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Limited Benefit & Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Enrollees of California: In order to enroll in the Fixed Indemnity Medical Benefit, you and any dependent must have minimum essential coverage and be enrolled in major medical coverage.

THE FIXED INDEMNITY MEDICAL PLAN IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW.

The Essential StaffCARE Fixed Indemnity Medical, Prescription Drug, Accidental Loss of Life, Limb & Sight, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1214, 26.212, and 26.213. The Term Life and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: https://www.healthcare.gov/coverage/preventive-care-benefits. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Voluntary Electronic Availability of Summary Health Information for MEC/Wellness Preventive Plan

A sample copy of the Summary of Benefits and Coverage ("SBC") from Essential StaffCARE ("ESC") is available at the following link: www.enrollment.care/info/sbcmec.

While you may have other health plans, this is the link for your MEC plan with ESC. This important document explains the terms and conditions of your Health Plan, including eligibility, coverage amounts and exclusions along with your rights and responsibilities. At any time, you may request paper copies or revoke your consent to electronic delivery, free of charge, by calling 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

ESC Essential StaffCARE

B1 **2994001-BGV-1** OFFICE USE ONLY LOCATION _____ New Hire ☐ Rehire ☐ Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC/MEC CU(4EUSLi) P12Mi v23.0

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name

Phone

Social Security Number

Date of Birth / / | Gender M F

Address | Apt.

City | State | Zip

B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare Benefits?

☐ Yes ☐ No If Yes, fill out the remainder of this section.

Medicare Health Insurance Claim Number (HICN):

Medicare Effective Date:

Name of Covered Person(s):

1.

2.

3.

C. REQUIRED DEPENDENT INFORMATION

Name | DOB / /

Social Security # | Gender M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name | DOB / /

Social Security # | Gender M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name | DOB / /

Social Security # | Gender M F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

D. BENEFICIARY INFORMATION

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name

Relationship

E. LIMITED BENEFIT PLAN SELECTION

You MUST select a coverage level before any benefits. Your coverage level for all the benefits will be identical.

SELECT COVERAGE LEVEL

☐ Employee Only ☐ Employee + Spouse

☐ Employee + Child(ren) ☐ Employee + Family

☐ **NO to ALL Benefits**

FIXED INDEMNITY MEDICAL PLAN	Plan 1	Plan 2	Semi-Monthly Rates
☐ **Plan 1**	**$34.62**	**$43.29**	Employee Only
	$57.50	**$71.86**	Employee + Child(ren)
☐ **Plan 2**	**$65.78**	**$82.25**	Employee + Spouse
	$87.62	**$109.52**	Employee + Family
☐ **NO** Medical Plan			

DENTAL		
☐ **YES**	**$11.70**	Employee Only
	$31.59	Employee + Child(ren)
☐ **NO**	**$23.40**	Employee + Spouse
	$44.46	Employee + Family
VISION		
☐ **YES**	**$5.24**	Employee Only
	$14.17	Employee + Child(ren)
☐ **NO**	**$10.49**	Employee + Spouse
	$19.93	Employee + Family
TERM LIFE		
☐ **YES**	**$1.30**	Employee Only
	$1.95	Employee + Child(ren)
☐ **NO**	**$1.95**	Employee + Spouse
	$3.90	Employee + Family
CRITICAL ILLNESS		
☐ **YES**	**$5.87**	Employee Only
	$5.96	Employee + Child(ren)
☐ **NO**	**$10.81**	Employee + Spouse
	$10.92	Employee + Family
SHORT-TERM DISABILITY**		
☐ **YES**	**$9.10**	Employee Only
☐ **NO**		

*** STD is not available to persons who work in **CA, HI, NJ, NY,** or **RI.***

F. MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

MEC PLAN[1]
Semi-Monthly List Bill Rates

82994001-M-BGV-1

☐	**$29.10**	Employee Only
☐	**$32.90**	Employee + Child(ren)
☐	**$35.51**	Employee + Spouse
☐	**$40.44**	Employee + Family
☐	**NO to MEC Plan**	

[1]*Enrolling in the Optional MEC Wellness/Preventive Benefit may DISQUALIFY you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is NOT underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Note: the federal Affordable Care Act (ACA) individual mandate no longer imposes a penalty; however, please check your state for any individual mandate requirements or penalties. Rates for the MEC Wellness/Preventive Benefit are billed semi-monthly.*

G. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans; I've been offered self-funded ACA compliant coverage (MEC Wellness/Preventive) and open enrollment is only available for a limited time. I also understand that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**

LIMITED BENEFITS SUMMARY

Policy Number **2994001-BGV-1**

FIXED INDEMNITY MEDICAL BENEFIT

For more details, please see your Summary Plan Description.

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by an accident or illness. If the covered event costs more, you pay the difference. But if the covered event costs less, you keep the difference.

Outpatient Benefits [1]	**Plan 1**	**Plan 2**	**Inpatient Benefits**	**Plan 1**	**Plan 2**
Physician Office Visit per day	$60	$105	Standard Care per day	$300	$500
Diagnostic (Lab) per day	$75	$75	Intensive Care Unit Maximum per day [5]	$400	$600
Diagnostic (X-Ray) per day	$150	$200	Inpatient Surgery per day	$2,000	$2,000
Ambulance Services per day	$300	$300	Anesthesia per day	$400	$400
Physical, Speech, or Occupational Therapy per day	$50	$50	Skilled Nursing per day [6]	$100	$100
Emergency Room Benefit - Sickness per day	$100	$200	First Hospital Admission (1 per year)	N/A	$250
Emergency Room Benefit - Accident per day [2]	$300	$500	Annual Inpatient Maximum [7]	No Limit	No Limit
Outpatient Surgery per day	$500	$500	**Accidental Loss of Life, Limb & Sight**		
Anesthesia per day	$200	$200	Employee/Spouse	$20,000	$20,000
Annual Outpatient Maximum	$2,000	$2,000	Dependent (6 months to 26 years)	$5,000	$5,000
Prescription Drugs (via reimbursement) [3, 4]	**Plan 1**	**Plan 2**	Dependent (15 days to 6 months)	$2,500	$2,500
Annual Maximum	$600	$600	**Wellness Care**	**Plan 1**	**Plan 2**
Generic/Brand Coinsurance	70%/50%	70%/50%	Wellness Care (one per year)	$75	$100
Telemedicine Discount Service (phone/video) (per visit)	$25	$25			

[1]all outpatient benefits are subject to the outpatient maximum [2]covers treatment for off the job accidents only [3]not subject to outpatient maximum [4]To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. [5]pays in addition to standard care benefit [6]for stays in a skilled nursing facility after a hospital stay [7]subject to internal limits of plan

DENTAL BENEFIT

Waiting Period/Coinsurance | **Annual Maximum Benefit** $750 | **Deductible** $50

Coverage A	None / 80%	Exams, Cleanings, Intraoral Films, and Bitewings
Coverage B	3 Months / 60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures
Coverage C	12 Months / 50%	Periodontics, Crowns, Bridges, Endodontics and Dentures

VISION BENEFIT

	In-Network		**Out-of-Network**	
	You Pay	Plan Pays	You Pay[3]	Plan Pays
Eye Exam [1] (including dilation)	$10 Copay	100%	100%	$35
Standard Contact Lens Fit Exam (includes follow up)	Up to $55	$0	100%	$0
Premium Contact Lens Fit Exam (includes follow up)	100%, after 10% discount	$0	100%	$0
Frames (once every 24 months)	80%, after $110 allowance	20% plus $110 allowance	100%	$55
Standard Plastic Lenses (single, bifocal, trifocal) [1,2]	$25 Copay	100%	100%	$25-$55
Contact Lenses (Conventional) (materials only) [1]	85%, after $110 allowance	15% plus $110 allowance	100%	$88
Contact Lenses (Disposable) (materials only) [1]	100%, after $110 allowance	$110 allowance	100%	$88
Contact Lenses (Medically Necessary) (materials only) [2]	$0 Copay	100%	100%	$200

[1]Once every 12 months [2]$15 higher in AK, CA, HI, OR, WA [3]After plan payment

SEMI-MONTHLY LIMITED BENEFITS PREMIUM	**Plan 1**	**Plan 2**	**Dental**	**Vision**
Employee Only	$34.62	$43.29	$11.70	$5.24
Employee + Child(ren)	$57.50	$71.86	$31.59	$14.17
Employee + Spouse	$65.78	$82.25	$23.40	$10.49
Employee + Family	$87.62	$109.52	$44.46	$19.93

LIMITED BENEFITS SUMMARY

Policy Number **2994001-BGV-1**

GROUP TERM LIFE BENEFIT

For more details, please see your Summary Plan Description.

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	**Child Amount (6 mos to 26 yrs old)**	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount (15 days to 6 mos)**	$1,000

SHORT-TERM DISABILITY BENEFIT

Benefit Amount	60% of base pay up to $150 per week
Waiting Period/Maximum Benefit Period	7 days for injury or sickness / up to 26 weeks

CRITICAL ILLNESS BENEFIT

Pre-existing Condition Limitation: 12/12 **Waiting Period:** 30 days

Critical Illness Insurance pays a lump sum benefit for the first ever diagnosis of a covered critical illness. Features a lump sum benefit payment to use as you see fit, and dependent coverage for spouse and/or dependent children.

Heart Attack	100%	**Employee Policy Face Amount[1]**	$5,000
Invasive Cancer	100%	**Spouse Amount**	$3,750
Stroke	100%	**Child(ren) Amount**	$2,500
Carcinoma in Situ	25%		
Skin Cancer	$250		

[1]If dependent coverage is selected, coverage is payable at 75% of the Employee Policy Face Amount for a spouse and at 50% for any child(ren)

SEMI-MONTHLY LIMITED BENEFITS PREMIUM	Term Life	STD	Critical Illness
Employee Only	$1.30	$9.10	$5.87
Employee + Child(ren)	$1.95	-	$5.96
Employee + Spouse	$1.95	-	$10.81
Employee + Family	$3.90	-	$10.92

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

Policy Number **82994001-M-BGV-1**

ACA The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunization and routine health screening. It does not cover conditions caused by accident or illness.

Benefit	In-Network	Non-Network
Preventive Services for Adults	100%	40%
Preventive Services for Women	100%	40%
Covered Preventive Services for Children	100%	40%

[1] For more information about preventive services, please visit www.healthcare.gov.

SEMI-MONTHLY MEC PREMIUM	MEC
Employee Only	$29.10
Employee + Child(ren)	$32.90
Employee + Spouse	$35.51
Employee + Family	$40.44

LIMITED BENEFIT EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

FIXED INDEMNITY MEDICAL AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane
- Declared or undeclared war
- Serving on full-time active duty in the armed forces
- The covered person's commission of a felony
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law or
- With regard to the accidental loss of life, limb or sight benefit - sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions
- Hearing examinations or hearing aids
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force
- Services provided by a member of the covered person's immediate family.

The fixed indemnity medical plan is not available to residents of Hawaii, New Hampshire or Puerto Rico.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on covered procedures or limitations, please see your summary plan description.

VISION

No benefits will be paid for any materials, procedures or services provided under worker's compensation or similar law; non-prescription lenses, frames to hold such lenses, or non-prescription contact lenses; any materials, procedures or services provided by an immediate family member or provided by you; charges for any materials, procedures, and services to the extent that benefits are payable under any other valid and collectible insurance policy or service contract whether or not a claim is made for such benefits.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent, or a person who resides in your home
- Declared or undeclared war or act of war
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony
- Your participation in a riot
- If you engage in an illegal occupation
- Release of nuclear energy
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

GROUP TERM LIFE

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

CRITICAL ILLNESS

The Company will NOT pay the Benefit Amount for a covered condition if: i.Such covered condition is not covered under this Policy; ii.Such covered condition First Occurred while this Policy was not in force; iii.Such covered condition was diagnosed by a person who is not a Physician; iv.Such covered condition was diagnosed outside the U.S., unless the Diagnosis is confirmed in the U.S.; v. Such covered condition or surgical procedure was performed outside the U.S., unless on a U.S. military base or facility; or within another U.S. military or government building or facility; or

vi. the Insured's date of birth, Age or sex was misstated on the Application and at the correct date of birth, Age or sex the Policy would not have become effective or would have terminated.

Any Benefit Amount payment under this Policy is subject to the adjustments provided in the Policy provisions; including, but not limited to, the Time Limit for Certain Defenses, Misstatement of Age or Sex, Binding Arbitration and Grace Period provisions.

If the Insured is Age 60 or older on the Policy Effective Date, the Initial Benefit Amount will be reduced by 50 percent on the fifth anniversary of the Policy Effective Date. In all other cases, the Benefit Amount will be reduced by 50 percent when the Insured reaches Age 65. After this reduction occurs, the current benefit amount for a category is 50 percent of the benefit remaining in that category on the day prior to the reduction.

The insurance on an Insured will cease on the earliest of: i. the last day of the payroll deduction period during which the Insured ceases to be a member of a class eligible for coverage as shown in the Schedule; ii. the end of the last period for which premium payment has been made to the Company; iii. the date the Policy terminates; iv. the last day of the payroll deduction period during which the Insured is retired or pensioned; v. with respect to those Insureds working for employers with less than 20 employees on a typical work day in the preceding Calendar Year, the last day of the payroll deduction period during which the Insured attains age 70; or vi. the last day of the payroll deduction period during which the Insured

terminates employment. vii. the date on which the maximum benefit has been paid in all three categories.

The insurance on a Dependent will cease on the earliest of: i. the date the Insured's coverage terminates; ii. the end of the last period for which premium payment has been made to the Company; iii. the date the Dependent no longer meets the definition of Dependent, as defined in the Policy; or

iv. the date the Policy is modified so as to exclude Dependent coverage. v. the date on which the maximum benefit has been paid in all three categories. vi. The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

The Policy, and the coverage of a Policyholder under the Policy, may be terminated as described below.

A Policyholder may terminate coverage under the Policy by giving written notice to the Company. Termination will be effective on the latter of: i. the date we receive the notice; or ii. the requested termination date.

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

Member Services:

For frequently asked questions and network information for the Fixed Indemnity Medical Plan, visit *https://enrollment.care/info/bcs/ind/*.. For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as well as the MEC SBC, please visit *https://enrollment.care/info/bcs/mmdp*. A paper copy of the SBC is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

PLEASE NOTE: Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Members."