Purchasing Card User Agreement

I, _____, acknowledge receipt of an Apta Cash Health Plan Akimbo Mastercard issued by Sunrise Banks N.A. ("Card") and administered by Asserta Health ("Direct Payment Program").

As a Cardholder, I agree to comply with the following terms and conditions regarding my use of the Card:

1. I understand that I am being entrusted with a valuable purchasing tool to streamline and simplify the payment for certain healthcare products and services and facilitate access to healthcare I will receive in connection with my participation in the Direct Payment Program offered by my employer, **Novo Professional Services** (Employer). The authorized limit on the card will be designated by Asserta Health, from time to time.

2. I understand that Employer funds all charges made on the Card. Therefore, if an unauthorized charge is made with my card, I may be required to reimburse Employer in the amount of the charge(s). In the event of unauthorized use, additional penalties may apply as determined by Employer.

3. I agree to not share my Card or Card number with anyone other than a licensed healthcare provider for a service that Asserta Health, Inc. has approved. I understand that if I or any of my dependents share my Card or Card number with anyone other than a licensed healthcare provider rendering a service authorized by Asserta Health, Inc., I may be subject to disciplinary action as determined by Employer as a result.

4. I agree to use this Card only for approved purchases and agree not to use the Card for any other purpose or charge personal purchases at any time. I understand that Asserta Health, Inc. will monitor and review the use of this Card and the related management reports and inform Employer of any suspected discrepancies.

5. I agree that if my employment with Employer comes to an end, I can no longer use the Card for any purchases.

6. I understand I will be required to provide documentation (e.g. an itemized receipt from the healthcare provider rendering the authorize service) for all transactions.

7. I will follow the above guidelines for the use of the Card. Failure to do so may result in either revocation of my privileges or other disciplinary actions, as determined by Employer.

8. I agree to allow Employer to collect any amounts owed by me or my dependents for improper purchases even if Employer no longer employs me. Should I fail to use the Card properly I authorize Employer to take whatever legal steps are necessary to collect an amount equal to the total of the improper purchases. If Employer initiates legal proceedings to recover amounts owed by me under this Agreement, I agree to pay all legal fees incurred by Employer.

9. I agree to return or destroy the Card immediately upon request by Asserta Health, Inc. or upon termination of employment (including retirement).

10. If the Card is lost or stolen, I agree to notify Asserta Health, Inc. immediately.

_____ _____

Card Holder Signature Printed Name

_____

Date