medical emergency, call 911 or go to the nearest emergency room. After you get treated for your emergency, all follow-up and non-emergency care must be set up through your Treating Doctor.

Selecting a Treating Doctor
You must pick a Treating Doctor from the Provider Directory. Your Treating Doctor must be located in your Service Area. The Provider Directory will show which providers are taking new patients. If you would like help picking a Treating Doctor, please call your claims administrator.

If you are a member of a Health Maintenance Organization (HMO) you may pick your Primary Care Physician as your Treating Doctor. You must have chosen this doctor as your primary care physician through your HMO before your work related injury occurred and your HMO Primary Care Physician has to agree to treat your workers' compensation injury. To do this, complete the attached "Physician pre-designation form". Return the completed form to your employer. If you would like your HMO Primary Care Physician to treat you for a work injury, please contact your claims administrator. Your claims administrator will review your request and notify you of their decision within 72 hours. Your HMO Primary Care Physician will not be considered as an initial choice of a Treating Doctor unless this process is followed.

The following also will not be considered an initial choice of Treating Doctor:

- A Doctor who works for your employer;
- A Doctor providing emergency care; or
- Any doctor who provided care before the employee was enrolled in the ZHCN, unless it was your HMO Primary Care Physician which you pre-designated using the process set forth above.

You may not be happy with the first Treating Doctor you picked. If this happens, you can pick an alternate Treating Doctor. Contact your claims administrator for help picking an alternate Treating Doctor. When you pick an alternate Treating Doctor, you must provide the name of the Doctor to your claims administrator.

If you are not happy with the alternate Treating Doctor, you must contact your claims administrator to submit a request for additional changes. They will review your request and give you written notice of their decision within seven (7) days.

Continuing your Treatment if your Treating Doctor is Terminated from the Network
If your Treating Doctor leaves the Network, you will be notified in writing. If this happens, and you need to continue treatment, you must pick another Treating Doctor. To do this, pick a new Treating Doctor from the Provider Directory. If you would like help with this, call your claims administrator.

You may continue treatment with your original Treating Doctor under certain circumstances:

- If you have a life-threatening medical condition.
- Your medical condition is acute and a disruption in care could harm you.

If one of these conditions applies to you, your Treating Doctor has to contact your claims administrator and request a review. Your claims administrator will review the Treating Doctor's request then give you and your

Doctor written notice of their decision. If you or your Doctor disagrees with your claims administrator's decision, you may file a complaint (See Complaints section for more information).

Services Requiring Pre-Authorization
All health care must be set up through your Treating Doctor. Your Treating Doctor will treat you. Your Treating Doctor may refer you for treatment for your work injury. Certain services must be approved by your claims administrator in advance. Services that require preauthorization are listed on the Zenith Health Care Network and Non-Network Services Requiring Pre-Authorization List ("Pre-Authorization List"). A copy is included in this Employee Notice of Network Requirements.

To have any of the services requiring preauthorization approved, your Doctor must follow ZHCN preauthorization requirements. You will be given written notice of the decision. You have a right to request a reconsideration of an adverse determination (an adverse determination is when the proposed medical care is determined not medically necessary). You will receive information with the adverse determination notice about how to submit a reconsideration. You also have a right to request a review by an Independent Review Organization if the reconsideration decision on an adverse determination is upheld. You will be given information about these rights as well. The review will be randomly assigned to an Independent Review Organization by the Texas Department of Insurance. An employee with a life-threatening condition is allowed an immediate review by an Independent Review Organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

Complaints
If you are unhappy with ZHCN, you may file a complaint. You may complain about any part of the ZHCN operation. Verbal complaints and written complaints are accepted.

You have 90 days to submit a complaint. The 90 day period starts on the date when the problem or issue first came up. When your complaint has been received, it will be reviewed. A written notice explaining the review and decision will be sent to you within 30 calendar days from the date your complaint is received.

Complaints should be directed to your claims administrator.

You may not be satisfied with how your complaint was handled. If this happens, you have a right to complain. There is a form to use for your complaint. Your completed form should be sent to the Texas Department of Insurance's Health & Workers' Compensation Network (HWCN) Division.

The Department's complaint form can be obtained from www.tdi.texas.gov or:

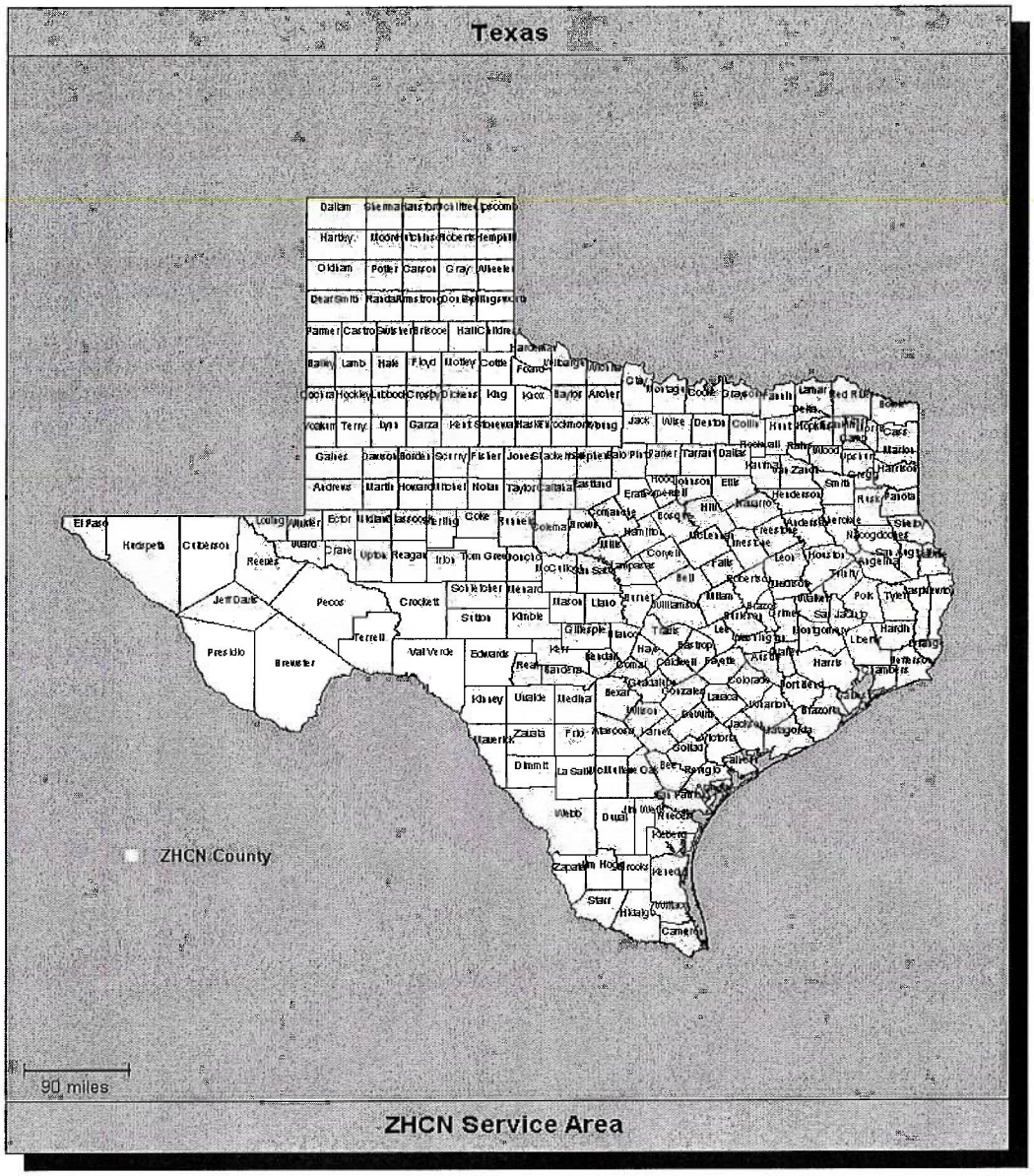
Texas Department of Insurance
Division of Workers' Compensation, MS-8
7551 Metro Center Drive, Suite 100
Austin, TX 78744

The completed form should be sent to the address indicated on the form.

It is not legal for a network to retaliate against an employee, employer, or medical provider for filing a complaint. It is not legal for a network to retaliate against an employee or medical provider who appeals a decision of the network.

*The Zenith Health Care Network is owned and operated by Zenith Insurance Management Services, Inc. acting only in the capacity of network administrator and not as your claims administrator.

Zenith Health Care Network (ZHCN)



Zenith Health Care Network
HCN License Number: 13041730

The Network's service area consists of 231 counties. The counties in bold and with the * below were originally effective February 16, 2010. Please also refer to the accompanying map.

Anderson	Cooke	***Harris**	Loving	Robertson	***Wilson**
Andrews	Coryell	***Harrison**	***Lubbock**	***Rockwall**	Winkler
Angelina	Crane	Hartley	Lynn	Runnels	***Wise**
Aransas	Crosby	Haskell	Madison	Rusk	Wood
Archer	Dallam	***Hays**	Marion	Sabine	Yoakum
Armstrong	***Dallas**	Hemphill	Martin	San Augustine	***Young**
***Atascosa**	Dawson	Henderson	Mason	***San Jacinto**	
***Austin**	Deaf Smith	***Hidalgo**	Matagorda	San Patricio	
Bailey	Delta	Hill	McCulloch	San Saba	
***Bandera**	***Denton**	Hockley	McLennan	Schleicher	
***Bastrop**	DeWitt	***Hood**	***McMullen**	Scurry	
Baylor	Dickens	Hopkins	***Medina**	Shackelford	
Bee	Donley	Houston	Menard	Shelby	
***Bell**	Duval	Howard	Midland	Sherman	
***Bexar**	Eastland	Hudspeth	Milam	***Smith**	
Blanco	Ector	***Hunt**	Mills	***Somervell**	
Borden	***El Paso**	Hutchinson	Mitchell	Starr	
Bosque	***Ellis**	Irion	Montague	Stephens	
***Bowie**	Erath	Jack	***Montgomery**	Sterling	
***Brazoria**	Falls	Jackson	Moore	Stonewall	
Brazos	Fannin	Jasper	Morris	Swisher	
Briscoe	Fayette	***Jefferson**	Motley	***Tarrant**	
Brooks	Fisher	Jim Hogg	Nacogdoches	Taylor	
Brown	Floyd	Jim Wells	***Navarro**	Terry	
Burleson	***Fort Bend**	***Johnson**	Newton	Throckmorton	
***Burnet**	Franklin	Jones	Nolan	Titus	
***Caldwell**	Freestone	Karnes	***Nueces**	Tom Green	
Calhoun	***Frio**	***Kaufman**	Ochiltree	***Travis**	
Callahan	Gaines	***Kendall**	Oldham	Trinity	
***Cameron**	***Galveston**	Kenedy	Orange	Tyler	
Camp	Garza	Kent	***Palo Pinto**	Upshur	
Carson	Gillespie	Kerr	Panola	Upton	
Cass	Glasscock	Kimble	***Parker**	Uvalde	
Castro	Goliad	Kleberg	Parmer	Van Zandt	
***Chambers**	Gonzales	Lamar	Pecos	Victoria	
Cherokee	Gray	Lamb	Polk	***Walker**	
Clay	***Grayson**	Lampasas	Potter	***Waller**	
Cochran	Gregg	Lavaca	Rains	Ward	
Coke	***Grimes**	Lee	Randall	Washington	
Coleman	***Guadalupe**	Leon	Reagan	Webb	
***Collin**	Hale	***Liberty**	Real	***Wharton**	
***Colorado**	Hall	Limestone	Red River	Wichita	
***Comal**	Hamilton	Lipscomb	Reeves	Wilbarger	
Comanche	Hansford	Live Oak	Refugio	Willacy	
Concho	Hardin	***Llano**	Roberts	***Williamson**	

PRE-DESIGNATED PHYSICIAN FORM FOR ON–THE-JOB INJURIES

EMPLOYEE TO COMPLETE THIS SECTION:	PHYSICIAN TO COMPLETE THIS SECTION:
Employee Name: _____ (please print) You can be treated immediately by your personal medical doctor if: • You are part of an HMO health plan • The doctor treated you in the past and has your medical records • You give your employer the doctor's name and address in writing on this form. _____ Employee Signature: _____ Company Name: _____ Company Address: If I get hurt on the job, I want to receive treatment from: _____ Name of Doctor: _____ Address: _____ Telephone number:	I agree to treat the above named individual for their work injury or illness. I understand that medical services in the Texas Workers' Compensation system are subject to preauthorization of non-emergency services, utilization review, reporting requirements, and fees governed by the Division of Workers Compensation. I also agree that, upon treating the above individual, I will abide by the terms of the Zenith Health Care Network Medical Provider Manual (available for download at www.coventryprovider.com) and I will comply with Texas Insurance Code chapter 1305, subchapter D-I and commensurate rules adopted under these subchapters. Physician Name (please print): _____ Physician Signature: _____ Date: _____ Name of HMO Plan: _____ Office Manager/Billing Contact: _____ Street Address: _____ Mailing Address: _____ Phone Number: _____ Email: _____ Physician Tax ID: _____

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Zenith Health Care Network
HCN License Number: 13041730

ZENITH HEALTH CARE NETWORK WORKERS' COMPENSATION NETWORK ACKNOWLEDGEMENT

I have received the "Employee Notice of Network Requirements" that explains how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the Service Area, I understand that:

1. I must choose a treating doctor from the Zenith Health Care Network.
2. I may select as my treating doctor a doctor, whom I selected as my primary care physician or provider through my HMO Plan.
3. I must go to my treating doctor for all treatment for my work injury. If I need a specialist, my treating doctor will refer me.
4. If I need emergency care, I may go anywhere.
5. The insurance carrier will pay the network providers all mandated amounts if my injury is caused by my job.
6. I may have to pay for my medical treatment if I get health care from someone not in the Zenith Health Care Network.

The "Employee Notice of Network Requirements" explains all of the above issues in detail. A map of the Service Area is attached to the "Employee Notice of Network Requirements".

Signature: _____

Date: _____

Printed Name: _____

The address where I live:

_____

Name of Employer: _____

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ZENITH HEALTH CARE NETWORK AND NON-NETWORK
Services Requiring Preauthorization

	Non-Network – 134.600(p)	Network – 413.014; TIC 1305; 28 TAC 10(Subchapter F)
Hospital/ Inpatient	Non-emergency inpatient admissions (including principal scheduled procedure and length of stay.)	Same + all nursing home/ convalescent/ services.
Surgery	Outpatient surgical or ambulatory surgical services. Spinal surgery. Bone growth stimulators would be covered as part of the surgery so no discrepancy.	Same, and specifies that radiological cryotherapy, manipulation under anesthesia, and certain injections (see below) are classified as surgery. All implantable Bone Growth Stimulators. All vertebral axial decompressions (Vax-D), radio frequency thermocoagulation of facet joints (RFTC), and IDET procedures;
Injections	May require pre-auth as outpatient surgical services, depending on billing and where injection is performed.	All ESI's, facet injections, trigger point injections, SI joint injections, prolotherapy injections, chemonucleolysis, and discograms.
Psych	Psych testing, psych therapy, repeat psych interviews, and biofeedback (unless part of a preauthorized or DWC exempted RTW program.)	Same (excluding an initial psych eval.)
Diagnostics	Repeat diagnostic study > $350 per fee schedule, or without fee schedule value.	Same + All myelograms, discograms, venograms, surface electromyograms, EMGs, and nerve conduction studies.
PT/ OT/ Chiro/ home health / gym	PT/ OT/ Chiropractic PT/ Orthotics/ Prosthetics Management, except for the first 6 visits of PT/ OT within 2 weeks immediately following the DOI or date an approved surgery was performed.	Same + all home health/ residential treatment, and all gym memberships: Just requires for PT OT no specifics
Work Hardening/ Conditioning	All work hardening or work conditioning services.	Same
Pain Management/ Other Programs	All Chronic Pain Management/ Interdisciplinary Pain Rehab programs.	Same + All chemical dependence and weight loss programs
DME	DME > $500 billed charges per item (purchase or expected cumulative rental.) Bone Growth Stimulators would be covered as part of DME because they exceed $500.00	Same + All Bone Growth Stimulators, and All TENS units/ neuromuscular stimulators/ interferential units
Rx	Drugs not included in the Division's Formulary (aka N-Drugs). All drugs created by compounding. (prescribed and dispensed on or after 7/1/2018) Intrathecal drug delivery systems (including refills for drugs excluded from the closed formulary or for changes in dosing or changes in doctors)	Same
Other		All chemonucleolysis, vertebral axial decompressions (Vax-D), radio frequency thermocoagulation of facet joints (RFTC), and IDET procedures.
Treatment Outside of ODG	All treatment that exceeds or is not addressed by ODG and which are not contained in a treatment plan that has been previously approved. All investigational/ experimental services not yet broadly accepted as the prevailing standard of care.	Same
Investigational Treatment	Any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device that is not yet broadly accepted as the prevailing standard of care.	
Treatment for Disputed Body Parts/ Conditions	Any treatment for an injury or diagnosis that is not accepted by the carrier per §408.0042 and §126.14.	Same
Required Treatment Plans	Mandated UR	

Note: Emergency treatment does not require preauthorization

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ZENITH HEALTH CARE NETWORK AND NON-NETWORK
Services Requiring Preauthorization

A to Z:

Non-Network	Network
Ambulatory Surgery	Ambulatory Surgery
Biofeedback	Biofeedback
Bone Growth Stimulators	Bone Growth Stimulators
Chemonucleolysis	Chemical Dependence Programs
Chiropractic Therapy*	Chemonucleolysis
Chronic Pain Management Programs	Chiropractic Therapy*
Compounded drug (prescribed and dispensed on or after 7/1/2018)	Chronic Pain Management Programs
Diagnostics- repeat studies > $350	Compounded drug (prescribed and dispensed on or after 7/1/2018)
Discograms	Convalescent Services
DME > $500	CT Myelograms
Experimental Treatment	Diagnostics- repeat studies > $350
Hospital Admissions	Discograms
IDET Procedures	DME > $500 billed charges
Injections done in Outpatient Surgical Setting	EMGs (Electromyograms)
Inpatient Hospital Length of Stay	ESI's (Epidural Steroid Injections)
Interdisciplinary Pain Rehab Programs	Experimental Treatment
Interferential Units > $500	Facet Injections
Intrathecal drug delivery systems, including refills	Gym Memberships
Investigational Treatment	Home Health Services
Manipulation Under Anesthesia	Hospital Admissions
N-Drugs	IDET Procedures
Neuromuscular Stimulators > $500	Interferential Units
Occupational Therapy*	Injections done in Outpatient Surgical Setting
Orthotics Management*	Inpatient Hospital Length of Stay
Outpatient Surgery	Interdisciplinary Pain Rehab Programs
Physical Therapy*	Intrathecal drug delivery systems, including refills
Prosthetics Management*	Investigational Treatment
Psych Interviews- Repeat	Manipulation Under Anesthesia
Psych Testing	Myelograms
Psych Therapy, Chemical Dependency Programs,	N-Drugs
Radiofrequency Thermocoagulation (RFTC)	Nerve Conduction Studies (NCS, NCV)
Radiological Cryotherapy	Neuromuscular Stimulators
Repeat Psych Interviews	Nursing Home Stays
Rx outside of ODG (N-Drugs)	Occupational Therapy*
Spinal Surgery	Orthotics Management*
Surface EMG	Outpatient Surgery
Surgery	Physical Therapy*
Treatment for disputed conditions	Prolotherapy Injections
Treatment Outside of ODG	Prosthetics Management*
Vertebral Axis Decompression (Vax-D)	Psych Interviews- Repeat
Work Conditioning	Psych Testing
Work Hardening	Psych Therapy
	Radio Frequency Thermocoagulation (RFTC)
	Radiological Cryotherapy
	Repeat Psych Interviews
	Residential Treatment/ Services
	Rx outside of ODG (N-Drugs)
	Sacroiliac (SI) Joint Injections
	Spinal Surgery
	Surface EMGs
	Surgery
	TENS Units
	Treatment for disputed conditions
	Treatment Outside of ODG
	Trigger Point Injections
	Vertebral Axial Decompressions (Vax-D)
	Weight Loss Programs
	Work Conditioning
	Work Hardening

* Beyond up to 6 sessions performed within 2 weeks of DOI/ Date of approved surgery

Zenith Health Care Network
HCN License Number: 13041730

Zenith®
Health Care Network

Red de Servicios Médicos de Zenith

Aviso para empleados de requisitos de la red

Su empleador provee prestaciones de salud para lesiones relacionadas con el trabajo por medio de la Red certificada de Servicios Médicos de Zenith (ZHCN, por su sigla en inglés). La ZHCN incluye médicos, hospitales y otros proveedores médicos en 231 condados que comprenden el área de servicio de la ZHCN.

Si usted se lesiona en el trabajo debe comprobar que vive en el área de servicio de la ZHCN. Si vive en el área de servicio de la ZHCN, debe recibir toda la atención médica de su lesión a través de la ZHCN.

La información en este aviso le explicará el área de servicio de la ZHCN y le ayudará a obtener atención de salud a través de la ZHCN. Si tiene alguna pregunta, puede consultar a su empleador o llamar al 1-800-841-3987.

Administrador de reclamaciones
Su administrador de reclamos es:
Zenith Insurance Company

Contacto para quejas:
Zenith Insurance Company
ATTN: Provider Relations

Dirección de envio:
21255 Califa Street
Woodland Hills, CA 91367

Correo electrónico para quejas:
txnetwork@thezenith.com

Acceso a atención de salud
Cuando así lo solicite, la ZHCN debe concertar los servicios médicos de manera oportuna, teniendo en cuenta sus circunstancias y su estado de salud. Esto incluye recomendaciones a especialistas. En cualquier caso, los servicios deben concertarse a más tardar 21 días después de la fecha de la solicitud.

Área de servicio de la ZHCN
Se adjunta un mapa del área de servicio de la ZHCN.

Si usted vive en el área de servicio de la ZHCN, debe escoger al médico de cabecera del Directorio de Proveedores de la ZHCN. Su médico de cabecera podrá enviarlo a otro profesional de la salud.

Si piensa que no vive en el área de servicio de la ZHCN, puede comunicarse su examinador/ra de reclamos. Usted tiene que solicitar una revisión por escrito. Si solicita una revisión, tiene que presentar pruebas para demostrar que no vive en el área de servicio de la ZHCN.

Su solicitud de revisión debe ser enviada a Su administrador/ra de reclamos.

Su administrador/ra de reclamos revisará su solicitud y dentro de los siete (7) días siguientes a la recepción de esta, tomará una decisión y se la enviará por escrito. Si no está de acuerdo con la decisión de Zenith, puede presentar una queja. Las quejas deben ser presentadas ante el Departamento

de Seguros (vea la sección de Quejas para más información).

Mientras su solicitud se encuentra en proceso de revisión, puede acudir a recibir todo su tratamiento médico dentro de la red. Para ello, debe seleccionar un médico de cabecera de la ZHCN. Todo el tratamiento médico para su lesión de trabajo será planificado con su médico de cabecera.

Si es determinado que usted vive en el área de servicio de la ZHCN, es posible que tenga que pagar por el tratamiento médico si fue a un proveedor que no está en la ZHCN.

Cómo obtener atención de salud a través de ZHCN
Informe a su supervisor o gerente de inmediato si usted se lesiona en el trabajo.

Usted debe escoger su médico de cabecera del Directorio de Proveedores de la ZHCN. Es posible que necesite que lo envíen a un médico especialista o a otro profesional de la salud. Su médico de cabecera de la ZHCN debe hacer todas las recomendaciones. Si necesita atención de urgencia, no tiene que pasar por su médico de cabecera de la ZHCN.

Los proveedores de la ZHCN solo tratarán y facturarán a la aseguradora de compensación para trabajadores de su empleador o al administrador de reclamos por los servicios relacionados con un accidente de trabajo indemnizable. Los proveedores de ZHCN no le facturarán.

Puede que desee obtener atención de salud de proveedores que no están en la ZHCN. Para ello, primero debe obtener la aprobación de su administrador/ra de reclamos. Si no recibe la aprobación para utilizar proveedores que no están en la ZHCN, es posible que tenga que pagar por esos servicios usted mismo.

Las excepciones a esta regla son:
- Cuidados de urgencia
- Si usted no vive en el área de servicio de la ZHCN
- Atención fuera de la red preautorizada por su administrador/ra de reclamos
- El médico de cabecera de su plan HMO es el médico de cabecera encargado de su tratamiento.

Atención de urgencia
Si usted se lesiona en cualquier momento y piensa que es una urgencia de salud mental o física, llame al 911 o diríjase al centro médico más cercano que ofrezca servicios de atención de urgencia.

Es posible que se lesione mientras se encuentra fuera del área de servicio de la ZHCN. Si esto ocurre y usted piensa que es una urgencia de salud mental o física, diríjase al centro médico más cercano que ofrezca servicios de atención de urgencia o llame al 911.

Debe comunicarse con administrador/ra de reclamos tan pronto como sea posible para reportar su lesión.

La Ley de Texas define el término "urgencia médica", como un problema de salud agudo que ocurre repentinamente. Los síntomas son graves e incluyen dolor severo. La salud, la función corporal o función de cualquier órgano de un paciente podrían estar en peligro si no recibe atención médica inmediata. La ley de Texas también define el término "urgencia de salud mental". Es una condición que razonablemente podría presentar peligro para la persona que experimenta la condición de salud mental o para otra persona.

Cuidados que no sean de urgencia
Si usted se lesiona en el trabajo y no es una urgencia, elija un médico de cabecera del Directorio de Proveedores.

El Directorio de Proveedores está disponible en el sitio web de su administrador de reclamos.

También puede llamar a su administrador de reclamos para que le ayude a elegir un médico tratante. Su administrador de reclamos aparece arriba.

Debe llamar a su médico de cabecera para hacer una cita. Su administrador de reclamos también puede ayudarle a concertar una cita.

Es posible que se lesione mientras se encuentra fuera del área de servicio. Si esto ocurre y necesita atención de salud que no sea de urgencia, por favor llame a su administrador de reclamos. Su administrador de reclamos lo ayudará a localizar un proveedor médico.

Atención fuera del horario
Es posible que necesite cuidados médicos después de las horas de atención. Si esto ocurre, llame a su administrador de reclamos. Su administrador de reclamos le ayudará a encontrar un proveedor o centro. También puede visitar el sitio web para seleccionar un proveedor del directorio en línea. Debe contactar a su empleador para reportar su lesión lo antes posible.

Si usted tiene una urgencia médica, llame al 911 o diríjase a la sala de urgencias más cercana. Después de recibir tratamiento para su urgencia, todo el seguimiento y la atención que no sea de urgencia deben planificarse a través de su médico de cabecera.

Selección de un médico de cabecera
Usted debe escoger un médico de cabecera del Directorio de Proveedores. Su médico de cabecera debe estar ubicado en su área de servicio. El Directorio de Proveedores mostrará los proveedores que aceptan nuevos pacientes. Si desea ayuda para escoger un médico de cabecera, por favor llame a administrador/ra de reclamos .

Si pertenece a una Organización de Mantenimiento de la Salud (HMO), usted puede escoger su médico de atención primaria como su médico de cabecera. Usted debe haber elegido este médico como su médico de atención primaria por medio de su HMO antes de que ocurriera su lesión relacionada con el trabajo y su médico de atención primaria de la HMO tiene que estar de acuerdo en tratar su lesión de indemnización por accidentes laborales. Para ello, complete el formulario de "Designación previa del médico" adjunto. Envíe el formulario completo a su empleador. Si desea que su médico de atención primaria de la HMO lo trate por una lesión relacionada con el trabajo, comuníquese con su administrador/ra de reclamos. Su administrador/ra de reclamos revisará su solicitud y le notificará de su decisión dentro de las 72 horas. Su médico de atención primaria de la HMO no será considerado como una opción inicial de médico de cabecera a no ser que se siga este proceso.

Lo siguiente tampoco se considerará una opción inicial de médico de cabecera:

- Un médico que trabaja para su empleador;
- Un médico que proporciona servicio de urgencia; o
- Cualquier médico que atendió al empleado antes de que se inscribiera en la ZHCN, a menos que fuera el médico de atención primaria de su HMO previamente designado por usted mediante el proceso establecido anteriormente.

Es posible que no esté satisfecho con el primer médico de cabecera que escoja. Si esto ocurre, usted puede escoger un médico de cabecera alternativo. Póngase en contacto con su administrador/ra de reclamos para recibir ayuda para escoger un médico de cabecera alternativo. Cuando escoja un médico de cabecera alternativo,

deberá proporcionar el nombre de su médico a su administrador/ra de reclamos.

Si usted no está satisfecho con el médico de cabecera alternativo, debe comunicarse con su administrador/ra de reclamos para presentar una solicitud de cambios adicionales. Ellos revisarán su solicitud y le darán un aviso por escrito de su decisión dentro de los siete (7) días.

Continuación de su Tratamiento si su Médico de Cabecera es Despedido de la Red

Si su médico de cabecera es despedido de la Red, se lo notificará por escrito. Si esto ocurre y necesita continuar con el tratamiento, debe elegir otro médico de cabecera. Para ello, elija un nuevo médico de cabecera del Directorio de Proveedores. Si necesita ayuda con esto, llame a su administrador/ra de reclamos.

Usted puede continuar el tratamiento con su médico de cabecera original bajo ciertas circunstancias:

- Si usted tiene un problema de salud potencialmente mortal
- Su problema de salud es agudo y una interrupción en la atención podría dañarle

Si una de estas condiciones es aplicable a su caso, su médico de cabecera tiene que ponerse en contacto con su administrador/ra de reclamos y solicitar una revisión. Su administrador/ra de reclamos revisará la solicitud del médico de cabecera y usted y su doctor recibirán una notificación por escrito de la decisión. Si usted o su doctor no está de acuerdo con la decisión de su administrador/ra de reclamos, puede presentar una queja (vea la sección de Quejas para más información).

Servicios que requieren autorización previa

Toda atención de salud debe ser concertada a través de su médico de cabecera. Su médico de cabecera lo atenderá. Su médico de cabecera puede referirlo para el tratamiento de su lesión relacionada con el trabajo. Ciertos servicios deben ser aprobados por su administrador/ra de reclamos con anticipación. Los servicios que requieren autorización previa están enumerados en la lista de Servicios de la Red de Servicios Médicos de Zenith y de Fuera de la Red que Requieren Autorización Previa ("lista de Autorización Previa"). También se incluye una copia en este Aviso para empleados sobre los requisitos de la red

Para que cualquiera de los servicios que requieren autorización previa sea aprobado, su médico debe seguir los requisitos de autorización previa de la ZHCN. Se le dará un aviso por escrito de la decisión. Usted tiene el derecho de solicitar una reconsideración de una determinación adversa (una determinación adversa es cuando se determina que no es médicamente necesario el cuidado médico propuesto). Usted recibirá información con el aviso de determinación adversa sobre cómo presentar una reconsideración. Usted también tiene derecho a solicitar una revisión por una Organización de Revisión Independiente si la determinación adversa es confirmada tras la solicitud de reconsideración. También se le dará información sobre estos derechos. La revisión será asignada al azar a una Organización de Revisión Independiente por el Departamento de Seguros de Texas. Los empleados con afecciones potencialmente mortales pueden solicitar una revisión inmediata por una organización de revisión independiente y no están obligados a seguir los procedimientos para solicitar la

reconsideración de una determinación adversa.

Quejas
Si no está satisfecho con ZHCN, puede presentar una queja. Usted puede quejarse de cualquier parte de la operación de la ZHCN. Se aceptan quejas verbales y quejas por escrito.

Usted tiene 90 días para presentar una queja. El período de 90 días comienza en la fecha en que el problema o asunto se produjo. Cuando se haya recibido su queja, se revisará. Se le enviará un aviso por escrito explicando la revisión y decisión. El aviso se enviará dentro de los 30 días naturales desde la fecha de recepción de su queja.

Las quejas deben ser dirigidas a su administrador/ra de reclamos.

Es posible que no esté satisfecho con la forma en que se maneja su queja. Si esto ocurre, usted tiene derecho a quejarse. Hay un formulario que puede usar para su queja. Su formulario completo deberá ser enviado al Departamento de la División de Seguros de Salud y Trabajadores de la Red de Compensación (HWCN) de Texas.

El formulario de quejas del Departamento se puede obtener en www.tdi.texas.gov o:

Texas Department of Insurance
Division of Workers' Compensation, MS-8
7551 Metro Center Drive, Suite 100
Austin, TX 78744

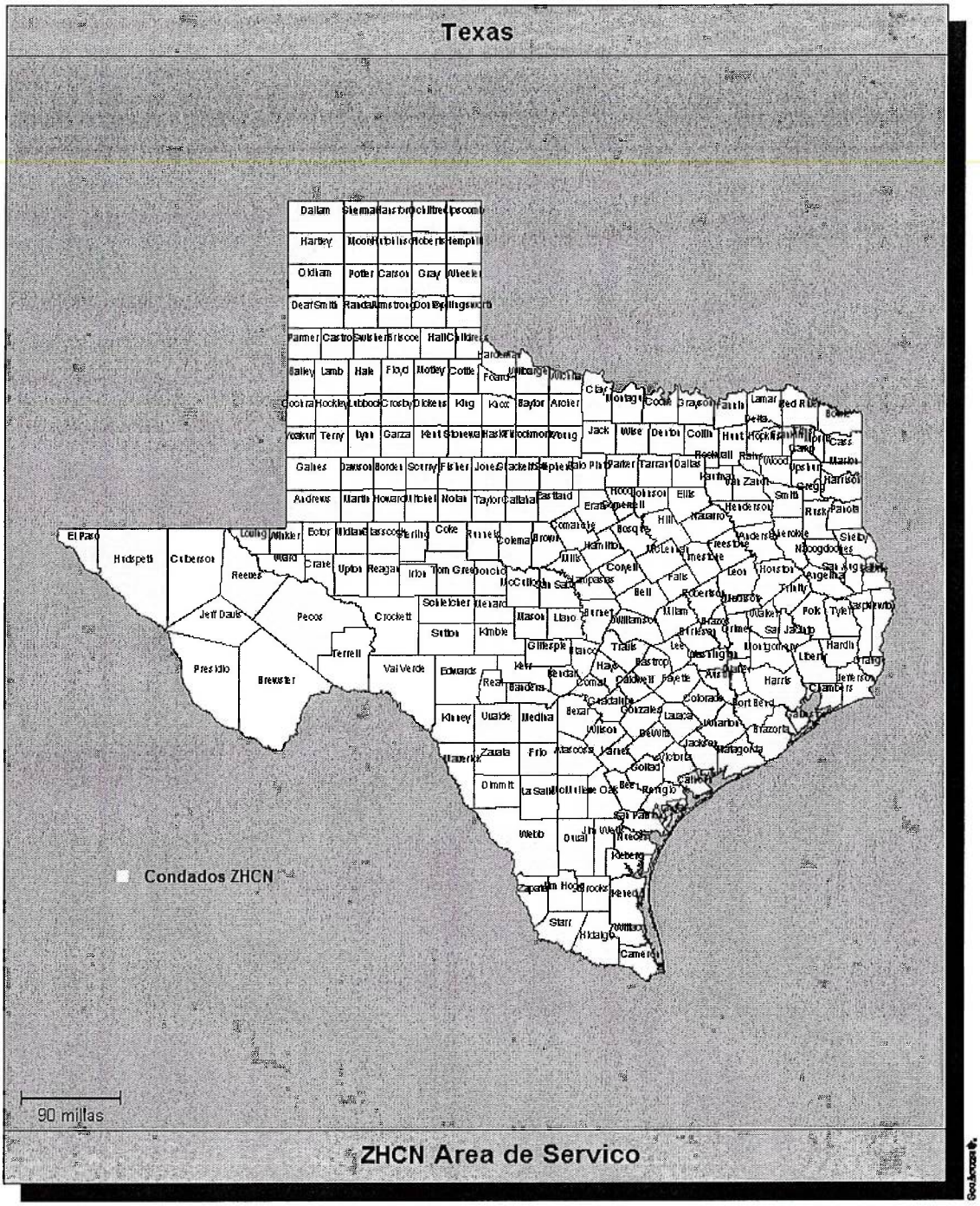
El formulario debidamente cumplimentado debe enviarse a la dirección indicada en dicho formulario.

Es ilegal que una red tome represalias contra un empleado, empleador o proveedor médico por presentar una queja. No es legal que una red tome represalias contra un empleado o proveedor médico que apela una decisión de la red.

* Zenith Health Care Network es propiedad y está operado por Zenith Insurance Management Services, Inc., que actúa solo en calidad de administrador de la red y no como administrador de reclamos.

[PÁGINA DEJADA EN BLANCO INTENCIONALMENTE]

Zenith Health Care Network (ZHCN)



Zenith Health Care Network
HCN License Number: 13041730

El área de servicio de la red consiste en 231 condados. Los condados en negrita y con el * a continuación entraron originalmente en vigor el 16 de febrero de 2010. Por favor, consulte también el mapa adjunto.

Anderson	Cooke	***Harris**	Loving	Robertson	***Wilson**
Andrews	Coryell	***Harrison**	***Lubbock**	***Rockwall**	Winkler
Angelina	Crane	Hartley	Lynn	Runnels	***Wise**
Aransas	Crosby	Haskell	Madison	Rusk	Wood
Archer	Dallam	***Hays**	Marion	Sabine	Yoakum
Armstrong	***Dallas**	Hemphill	Martin	San Augustine	***Young**
***Atascosa**	Dawson	Henderson	Mason	***San Jacinto**	
***Austin**	Deaf Smith	***Hidalgo**	Matagorda	San Patricio	
Bailey	Delta	Hill	McCulloch	San Saba	
***Bandera**	***Denton**	Hockley	McLennan	Schleicher	
***Bastrop**	DeWitt	***Hood**	***McMullen**	Scurry	
Baylor	Dickens	Hopkins	***Medina**	Shackelford	
Bee	Donley	Houston	Menard	Shelby	
***Bell**	Duval	Howard	Midland	Sherman	
***Bexar**	Eastland	Hudspeth	Milam	***Smith**	
Blanco	Ector	***Hunt**	Mills	***Somervell**	
Borden	***El Paso**	Hutchinson	Mitchell	Starr	
Bosque	***Ellis**	Irion	Montague	Stephens	
***Bowie**	Erath	Jack	***Montgomery**	Sterling	
***Brazoria**	Falls	Jackson	Moore	Stonewall	
Brazos	Fannin	Jasper	Morris	Swisher	
Briscoe	Fayette	***Jefferson**	Motley	***Tarrant**	
Brooks	Fisher	Jim Hogg	Nacogdoches	Taylor	
Brown	Floyd	Jim Wells	***Navarro**	Terry	
Burleson	***Fort Bend**	***Johnson**	Newton	Throckmorton	
***Burnet**	Franklin	Jones	Nolan	Titus	
***Caldwell**	Freestone	Karnes	***Nueces**	Tom Green	
Calhoun	***Frio**	***Kaufman**	Ochiltree	***Travis**	
Callahan	Gaines	***Kendall**	Oldham	Trinity	
***Cameron**	***Galveston**	Kenedy	Orange	Tyler	
Camp	Garza	Kent	***Palo Pinto**	Upshur	
Carson	Gillespie	Kerr	Panola	Upton	
Cass	Glasscock	Kimble	***Parker**	Uvalde	
Castro	Goliad	Kleberg	Parmer	Van Zandt	
***Chambers**	Gonzales	Lamar	Pecos	Victoria	
Cherokee	Gray	Lamb	Polk	***Walker**	
Clay	***Grayson**	Lampasas	Potter	***Waller**	
Cochran	Gregg	Lavaca	Rains	Ward	
Coke	***Grimes**	Lee	Randall	Washington	
Coleman	***Guadalupe**	Leon	Reagan	Webb	
***Collin**	Hale	***Liberty**	Real	***Wharton**	
***Colorado**	Hall	Limestone	Red River	Wichita	
***Comal**	Hamilton	Lipscomb	Reeves	Wilbarger	
Comanche	Hansford	Live Oak	Refugio	Willacy	
Concho	Hardin	***Llano**	Roberts	***Williamson**	

FORMULARIO DEL MÉDICO PREDESIGNADO PARA LESIONES LABORALES

SECCIÓN PARA COMPLETAR POR EL EMPLEADO: Nombre del empleado: _____ (letra de imprenta) Puede ser tratado inmediatamente por su médico personal si: • Usted pertenece a un plan de salud HMO • El médico lo trató en el pasado y tiene su historia clínica • Usted da a su empleador el nombre y la dirección del médico por escrito en este formulario. _____ Firma del empleado: _____ Nombre de la empresa: _____ Dirección de la empresa: Si me lesiono en el trabajo, quiero recibir tratamiento de: _____ Nombre del médico: _____ Dirección: _____ Número de teléfono:	SECCIÓN PARA COMPLETAR POR EL MÉDICO: *PHYSICIAN TO COMPLETE THIS SECTION:* *I agree to treat the above named individual for their work injury or illness. I understand that medical services in the Texas Workers' Compensation system are subject to preauthorization of non-emergency services, utilization review, reporting requirements, and fees governed by the Division of Workers Compensation. I also agree that, upon treating the above individual, I will abide by the terms of the Zenith Health Care Network Medical Provider Manual (available for download at www.coventyprovider.com) and I will comply with Texas Insurance Code chapter 1305, subchapter D-I and commensurate rules adopted under these subchapters.* *Physician Name (please print):* _____ *Physician Signature:* _____ *Date:* _____ *Name of HMO Plan:* _____ *Office Manager/Billing Contact:* _____ *Street Address:* _____ *Mailing Address:* _____ *Phone Number:* _____ *Email:* _____ *Physician Tax ID:* _____

[PÁGINA DEJADA EN BLANCO INTENCIONALMENTE]

RECONOCIMIENTO DE LA RED DE COMPENSACIÓN DE TRABAJADORES DE LA RED DE SERVICIOS MÉDICOS DE ZENITH

He recibido el "Aviso para empleados de requisitos de la red" que explica cómo obtener atención de salud bajo el seguro de indemnización a los trabajadores por accidentes laborales.

Si me lastimo en el trabajo y vivo en el área de servicio, entiendo que:

1. Debo elegir un médico de cabecera de la Red de Servicios Médicos de Zenith.
2. Puedo elegir como médico de cabecera al médico que seleccioné como médico de cabecera o proveedor de atención de salud a través de mi plan HMO.
3. Debo ir a mi médico de cabecera para todo el tratamiento para la lesión laboral. Si necesito un especialista, mi médico de cabecera me enviará a uno.
4. Si necesito atención de urgencia, puedo ir a cualquier parte.
5. La compañía de seguros pagará a los proveedores de la red todos los montos estipulados si mi lesión es causada por mi trabajo.
6. Tendré que pagar por mi tratamiento médico si obtengo atención de salud de alguien que no esté en la Red de Servicios Médicos de Zenith.

El "Aviso para empleados de requisitos de la red" explica todas las cuestiones mencionadas en detalle. Se adjunta un mapa del área de servicio a dicho "Aviso para empleados de requisitos de la red".

Firma: _____

Fecha: _____

Nombre en letra de imprenta: _____

La dirección donde vivo: _____

Nombre del empleador: _____

[PÁGINA DEJADA EN BLANCO INTENCIONALMENTE]

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RED DE SERVICIOS MÉDICOS DE ZENITH Y DE FUERA DE LA RED QUE REQUIEREN AUTORIZACIÓN PREVIA

	Fuera de la red - 134.600(p)	Dentro de la red - 413.014; TIC 1305; TAC 10 (subcapítulo F)
Hospital / hospitalización	La hospitalización no de urgencia (incluyendo el procedimiento programado principal y la duración de la hospitalización)	Igual + servicios de residencia de ancianos / convaleciente
Cirugía	Servicios de cirugía ambulatoria. Cirugía de la columna vertebral. Los estimuladores de crecimiento óseo se cubrirían como parte de la cirugía, por lo que no hay discrepancia.	Igual y especifica que la crioterapia radiológica, manipulación bajo anestesia y ciertas inyecciones (ver abajo) son clasificadas como cirugía. Todos los estimuladores de crecimiento óseo implantables. Todas las descompresiones axiales vertebrales (Vax-D), termocoagulación con radiofrecuencia de las articulaciones facetarias (RFTC, por su sigla en inglés) y procedimientos de terapia electrotérmica intradiscal (IDET, por su sigla en inglés).
Inyecciones	Pueden requerir autorización previa como servicios quirúrgicos ambulatorios, dependiendo de la facturación y de dónde se aplique la inyección.	Todos los ESI, inyecciones facetarias, inyecciones en zonas reflexógenas, inyecciones en la articulación sacroilíaca (SI), inyecciones de proloterapia, quimionucleosis y discografías.
Psico-	Pruebas psicológicas, psicoterapia, repetición de entrevistas psicológicas y biorregulación (a menos que sea parte de un programa de regreso al trabajo preautorizado o exento por la División de Compensación de Trabajadores).	Igual (excluyendo la evaluación psicológica inicial).
Diagnósticos	Estudios diagnósticos repetidos > $350 según la lista de tarifas o sin valor en la lista de tarifas.	Igual + Todas las mielografías, discografías, venografías, electromiografía, EMG y estudios de conducción nerviosa.
TF/ TO/ quiropractica/salud en el hogar / gimnasio	TF / TO/ Quiropratica / Ortesis/Manejo protésico, excepto para las primeras 6 visitas de TF / TO dentro de las 2 semanas inmediatamente siguientes a la fecha de la lesión o fecha en que se realizó la cirugía aprobada.	Igual + todos los tratamientos de salud en el hogar, tratamientos residenciales y todas las membresías de gimnasio. Solo se requiere para TF/ TO sin detalles
Endurecimiento/Acondicionamiento laboral	Todos los servicios de endurecimiento o acondicionamiento laboral.	Igual
Manejo del dolor / Otros programas	Todos los programas de manejo del dolor crónico / rehabilitación interdisciplinaria del dolor.	Igual + todos los programas de dependencia química y de pérdida de peso.
EQUIPO MÉDICO DURADERO	Equipo médico duradero > $500 facturado por artículo (compra o costo esperado del alquiler acumulado). Los estimuladores de crecimiento óseo se cubrirían como parte del equipo médico duradero porque superan los $500.00.	Igual + Todos los estimuladores de crecimiento óseo y todas las unidades de neuroestimulación eléctrica transcutánea/estimuladores neuromusculares/equipos interferenciales
Farmacia	Medicamentos no incluidos en el formulario de la División (también conocidos como Medicamentos N). Todos los medicamentos creados por compuestos (recetados y dispensados después de 7/1/2018) Systemas de Administración de medicamentos intratecales (incluso las recargas para medicamentos excluidos del formulario cerrado o para los cambios en la dosificación o cambios en los médicos)	Igual
Otro		Todas las quimionucleólisis, descompresiones axiales vertebrales (Vax-D), termocoagulación con radiofrecuencia de las articulaciones facetarias (RFTC, por su sigla en inglés) y procedimientos de terapia electrotérmica intradiscal (IDET, por su sigla en inglés).
Tratamiento fuera de las Directrices Oficiales de Discapacidad	Todo tratamiento que exceda o no sea abordado por las Directrices Oficiales de Discapacidad (ODG, por su sigla en inglés) y que no esté incluido en un plan de tratamiento aprobado previamente. Todo servicio de investigación/experimental que no esté todavía aceptado de forma generalizada como el tratamiento habitual.	Igual

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RED DE SERVICIOS MÉDICOS DE ZENITH Y DE FUERA DE LA RED QUE REQUIEREN AUTORIZACIÓN PREVIA

	Fuera de la red - 134.600(p)	Dentro de la red - 413.014; TIC 1305; TAC 10 (subcapítulo F)
Tratamiento experimental	Cualquier servicio o dispositivo de investigación o experimental para el que hay pruebas clínicas o científicas en desarrollo o tempranas que demuestran la eficacia potencial del tratamiento, servicio o dispositivo pero que no está todavía aceptado de forma generalizada como el tratamiento habitual.	
Tratamiento de partes del cuerpo / enfermedades disputadas	Cualquier tratamiento para una lesión o diagnóstico que no haya sido aceptado por la compañía de seguros conforme a los artículos 408.0042 y 126.14.	Igual
Planes de tratamiento obligatorios	UR obligatorio	

Nota: El tratamiento de urgencia no requiere autorización previa

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RED DE SERVICIOS MÉDICOS DE ZENITH Y DE FUERA DE LA RED QUE REQUIEREN AUTORIZACIÓN PREVIA

A a Z:

Fuera de la red	Dentro de la red
Admisiones de Hospital	Admisiones de Hospital
Biorretroalimentación	Biorretroalimentación
Cirugía	Cirugía
Cirugía ambulatoria	Cirugía ambulatoria
Cirugía de la columna vertebral	Cirugía de la columna vertebral
Cirugía Externa o ambulatoria	Cirugía Externa o Ambulatoria
Condicionamiento Laboral	Condicionamiento Laboral
Crioterapia radiológica	Crioterapia radiológica
Descompresion del eje Vertebral (Vax-D)	Descompresion del eje Vertebral (Vax-D)
Diagnósticos: estudios repetidos > $350	Diagnósticos: estudios repetidos > $350
Discografías	Discografías
Duración de la hospitalización	Duración de la hospitalización
Electromiografías de superficie	Electromiografías (EMG)
Endurecimiento por trabajo	Electromiografías de superficie
Entrevistas psicológicas: repetición	Endurecimiento por trabajo
Equipo médico duradero > $500	Entrevistas psicológicas: repetición
Equipos interferenciales > $500	Equipo médico duradero > Cargos facturados de $500
Estimuladores de crecimiento óseo	Equipos interferenciales
Estimuladores neuromusculares > $500	Estancias en residencia de ancianos
Gestión de Ortesis*	Estimuladores de crecimiento óseo
Gestión de Prótesis*	Estimuladores neuromusculares
Inyecciones realizadas en entorno quirúrgico ambulatorio	Estudios de conducción nerviosa
Manipulación bajo anestesia	Gestión de Ortesis*
Medicamento Compuesto (recetado y dispensado después de 7/1/2018)	Gestión de Prótesis*
Medicamentos no incluidos en el formulario de medicamentos de la División (también conocidos como Medicamentos N)	Inyecciones de proloterapia
Prescripción fuera de las Directrices Oficiales de Discapacidad (Medicamentos N)	Inyecciones de Punto Gatillo
Procedimientos de terapia electrotérmica intradiscal (IDET, por su sigla en inglés)	Inyecciones en etorno quirúrgico ambulatorio
Programas de dependencia química	Inyecciones en la articulación sacroilíaca (SI)
Programas de manejo del dolor crónico	Inyecciones epidurales de esteroides
Programas interdisciplinarios de rehabilitación del dolor	Inyecciones facetarias
Pruebas psicológicas	Manipulación con anestesia
Psicoterapia	Medicamento Compuesto (recetado y dispensado después de 7/1/2018)
Quimionucleólisis	Medicamentos no incluidos en el formulario de medicamentos de la División (también conocidos como Medicamentos N)
Repetición de entrevistas psicológicas	Membresías a gimnasios
Sistemas de administración de medicamentos intratecales, incluyendo las recargas	Mielografía
Terapia física*	Mielografías por tomografía
Terapia ocupacional*	Prescripción fuera de las Directrices Oficiales de Discapacidad (Medicamentos N)

TheZenith
A FAIRFAX Company

RED DE SERVICIOS MÉDICOS DE ZENITH Y DE FUERA DE LA RED QUE REQUIEREN AUTORIZACIÓN PREVIA

Fuera de la red	Dentro de la red
Terapia quiropráctica*	Procedimientos de terapia electrotérmica intradiscal (IDET, por su sigla en inglés)
Termocoagulación por Radiofrecuencia (RFTC, por su sigla en inglés)	Programas de abordaje del dolor crónico
Tratamiento de enfermedades disputadas	Programas de dependencia química
Tratamiento de investigación	Programas interdisciplinarios de rehabilitación del dolor
Tratamiento experimental	Programas para perder peso
Tratamiento no incluido en las Directrices Oficiales de Discapacidad	Pruebas psicológicas
	Psicoterapia
	Quimionucleólisis
	Repetición de entrevistas psicológicas
	Servicios de salud en el hogar
	Servicios para convalecencia
	Sistemas de administración de medicamentos intratecales, incluyendo las recargas
	Terapia física*
	Terapia ocupacional*
	Terapia quiropráctica*
	Termocoagulación por radiofrecuencia (RFTC, por su sigla en inglés)
	Tratamiento de enfermedades disputadas
	Tratamiento de investigación
	Tratamiento experimental
	Tratamiento no incluido en las Directrices Oficiales de Discapacidad
	Tratamiento / servicios residenciales
	Unidades de neuroestimulación eléctrica transcutánea (TENS, por su sigla en inglés)

*** Más allá de hasta 6 visitas dentro de las 2 semanas inmediatamente siguientes a la fecha de la lesión o fecha en que se realizó la cirugía aprobada**

Quest Asset Management, Inc.

Benefits Enrollment/Change Form

Plan Year: October 1, 2025 - September 31, 2026

ENROLLMENT TYPE (CHECK ONE): ☐ Initial Enrollment ☐ Newly Eligible Enrollment ☐ Re-hire

☐ Open Enrollment ☐ Change: _____

EMPLOYEE INFORMATION

Last Name:	First Name:	Middle:	Marital Status:	
			☐ Single ☐ Married	
Social Security Number:	Home/Cell Phone:	Date of Birth:	Age:	Gender:
				☐ M ☐ F
Street Address:	Apt/Unit #:	City:	State:	Zip Code:
Full-Time Date of Hire/Rehire:	Salary:	Job Title:		Location:

DEPENDENT INFORMATION

Last, First, Middle	Date of Birth:	SSN:	Relationship:	Gender:
			Spouse / Child	☐ M ☐ F
Last, First, Middle	Date of Birth:	SSN:	Relationship:	Gender:
			Child	☐ M ☐ F
Last, First, Middle	Date of Birth:	SSN:	Relationship:	Gender:
			Child	☐ M ☐ F
Last, First, Middle	Date of Birth:	SSN:	Relationship:	Gender:
			Child	☐ M ☐ F

If dependent has a different mailing address than primary insurance holder, please provide separately.

BENEFIT ELECTION INFORMATION

MEDICAL - 24 Payroll deductions out of 26 paychecks

☐ **Elect** ☐ **Decline**

I decline to apply for medical group coverage because of :

☐ Spousal Coverage ☐ Medicare Supplement ☐ Individual Coverage ☐ Other Employer Coverage

BCBS MTBAB012H - HSA Base Plan — Please provide the Primary Care Physician Information below

☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
$78.38 /per pay period	**$433.79** /per pay period	**$187.17** /per pay period	**$542.61** /per pay period

Primary Care Physician Name: _____ **Primary Care Physician ID#** _____

BCBS MTBAB042 - Mid Plan — Please provide the Primary Care Physician Information below

☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
$158.89 /per pay period	**$605.57** /per pay period	**$295.62** /per pay period	**$742.33** /per pay period

Primary Care Physician Name: _____ **Primary Care Physician ID#** _____

BCBS- MTBCB019 -PPO Buy Up Plan

☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
$287.43 /per pay period	**$879.81** /per pay period	**$468.76** /per pay period	**$1,061.19** /per pay period

HEALTH SAVINGS ACCOUNT (H.S.A.)

☐ I do **not** want to contribute to a Health Savings Account.

☐ I want to contribute $_____ per plan year to a Health Savings Account. see IRS Pub 8889

If you participate in the HDHP/HSA, and you are not covered by any other medical plan, you may set aside tax free dollars in an HSA, must reduce by $4,150 Individual/$8,300 Family annually for calendar year 2019. Individuals age 55 and older can make an additional $1,000 catch-up contribution.

DENTAL - 24 Payroll deductions out of 26 paychecks

☐ **Elect** ☐ **Decline**

UHC Dental

☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
$22.89 /per pay period	**$45.78** /per pay period	**$56.25** /per pay period	**$86.78** /per pay period

VISION - 24 Payroll deductions out of 26 paychecks

☐ **Elect** ☐ **Decline**

UHC Vision

☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
$3.80 /per pay period	**$7.22** /per pay period	**$7.60** /per pay period	**$11.18** /per pay period

LIFE/AD&D

Blue Cross Blue Shield Group Term Life/AD&D ☑ Elect *Group Term Life Policy is paid for 100% by Quest Asset Management, Inc.*

Primary Beneficiary Last Name, First Name	Relationship	Address	SSN:	Percentage
				%
Primary Beneficiary Last Name, First Name	**Relationship**	**Address**	**SSN:**	**Percentage**
				%
Contingent Beneficiary Last Name, First Name	**Relationship**	**Address**	**SSN:**	**Percentage**
				%
Contingent Beneficiary Last Name, First Name	**Relationship**	**Address**	**SSN:**	**Percentage**
				%

If I have previously waived coverage, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish proof of each person's insurability, and the carrier reserves the right to reject my request.

VOLUNTARY LIFE/AD&D

Blue Cross Blue Shield Voluntary Term Life/AD&D ☐ Elect ☐ Decline

Employee Requested Life & AD&D Amount: $_____

Spouse Requested Life & AD&D Amount: $_____

Dependent Requested Amount: $_____

	Employee:	Spouse	Child
Increments:	$10,000	$5,000	$10,000
Guaranteed Issue:	$150,000 70+ $10,000	$30,000 70+ - $10,000	$10,000
Max:	$500,000	$150,000	$10,000

If requesting over the Guaranteed Issue amount, your coverage is not effective until an Evidence of Insurability form (EOI) is provided and approved by the carrier.

If I have previously waived coverage, I understand that if I request coverage for myself and/or my eligible dependents at a later date, I will be required to furnish proof of each person's insurability, and the carrier reserves the right to reject my request.

I understand and agree that the medical, dental and vision benefits are provided through a cafeteria plan arrangement and that my share of the cost (if any) will be deducted from my pay on a pre-tax basis, reducing my taxable income. I realize that my elections will continue in effect through September 31, 2026, and I can change these elections only during the annual open enrollment period or if there has been a qualifying change in my family status, employment or group healthcare coverage.

DISCLAIMER

I understand and agree:

- 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) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- I may be required to furnish evidence of health status satisfactory to the carrier.
- If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost (or if the employer stops contributing towards that coverage). However, I must request enrollment within 30 days* or any longer period that applies under the plan administrator after the other coverage ends (or after the employer stops contributing toward the other coverage).
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents. However, I must request enrollment within 30 days* or any longer period that applies under the plan administrator after the marriage, birth, adoption, or placement for adoption.
- If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days* after coverage ends under Medicaid or the state children's health insurance program.
- The carrier reserves the right to delay medical coverage and/or deny dental, basic life or voluntary life with any future application for coverage.
- If I gain eligibility for a state premium assistance subsidy through a Medicaid plan under Title XIX of the Social Security Act, or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act, I may be able to enroll myself and my dependents in this plan. However, I must request enrollment within 60 days* or any longer period that applies under the plan administrator.
- If I decline enrollment for myself or for an eligible dependent (including my spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, I may be able to enroll myself and my dependents in this plan if eligibility for that other coverage is lost. However, I must request enrollment within 60 days* after coverage ends under Medicaid or the state children's health insurance program.

Authorization/Acknowledgement: I hereby authorize those providing services to me, or my dependents, to release relevant information or medical records to this plan. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I understand that if I have made a material false statement, misrepresentation or omission on this form that changes the risk assumed by this plan I may lose coverage under this plan. I also understand that those who provide services to me under this plan are not agents, representative or employees of this plan. I understand that my salary will be reduced in accordance to the plan guidelines if payroll deductions are necessary.

_____ By initialing here, I, am waiving the opportunity to enroll in the medical plan offered by Quest Asset Management, Inc. for the October 1, 2025 - September 31, 2026 plan year.

I understand that the medical plan being offered is designed to meet the 'Affordability' and 'Minimum Value' requirements of the Affordable Care Act; and as a result, I may be ineligible to receive a premium tax credit and/or cost-sharing subsidy.

Disclaimer: The actual terms of the plan are contained in the plan document. In the event of any discrepancy or conflict, the official plan documents will govern. The plan sponsor reserves the right to change, amend or cease these benefits, including rate adjustments, at any time.

EMPLOYEE SIGNATURE - Required for Enrollment and/or Waiver

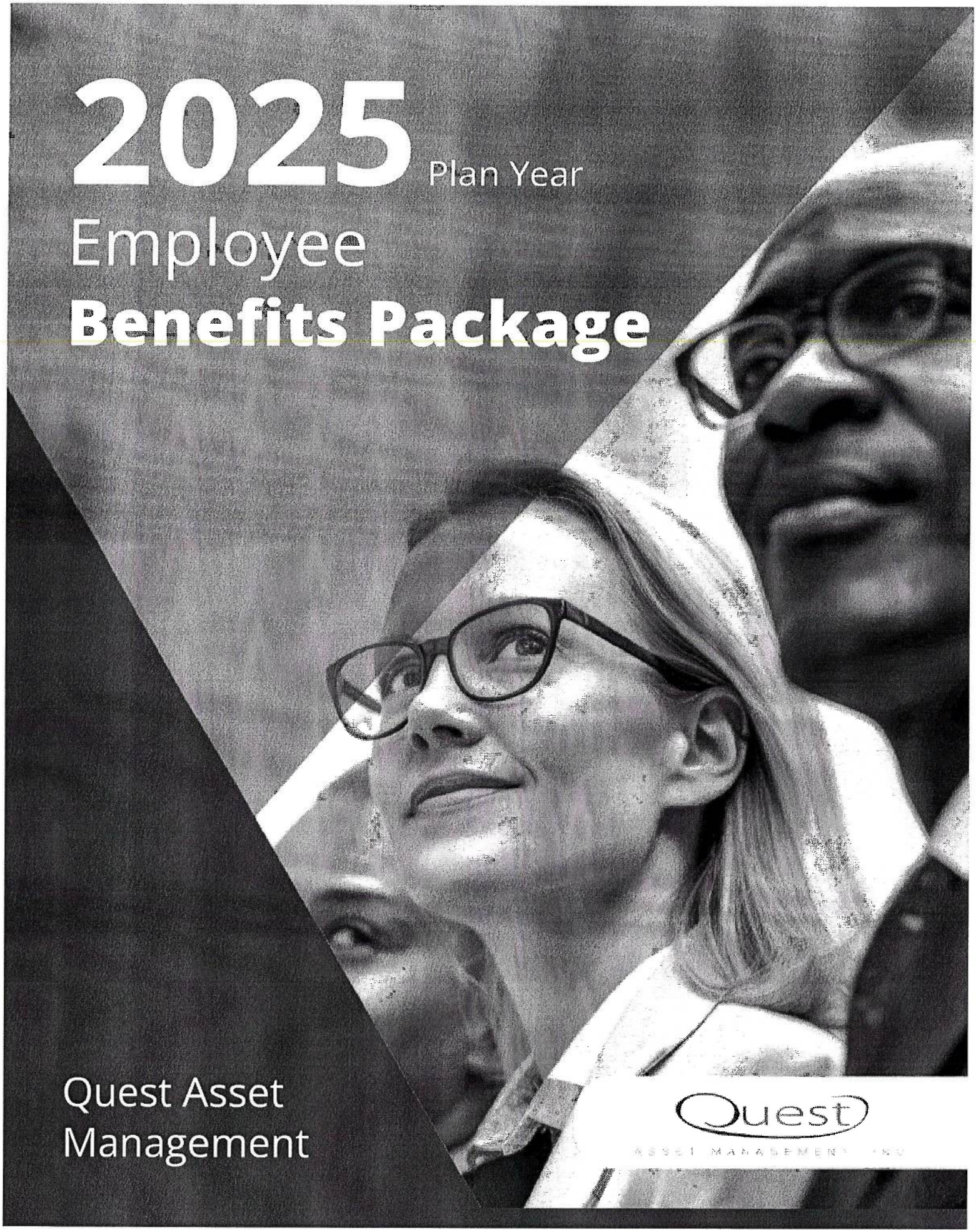
x_____ Date: _____

Signature

_____

Printed Name

2025 Plan Year
Employee **Benefits Package**



Quest Asset Management

Quest
ASSET MANAGEMENT

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Important Items to Remember

HOW TO ENROLL

Choose your benefits for the 2025 plan year by completing the Election Form for coverage. Once you have made your elections, you will not be able to change them until Quest Asset Management's next open enrollment period, unless you have a qualified life change.

WHEN TO ENROLL

Current Employees: The benefits you choose during open enrollment will become effective on October 1, 2025.

New Hires: You will become eligible for benefits on the 1st of the month following your date of hire. The benefits you elect will stay in effect through September 30th, 2026.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal speration
- Birth or adoption of a child
- Change in a child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. Your employer DOES NOT contribute to this coverage as they may when you are employed with them. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc... is in your network

Medical & Prescription Drug Insurance

	HSA - Base Plan MTBAHB012H	EPO - Mid Plan MTBAB042	PPO - Buy Up Plan MTBCB519	
Deductible	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Single	$5,000	$5,000	$2,000	$4,000
Family	$10,000	$14,700	$6,000	$12,000
Coinsurance				
Member %	20%	20%	20%	40%
Out of Pocket Maximum				
Single	$6,900	$7,350	$6,000	Unlimited
Family	$13,800	$14,700	$15,700	Unlimited
Commonly Used Services				
Primary Care Physician Office Visit	20% after Deductible	$45	$35	40% after Deductible
Specialist Office Visit	20% after Deductible	$90	$70	40% after Deductible
Urgent Care	20% after Deductible	$75	$75	40% after Deductible
Emergency Room	20% after Deductible	$500 + 20% after Deductible	$500 + 20% after deductible	$500 + 20% after deductible
Preventive Care				
Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%	40% after Deductible
Major Medical Expenses				
Outpatient Surgery	20% after Deductible	20% after Deductible	20% after Deductible	40% after Deductible
Inpatient Hospitalization / Surgery	20% after Deductible	20% after Deductible	20% after Deductible	40% after Deductible
CT scan, PT scan, MRI	20% after Deductible	20% after Deductible	20% after Deductible	40% after Deductible
Hospital Newborn Delivery	20% after Deductible	20% after Deductible	20% after Deductible	40% after Deductible
Prescription Drug Coverage				
Preferred Generic	10% / 20%*	$0 / $10*	$0 / $10*	$10 + 50% additional charge
Non-Preferred Generic	10% / 20%*	$10 / $20*	$10 / $20*	$20 + 50% additional charge
Preferred Brand	20% / 30%*	$50 / $70*	$50 / $70	$70 + 50% additional charge
Non-Preferred Brand	30% / 40%*	$100 / $120*	$100 / $120	$120 + 50% additional charge
Preferred Specialty	40%	$150	$150	$150 + 50% additional charge
Non-Preferred Specialty	50%	$250	$250	$250 + 50% additional charge
Mail Order - 90 day Supply	N/A	3x RX Copay	3x RX Copay	Not Covered

Preferred Participating Pharmacy / Non-Preferred Participating Pharmacy

Premium Per Employee Paycheck

Employee Only	$78.38	$158.89	$287.43
Employee + Spouse	$433.79	$605.57	$879.81
Employee + Child(ren)	$187.17	$295.62	$468.76
Family	$542.61	$742.33	$1,061.19

Dental Insurance

BlueCross BlueShield of Texas

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body - including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Deductible	Contracting Dentist	Non-Contracting Dentist
Single	$50	$50
Family	$150	$150
Maximum the carrier will pay		
Annual Maximum	$1,500	$1,500
Dental Coverage		
Cleanings	100%	100%
Exams	100%	100%
X-Rays	100%	100%
Sealants	80%	80%
Fillings	80%	80%
Simple Extractions	80%	80%
Root Canal	50%	50%
Periodontal Gum Disease	80%	80%
Oral Surgery	50%	50%
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
Implants	Not Covered	Not Covered
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,000	
Orthodontia Maximum Age	19	
Out of Network Explanation		
	Your insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist, which may result in a balance bill.	

Dental implants are not covered.

The above is a listing of common services available through your network of Contracting Dentists. The Member's share of the cost is determined by whether care is received by a Contracting or Non-Contracting Dentist.

Benefits for covered services received from a Contracting Dentist are based on the Allowable Amount, and such Dentist cannot balance bill for charges in excess of this allowable amount. Benefits for covered services from a Non-Contracting Dentist will be based upon an Allowable Amount determined by BCBSTX, where non-contracting Allowable Amount will be not less than the amount BCBSTX would have paid, for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist, and it is possible that such Dentist will balance bill for amounts above this.

This plan includes BlueCare Dental Enhanced Benefit. The Enhanced Benefit provides additional dental benefits, such as an extra cleaning for members with specific health issues. Please refer to you Dental Benefit Booklet for additional benefit infomration.

Premium Per Employee Paycheck

Employee Only	$22.89
Employee + Spouse	$45.78
Employee + Child(ren)	$56.25
Family	$86.78

Vision Insurance

BlueCross BlueShield - Dearborn Group

Driving to work, reading a news article and watching TV are all activites you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. Quest Asset Managment has made the decision to offer vision benefits through BlueCross BlueShield this year.

Vision Coverage	In-Network	Out-of-Network Reimbursement
Eye Exam	$10	Up to $30
Single Vision Lens	$25	Up to $25
Lined Bi-Focal Lens	$25	Up to $40
Lined Tri-Focal Lens	$25	Up to $55
Lenticular Lens	$25	Up to $55
Contact Lens Allowance	$130 + 15% off remaining balance	Up to $104
Frame Allowance	$130 + 20% off remaining balance	Up to $65
Frequencies		
Exam Frequency	12 months	
Lens Frequency	12 months	
Frame Frequency	24 months	
Out of Network Explanation		
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you.	

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of fcovered benefits, limitations and exclusions, refer to your certificate of coverage.

Premium Per Employee Paycheck

Employee Only	$3.80
Employee + Spouse	$7.22
Employee + Child(ren)	$7.60
Family	$11.18

Employer-Paid Basic Life Insurance

BlueCross BlueShield of Texas

Quest Asset Management provides all full-time, benefits-eligible employees with $15,000 of Life and Accidental Death and Dismemberment (AD&D) Insurance through BlueCross BlueShield of Texas. Benefits reduce by 35% at age 70 and 45% at age 75. Contact Human Resources to update your beneficiary information.

Quest Asset Management pays for the full cost of this benefit - meaning you are not responsible for paying any monthly premiums. Please make sure to keep your beneficiary information up to date.

Life Insurance Benefits	
Life Insurance Coverage	$15,000
Accidental Death & Dismemberment	$15,000
Age Reduction Schedule	Reduced by 35% at age 70 and 45% at age 75

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Supplemental Life Insurance

BlueCross BlueShield of Texas

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions.

Employee

- Supplemental coverage is available in $10,000 increments, up to $500,000.
- At Open Enrollment, you can increase one increment of $10,000 if you currently have coverage, up to the Guarentee Issue amount of $150,000, without Evidence of Insurability.
- Employees age 70 and over have a Guarentee Issue amount of $10,000.
- Late Entry will require an Evidence of Insurabilty form, pending approval from BCBS. *If you did not enroll during your initial enrollment for any amount (you waived coverage at that time for Voluntary Life),* if you elect any amount at Open Enrollment, you will be required to complete the Evidence of Insurability Form, pending approval from BCBS.

Spouse

- Supplmental coverage is available in $5,000 increments up to $150,000 (not to exceed 50% of the employee's elected amount).
- Spouses Guarenteed Issuance amount is $30,000 uder age 70 and $10,000 age 70 and over.
- Spouses are required to complete an Evidence of Insurability form, pending approval from BCBS.
- Spouse premium is based on employee's date of birth.

Children

- Ages Birth to 14 Days: $1,000
- Ages 15 Days to 26 Years: $10,000

Employee and Spouse Bi-Monthly Rate

Supplemental Life/AD&D Insurance
Semi-Monthly Premium Cost (Based on 24 payroll deductions per year)

	ATTAINED AGE											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$10,000	$0.58	$0.58	$0.58	$0.62	$0.81	$1.18	$1.69	$2.61	$3.97	$5.42	$9.81	$10.52
$20,000	$1.16	$1.16	$1.16	$1.23	$1.62	$2.35	$3.37	$5.21	$7.93	$10.83	$19.61	$21.03
$30,000	$1.74	$1.74	$1.74	$1.85	$2.43	$3.53	$5.06	$7.82	$11.90	$16.25	$29.42	$31.55
$40,000	$2.32	$2.32	$2.32	$2.46	$3.24	$4.70	$6.74	$10.42	$15.86	$21.66	$39.22	$42.06
$50,000	$2.90	$2.90	$2.90	$3.08	$4.05	$5.88	$8.43	$13.03	$19.83	$27.08	$49.03	$52.58
$60,000	$3.48	$3.48	$3.48	$3.69	$4.86	$7.05	$10.11	$15.63	$23.79	$32.49	$58.83	$63.09
$70,000	$4.06	$4.06	$4.06	$4.31	$5.67	$8.23	$11.80	$18.24	$27.76	$37.91	$68.64	$73.61
$80,000	$4.64	$4.64	$4.64	$4.92	$6.48	$9.40	$13.48	$20.84	$31.72	$43.32	$78.44	$84.12
$90,000	$5.22	$5.22	$5.22	$5.54	$7.29	$10.58	$15.17	$23.45	$35.69	$48.74	$88.25	$94.64
$100,000	$5.80	$5.80	$5.80	$6.15	$8.10	$11.75	$16.85	$26.05	$39.65	$54.15	$98.05	$105.15
$110,000	$6.38	$6.38	$6.38	$6.77	$8.91	$12.93	$18.54	$28.66	$43.62	$59.57	$107.86	$115.67
$120,000	$6.96	$6.96	$6.96	$7.38	$9.72	$14.10	$20.22	$31.26	$47.58	$64.98	$117.66	$126.18
$130,000	$7.54	$7.54	$7.54	$8.00	$10.53	$15.28	$21.91	$33.87	$51.55	$70.40	$127.47	$136.70
$140,000	$8.12	$8.12	$8.12	$8.61	$11.34	$16.45	$23.59	$36.47	$55.51	$75.81	$137.27	$147.21
$150,000	$8.70	$8.70	$8.70	$9.23	$12.15	$17.63	$25.26	$39.08	$59.48	$81.23	$147.08	$157.73
$200,000	$11.60	$11.60	$11.60	$12.30	$16.20	$23.50	$33.70	$52.10	$79.30	$108.30	$196.10	$210.30
$250,000	$14.50	$14.50	$14.50	$15.38	$20.25	$29.38	$42.13	$65.13	$99.13	$135.38	$245.13	$262.88
$300,000	$17.40	$17.40	$17.40	$18.45	$24.30	$35.25	$50.55	$78.15	$118.95	$162.45	$294.15	$315.45
$350,000	$20.30	$20.30	$20.30	$21.53	$28.35	$41.13	$58.98	$91.18	$138.78	$189.53	$343.18	$368.03
$400,000	$23.20	$23.20	$23.20	$24.60	$32.40	$47.00	$67.40	$104.20	$158.60	$216.60	$392.20	$420.60
$450,000	$26.10	$26.10	$26.10	$27.68	$36.45	$52.88	$75.83	$117.23	$178.43	$243.68	$441.23	$473.18
$500,000	$29.00	$29.00	$29.00	$30.75	$40.50	$58.75	$84.25	$130.25	$198.25	$270.75	$490.25	$525.75

Dependent Life/AD&D (Children)
Monthly Premium per Family

$10,000	$3.30

AGENCY CONTACTS

Frost Insurance Agency
Maritza Facio
Maritza.Facio@frostinsurance.com
(214) 515-4136

Frost Insurance Agency
Lori Sorg
LSorg@frostinsurance.com
(214) 515-4152

CARRIER CONTACTS

BlueCross BlueShield of Texas (Medical)

1 (800) 521-2227
www.bcbstx.com

BlueCross BlueShield of Texas (Dental, Vision, Life and AD&D)

1 (877) 442-4207
www.bcbstx.com

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
https://www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
https://www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services (HHS) at: 1-800-985-3059. HHS will route complaints to the appropriate federal agency. Or, visit www.cms.gov/nosurprises for more information about your rights under federal law.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Deborah Griffin, Quest Asset Management5757 W Lovers Lane Suite 360 Dallas, TX 75209, (214) 350-8822, deborah@questami.com.

Important Notice from Quest Asset Management Inc About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Quest Asset Management Inc and about 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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Planor 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.**

2. **Quest Asset Management Inc has determined that the prescription drug coverage offered by the MTBAB042, MTBAB012H, MTBCB019 is, on average for all plan participants, expected to payout 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 to 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 MTBAB042, MTBAB012H, MTBCB019 coverage will not be affected. Covered employees and dependents can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current MTBAB042, MTBAB012H, MTBCB019 coverage, be aware that you and your dependents will not be able to get this coverage back unless you have a special enrollment right or at the next open enrollment.

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 Quest Asset Management 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...

Contact the person listed below for further information [or call Frost Insurance Agency at (866) 227-2099]. **NOTE:** 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 Quest Asset Management 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 ofyour 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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to paya higher premium (a penalty).

Date:	10/01/2025
Name of Entity/Sender:	Quest Asset Management Inc
Contact--Position/Office:	Deborah Griffin,
Address:	5757 W Lovers Lane Suite 360 Dallas, TX 75209
Phone Number:	(214) 350-8822