ESC
Essential StaffCARE

# Reference Manual

## Information for Branch Managers on **Fixed Indemnity Medical Plan**



FRONTLINE HRO
effective strategies & customized coverage

BGV-3
Insurance Applications Group, Inc.

v24.1

# Contact Information

## Branch Services:

Marketing Service Support: 803-210-2194 – Brent Turner

Branch and internal client staff will utilize this number to assist with payroll deduction issues, and provide assistance for any questions about the process and procedures of the Essential StaffCARE plan. We ask that employees not call this number as it is reserved for management.

Secondary Contact: 704-637-0022 ext. 203 – Essential StaffCARE Account Management
Use this contact in the event that the Primary Marketing Service Support Representative is unavailable and you are in need of immediate assistance. We ask that employees not call this number as it is reserved for management.

## Member Services (Employee):

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

Members will call this number for questions regarding their plan coverage, ID Card, claim status, policy booklets, and to cancel or change their coverage

Customer Service Call Center hours are M-F 8:30am to 8:00pm EST
Spanish Speaking representatives are available

## How To Make Changes and Cancel Coverage by Telephone

After your initial enrollment form has been submitted, you may make changes or cancel coverage by telephone. Changes can be made within 30 days of completing your enrollment form. If you do not have an assignment during the first 30 days, you can make changes to your coverage within 30 days from the pay check date of your first assignment.

Call 1-800-269-7783 (toll free) to make changes or cancel coverage by telephone. You may cancel or reduce coverage at any time unless your deductions are pre-tax. Remember, it will take two to three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction and refunds will not be issued for this time period.

# Fixed Indemnity Medical Benefits - Plans 1 & 2

| | Plan 1 | Plan 2 |
|---|---|---|
| Medical Network | First Health | First Health |
| Network Provider Must Accept Plan | Yes | Yes |
| Prescription Network | Optum | Optum |
| Pre-Existing Condition Limitation | None | None |
| **Wellness Care** | **Plan 1** | **Plan 2** |
| Wellness Care (one per year) | $75 | $100 |
| **Inpatient Benefits** | **Plan 1** | **Plan 2** |
| Standard Care | $300 per day | $500 per day |
| Intensive Care Unit Maximum [1] | $400 per day | $600 per day |
| Inpatient Surgery | $2,000 per day | $2,000 per day |
| Anesthesia | $400 per day | $400 per day |
| First Hospital Admission (1 per year) | N/A | $300 |
| Skilled Nursing *(for stays in a skilled nursing facility after a hospital stay)* | $100 per day | $100 per day |
| **Outpatient Benefits** [2] | **Plan 1** | **Plan 2** |
| Annual Outpatient Maximum | $2,000 | $2,200 |
| Physician Office Visit (Virtual or In-Person) | $60 per day | $115 per day |
| Diagnostic (Lab) | $75 per day | $90 per day |
| Diagnostic (X-Ray) | $150 per day | $250 per day |
| Ambulance Services | $300 per day | $350 per day |
| Physical Therapy, Speech Therapy, Occupational Therapy | $50 per day | $50 per day |
| Emergency Room Benefit - Sickness | $100 per day | $250 per day |
| Emergency Room Benefit - Accident [3] | $300 per day | $500 per day |
| Outpatient Surgery | $500 per day | $500 per day |
| Anesthesia | $200 per day | $200 per day |
| **Prescription Drugs** (via reimbursement) [4, 5] | **Plan 1** | **Plan 2** |
| Annual Maximum | $600 | $600 |
| Generic Coinsurance / Brand Coinsurance | 70% / 50% | 70% / 50% |

*[1] Pays in addition to standard care benefit [2]All outpatient benefits are subject to the outpatient maximum [3] Covers treatment for off the job accidents only [4]Not subject to outpatient maximum [5] To file a claim, save your receipt and remit to Planned Administrators, Inc.*

| Biweekly Premiums | Medical Plan 1 | Medical Plan 2 |
|---|---|---|
| Employee Only | $31.96 | $39.96 |
| Employee + Child(ren) | $53.08 | $66.33 |
| Employee + Spouse | $60.72 | $75.92 |
| Employee + Family | $80.88 | $101.10 |

# Dental, Vision, Term Life, Short Term Disability, & Accidental Loss Benefits

| Accidental Loss of Life, Limb & Sight | | | |
|---|---|---|---|
| Employee Amount | $20,000 | Child Amount (6 mos to 26 yrs old) | $5,000 |
| Spouse Amount | $20,000 | Infant Amount (15 days to 6 mos) | $2,500 |
| Accidental Loss of Life, Limb & Sight is part of the Medical Benefits | | | |

| Dental Benefits | | | | | | |
|---|---|---|---|---|---|---|
| | 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, Endodontics, Bridges and Dentures | | | |

| Vision Benefits | 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[1] (includes follow-up) | Up to $55 | $0 | 100% | $0 |
| Premium Contact Lens Fit Exam[1] (includes follow-up) | 100%, after 10% discount | $0 | 100% | $0 |
| Frames[2] (once every 24 months) | 80%, after $110 allowance | 20% plus $110 allowance | 100% | $55 |
| Standard Plastic Lenses[1] (single, bifocal, trifocal)[1,2] | $25 Copay | 100% | 100% | $25–$55 |
| Contact Lenses[1] *(Conventional) (materials only)* | 85%, after $110 allowance | 15% plus $110 allowance | 100% | $88 |
| Contact Lenses[1] *(Disposable) (materials only)* | 100%, after $110 allowance | $110 allowance | 100% | $88 |
| Contact Lenses[1] *(Medically Necessary) (materials only)* | $0 Copay | 100% | 100% | $200 |

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

| Term Life Benefits | | | |
|---|---|---|---|
| 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 | 60% of base pay up to $150 per week | Waiting Period/Maximum Benefit Period | 7 days/26 weeks |

| Critical Illness Benefits[4] | | | | | |
|---|---|---|---|---|---|
| Heart Attack | 100% | Carcinoma in Situ | 25% | Employee Amount | $5,000 |
| Invasive Cancer | 100% | Skin Cancer | $250 | Spouse Amount | $3,750 |
| Stroke | 100% | | | Child(ren) Amount | $2,500 |

*[1] Once every 12 months [2] Once every 24 months [3] Single Vision: $25, Bifocal: $40, Trifocal: $55 [4] Discount on balance above allowed amount; Frames: 20%, Conventional Contact Lenses: 15% [4] pre-existing condition limitation is 12/12 and waiting period is 30 days*

| Biweekly Premiums | Dental | Vision | Term Life | STD | Critical Illness |
|---|---|---|---|---|---|
| Employee Only | $10.80 | $4.84 | $1.20 | $8.40 | $5.42 |
| Employee + Child(ren) | $29.16 | $13.08 | $1.80 | n/a | $5.50 |
| Employee + Spouse | $21.60 | $9.68 | $1.80 | n/a | $9.98 |
| Employee + Family | $41.04 | $18.40 | $3.60 | n/a | $10.08 |

# Questions & Answers

**Q: Do all employees have to complete an enrollment form?**

**A:** Yes. By obtaining acknowledgement of either an acceptance or declination from each employee completes new-hire paperwork, you are limiting the liability you and your employer face. We never want an employee or family member of your agency to come back to you and say they were discriminated against and never offered insurance. It is in your company's best interest to make sure that all employees fill out the enrollment form and either elect or decline coverage.

**Q: When can an employee enroll for benefits?**

**A:** Employees may sign up for coverage during their first thirty (30) days of employment or during the company-wide open enrollment period. Employees who choose not to elect coverage during their own 30-day open enrollment period, or a company-wide open enrollment, will be asked to wait until the next company-wide open enrollment period before being allowed to elect coverage. Leaving one job assignment and immediately starting another does not constitute a "new" 30-day open enrollment period. If an employee has been terminated or laid off from an assignment and returns on a new assignment, after 6 or more weeks, he/she may re-enroll as a new hire. ESC/PAI considers an employee's first day on a job assignment, regardless of length, the start of their personal 30-day open enrollment period. This is why we encourage you to make sure ALL employees filling out new-hire paperwork complete an Essential StaffCARE enrollment form.

**Q: Will an employee's insurance be canceled if a premium payment is missed?**

**A:** No. Coverage may not be cancelled until the employee has missed six consecutive premium deductions. In the event that an employee misses a deduction(s), the employee may make direct payments to PAI, as long as there has been at least one payroll deduction made through their employer. It is the employee's responsibility to contact PAI to make arrangements for direct payments. PAI will NOT contact your employee if a premium payment is missed. Employees may not initiate coverage through a direct payment. If an employee chooses not to make payments for the week(s) they have a break, no benefit will be paid for claims incurred and submitted during the break in coverage. Payments must be received within 45 days of the date of the paycheck from which a premium deduction would have been made. If an employee comes back to work between one (1) and six (6) weeks, payroll deductions will automatically begin again and be applied on a going forward basis (the Monday following the next deduction). Deductions will only be taken weekly and will NOT be "caught up" by the employer or posted to back weeks.

**Q: When will an employee and his/her eligible dependents be eligible for COBRA?**

**A:** Employees become eligible to receive a COBRA offer if they have had at least one payroll deduction through their employer and have missed six consecutive premium payroll deductions. Once there is a six week break with no payroll premium reported, a COBRA letter is automatically generated and sent by PAI to the member's home address. If the employee or dependent is eligible, he or she may elect COBRA within sixty days from the date of their letter and the applicable premium must be remitted in full to the address provided in their letter. COBRA participants or "qualified beneficiaries", are not billed for their COBRA payment and must take responsibility to keep premium current. COBRA participants may generally stay on COBRA for up to 18 months from the date of a qualifying event that causes loss of coverage. A second qualifying event may allow extended COBRA coverage for up to 36 months. Qualifying events for COBRA are termination of employment, loss of coverage due to a reduction of hours, death of the employee, divorce or legal separation, change in status of a dependent, Medicare entitlement, retired employees, and for employer bankruptcy.

**Q: Who is considered an "eligible dependent"?**

**A:** Your eligible dependents are your spouse and your children under age 26 (this may vary by state).

**Q: When can an enrollee add coverage for himself/herself or dependents?**

**A:** An enrollee may add coverage for himself/herself during an annual open enrollment period or during a life changing event, such as birth, marriage, death, divorce, adoption, Medicare entitlement or loss of prior coverage. Proof of the event must be provided and enrollment or change must occur within thirty days of such event.

# Our Networks

Please utilize the web site addresses or phone numbers below to locate a physician, dentist, or vision provider. **DO NOT** call with questions about your health plan. The networks do not have any knowledge of your medical plan.

## Medical Network

**First Health Network**
www.myfirsthealth.com
1-800-226-5116

## Prescription Network

**For your pharmacy benefit information, visit:**
www.paisc.com
1-866-798-0803

## Dental Network

**Dentemax**
www.dentemax.com
1-800-752-1547

## Vision Network

**EyeMed Vision Care**
www.eyemedvisioncare.com
1-866-559-5252

# Ordering Materials

## Contact Essential StaffCARE to:

Adjust quantity of materials on restock, Stop Restock, and Order More Materials

**Phone Number:** 864-527-7929
**Email:** supplies@iagbenefits.com
**Website:** www.essentialstaffcare.com/supplies

## Restock

Upon request, your branch can receive an automatic recurring shipment (restock):

- Of English Enrollment Forms and/or Spanish Enrollment Forms
- Of Return Envelopes (for mailing employee applications to our third party administrator, PAI, for processing)
- All quantities can be adjusted for each branch's level of volume
- Restock is only adjustable in *quantities*, not frequency

If you choose to receive an automatic restock of forms, your forms will arrive every other month starting with your renewal month:

- If your plan renews in an odd month (Jan., March, May, July, Sept., Nov.), you will always receive restock in an odd month
- If your plan renews in an even month (Feb., April, June, Aug., Oct., Dec.), you will always receive restock in an even month
- **Example of how automatic restock works:** If your company renews your Indemnity plan in January, you will receive a *renewal* shipment in January with materials to hold Open Enrollment. You will then receive a *restock* of Enrollment Forms and Envelopes in March, May, July, Sept. and Nov.

## Order As Needed

If your branch does not wish to receive an automatic restock, you may order forms as your branch needs them:

- No more than six orders per year
- Materials can be ordered at any time, but please try to order enough forms to last 2-3 months
- All orders will be shipped ground with UPS and cannot be expedited
- You will be responsible for printing your own forms if you do not allow enough time for shipping
- All shipments are mailed from Greenville, SC (29615)
- Visit *www.ups.com/maps* to see an estimated shipment time
- Please allow 1-2 days for printing

## How to Submit Enrollment Forms

- Electronic Submission via Secure Site (2 business days)
  - *Most reliable way to submit for quick processing*
  - *Please contact service@iagbenefits.com to verify your FTP site*
- Faxing (4 business days)
  - *Please use Fax Cover Sheet on page 10*
- By Mail (up to 10 business days)
- **Please submit enrollment forms on a weekly basis. This will ensure benefit activation in a timely manner, as well as increase Compliance.**

# New Hire Procedures

1. All new hires who complete an I-9 and W-4 will need to complete the ESC enrollment form. Please incorporate the Essential StaffCARE (ESC) enrollment form into your New Hire paperwork.
2. Ask your employees to complete the form to the best of their knowledge.
3. Every new hire must check **'Yes' or 'No'** on the enrollment application.
4. Don't let employees take the application portion of the form home.
5. Check the form for completeness. We must have all personal information on the top portion of the application including:
    - Social Security Number
    - Date of Birth
    - First and Last Name
    - Phone Number
    - Address
    - Dependent information if dependent coverage is elected.
    - Signature and Date
    - Election of 'Yes' or 'No'
6. Any information left off of the top portion of the enrollment form may delay coverage for the employee.
7. Fax the completed forms to PAI's secure fax at 1-803-264-0772. Please include a fax cover sheet alerting PAI how many applications are included in the fax transmission. You will find, enclosed, a fax cover template which includes important information to accompany your fax. Please feel free to use this version, or create your own.
8. If you prefer to mail your enrollment forms to PAI at least once a week, we will supply you with postage paid return envelopes.

Ask your employees to fill out the Essential StaffCARE enrollment form to the best of their knowledge and hand the benefit election portion back to you. Do not allow this portion to leave your office. Your new hire employee may take the remainder of the form home with them. The take home portion contains valuable information about their plan and also how they can make changes until they receive their ID card and Summary Plan Description from Planned Administrators.

Please do not let the benefit election portion of the enrollment form leave your office--- the chances of getting the form back within the eligibility period is slim and also leaves your company open for a liability. If an employee is unsure of the type of coverage they need, have them complete the top portion of the enrollment form with all personal information and check the box titled "No to all benefits" They can take the remaining portion home with them to discuss with family members. If the employee would like to change their initial election, the take home portion of the application will alert them on how this may be done. They may call the Essential StaffCARE Customer Service line directly and a customer service representative will assist them in making changes.

Planned Administrators will do all the tracking of your employee's eligibility through their systems. We are receiving weekly payroll files from your corporate office, therefore we are able to monitor when deductions and benefits will begin. That is why we must insist that the Essential StaffCARE enrollment form be completed at the time the new hire paperwork is done and faxed to PAI at 1-803-264-0772 no less than once a week. Enrollment forms are date stamped upon receipt at PAI and keyed into the system within 4 business days. Once an employee has received an assignment, PAI will communicate back to your corporate office as to when premium deductions will begin.

ESC
Essential StaffCARE

# ENROLLMENT FORMS
# FAX COVER SHEET

## GROUP #2994003-BGV-3

NUMBER OF PAGES _____
BEING FAXED (INCLUDING COVER PAGE)

YOUR NAME _____

YOUR PHONE NUMBER _____

Please Fax to **ONE** of the following. Indicate which fax line you are using by checking the box below.

PAI's FAX NUMBERS:
- ☐ 1-803-264-0772
- ☐ 1-803-264-8571
- ☐ 1-803-264-8739
- ☐ 1-803-870-8060

B1 **2994003-BGV-3** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __ /__ __ /__ __ __ __

# ENROLLMENT FORM

ESC/MEC CU(4EUSWb) P12M v24.1

## A. REQUIRED EMPLOYEE INFORMATION

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

| Name | Phone | |
|---|---|---|
| Social Security # | Date of Birth / / | Gender M F |
| Address | | Apt. # |
| City | Zip | State |

## B. MEDICARE INFORMATION

Do you or any of your dependents receive Medicare benefits?
☐ Yes ☐ No. If Yes:

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Name of Covered Person(s):
1. 2.

## C. LIMITED BENEFIT PLAN SELECTION

**Payroll Deducted Biweekly Rates**

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for all the benefits in Section C will be identical. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

| SELECT COVERAGE LEVEL | FIXED INDEMNITY MEDICAL [1] | | DENTAL [1] | VISION [1] | TERM LIFE [1] | CRITICAL ILLNESS [1] | SHORT-TERM DISABILITY [1, 2] |
|---|---|---|---|---|---|---|---|
| | Plan 1 | Plan 2 | | | | | |
| ☐ Employee Only | $31.96 | $39.96 | $10.80 | $4.84 | $1.20 | $5.42 | $8.40 |
| ☐ Employee + Child(ren) | $53.08 | $66.33 | $29.16 | $13.08 | $1.80 | $5.50 | |
| ☐ Employee + Spouse | $60.72 | $75.92 | $21.60 | $9.68 | $1.80 | $9.98 | |
| ☐ Employee + Family | $80.88 | $101.10 | $41.04 | $18.40 | $3.60 | $10.08 | |
| ☐ **NO** to ALL Benefits | ☐ Plan 1 ☐ Plan 2 ☐ No Medical Plan | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, NJ, NY,** or **RI.**

**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

## D. REQUIRED DEPENDENT INFORMATION

| Name | Social Security # | Date of Birth | Gender | Relationship |
|---|---|---|---|---|
| | | / / | M F | ☐ Spouse ☐ Child ☐ Domestic Partner |
| | | / / | M F | ☐ Spouse ☐ Child ☐ Domestic Partner |

## E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

**82994003-M-BGV-3** **Payroll Deducted Biweekly Rates**

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 Patient Protection and Affordable Care Act (PPACA) individual mandate no longer imposes a penalty at the federal level; however, please check with your state for any state specific individual mandate requirements or penalties. Rates for the MEC Wellness/Preventive Benefit are billed weekly.

☐ **$26.84** Employee Only ☐ **$30.36** Employee + Child(ren) ☐ **$32.76** Employee + Spouse ☐ **$37.32** Employee + Family

☐ **NO** to MEC Wellness/Preventive

ACA

## F. 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 with a valid SSN.

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

Essential StaffCARE | Plans 1 & 2 - CHANGE FORM | 2994003-BGV-3

Mail / Fax to: Planned Administrators, Inc., PO Box 6702, Columbia, SC 29260
Telephone (866) 798-0803, Fax (803) 264-0772
Underwritten by BCS Insurance Company, Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

## A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

## B. REQUIRED EMPLOYEE INFORMATION

**MUST BE FILLED OUT** — **Address/Name Change**

| Name | Social Security # | Phone | | Gender M F |
|---|---|---|---|---|
| Address | City | State | Zip | Apt. # |
| Employer | | Hire Date / / | | Date of Birth / / |

### Add/Change Dependent Information

| Name | Social Security # | Date of Birth / / | Gender M F | Relationship |
|---|---|---|---|---|
| | | | M F | |
| | | | M F | |

## C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

**Biweekly Rates**

You **MUST** select a coverage level before adding any benefits in Section C. Your coverage level for all the benefits in Section C will be identical.

| SELECT COVERAGE LEVEL | FIXED INDEMNITY MEDICAL [1] | | DENTAL [1] | VISION [1] | TERM LIFE [1] | CRITICAL ILLNESS [1] | SHORT-TERM DISABILITY [1, 2] |
|---|---|---|---|---|---|---|---|
| | Plan 1 | Plan 2 | | | | | |
| ☐ Employee Only | $31.96 | $39.96 | $10.80 | $4.84 | $1.20 | $5.42 | $8.40 |
| ☐ Employee + Child(ren) | $53.08 | $66.33 | $29.16 | $13.08 | $1.80 | $5.50 | |
| ☐ Employee + Spouse | $60.72 | $75.92 | $21.60 | $9.68 | $1.80 | $9.98 | |
| ☐ Employee + Family | $80.88 | $101.10 | $41.04 | $18.40 | $3.60 | $10.08 | |
| ☐ **NO** to ALL Benefits | ☐ Plan 1 ☐ Plan 2 ☐ No Medical Plan | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, NJ, NY,** or **RI.**

### Add/Change Life/Accidental Loss of Life, Limb and Sight Beneficiary

Primary — Relationship

Secondary — Relationship

## D. MEC PLAN CHANGES - Select the change you wish to make.

82994003-M-BGV-3 **Biweekly Rates**

**MEC Wellness/Preventive** ☐ **Terminate** MEC Plan ☐ No Change

☐ **$26.84** Employee Only ☐ **$30.36** Employee + Child(ren) ☐ **$32.76** Employee + Spouse ☐ **$37.32** Employee + Family

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings for the Fixed Indemnity Plan and ancillary benefits. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded, however, coverage will continue as long as you have a paycheck deduction. If electing benefits for the MEC plan, I hereby authorize my employer to send an enrollment request to PAI. **I understand that making no selection in Section C and D for a benefit means I do not wish to make a change to that benefit.**

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

Essential StaffCARE | **Plans 1 & 2 - FORMULARIO DE CAMBIOS** | 2994003-BGV-3

Enviar por correo/fax a: Planned Administrators, Inc. PO Box 6702 Columbia, SC 29260 | Teléfono (866) 798-0803 Fax (803) 264-0772 | Con el aval de BCS Insurance Company Oakbrook Terrace, IL

Llene este formulario SÓLO si va a hacer cambios a la cobertura o a cancelarla.

## A. RAZÓN DEL CAMBIO

☐ Cambio de dirección ☐ Cambio de nombre ☐ Agregar dependiente(s) ☐ Cambio de cobertura ☐ Cancelar la cobertura

## B. INFORMACIÓN REQUERIDA DEL EMPLEADO — CONTESTAR TODO — Cambio de dirección/nombre

| Nombre | # de Seguro Social | Teléfono | | Género H M |
|---|---|---|---|---|
| Dirección | Ciudad | Estado | Código Zip | Apt. # |
| Empleador | | Fecha de contratación / / | | Fecha de nacimiento / / |

**Agregar/cambiar información de dependientes**

| Nombre | # de Seguro Social | Nacimiento / / | Género | Relación |
|---|---|---|---|---|
| | | | H M | |
| | | | H M | |
| | | | H M | |

## C. CAMBIOS AL PLAN DE COMPENSACIÓN FIJA - Elija el cambio que quiere en cada beneficio — Pagos Bisemanales

Usted **DEBE** seleccionar un nivel de cobertura antes de añadir ningún beneficio de la Sección C. Su nivel de cobertura será idéntica para cada beneficio de la Sección C.

| SELECCIONE NIVEL DE COBERTURA | PLAN MÉDICO DE COMPENSACIÓN FIJA [1] Plan 1 | Plan 2 | PLAN DENTAL [1] | PLAN DE LA VISTA [1] | SEGURO DE VIDA [1] | ENFERMEDADES CRÍTICAS [1] | DISCAPACIDAD A CORTO PLAZO [1, 2] |
|---|---|---|---|---|---|---|---|
| Solo empleado ☐ | **$31.96** | **$39.96** | **$10.80** | **$4.84** | **$1.20** | **$5.42** | **$8.40** |
| Empleado + Hijo(s) ☐ | **$53.08** | **$66.33** | **$29.16** | **$13.08** | **$1.80** | **$5.50** | |
| Empleado + Esposa/o ☐ | **$60.72** | **$75.92** | **$21.60** | **$9.68** | **$1.80** | **$9.98** | |
| Empleado + Familia ☐ | **$80.88** | **$101.10** | **$41.04** | **$18.40** | **$3.60** | **$10.08** | |
| **NO** a TODOS los beneficios ☐ | ☐ Plan 1 ☐ Plan 2 ☐ No Médico | | ☐ Si ☐ No | ☐ Si ☐ No | ☐ Si ☐ No | ☐ Si ☐ No | ☐ Si ☐ No |

[1] Cobertura no disponible a residentes de **NH, HI** o **PR.** [2] Beneficios de discapacidad a corto plazo no disponibles a residen en **CA, HI, NH, NJ, NY** o **RI.**

Agregar/cambiar al beneficiario del seguro de vida y del seguro por pérdida de la vida, de un miembro o de la vista por accidente

| Primario | Relación |
|---|---|
| Secundario | Relación |

## D. CAMBIOS AL PLAN MEC - Seleccione el cambio que quiere hacer — 82994003-M-BGV-3 Pagos Bisemanales

**MEC Wellness/Preventive** ☐ **Cancelar** el Plan MEC ☐ Sin cambio

☐ **$26.84** Solo empleado ☐ **$30.36** Empleado + Hijo(s) ☐ **$32.76** Empleado + Esposa/o ☐ **$37.32** Empleado + Familia

Por medio de este documento autorizo a mi empleador a deducir de mi pago las contribuciones requeridas para cubrir las primas del Plan médico de compensación fija (Fixed Indemnity Plan) y los beneficios secundarios. Comprendo que las deducciones podrían seguir siendo las mismas que eran para mis opciones previas hasta que este formulario sea recibido y procesado por PAI. Las deducciones no se reembolsan, sin embargo, la cobertura continuará mientras usted tenga una deducción de cheque de pago. Si se trata de la elección de beneficios del plan MEC, por medio de este documento autorizo a mi empleador a enviar una solicitud de registro a PAI. **Entiendo que el no hacer ninguna selección en las Secciones C y D de un beneficio, significa que no quiero hacer cambios a tal beneficio.**

FECHA __ __ /__ __ /__ __ __ __ ▶ **FIRMA**

# ID Card Information

**Q: How can employees get their ID cards?**

**A:** Within two weeks of their first deduction, ID card(s) and a confirmation of coverage letter will be mailed to the employee's home address. If an employee needs to receive their ID card(s) sooner they can contact the ESC Support Center at 1-866-798-0803 and request copies to be emailed or faxed to them or their provider.

**Q: After I sign up, when will my coverage go into effect?**

**A:** Your coverage goes into effect the Monday following your first payroll deduction. Coverage can not be initiated with a pre-payment.

**Q: How do I find an in-network physician or hospital?**

**A:** While your medical plan does not impose an in-network restriction, you may realize additional savings by utilizing an in-network medical provider.

First Health Network - www.myfirsthealth.com - 1-800-226-5116

**Q: Is there a phone number my doctor can call to get a list of my benefits?**

**A:** Yes, your provider may call the Essential StaffCARE Customer Service number 1-866-798-0803 for scheduled benefits and benefit maximums.

**Q: What if I need to have a prescription filled?**

**A:** For generic and brand prescriptions, present your ID card at a participating pharmacy to receive discounts. Generic and brand prescriptions are payable based on the schedule of benefits up to the annual prescription drug maximum. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay.

**Q: Where can I get claim forms?**

**A:** Medical and Dental claim forms may be obtained by calling our customer service line at 1-866-798-0803 or you may download claim forms from our website – www.paisc.com. Be sure to click on Forms on the home page and then select Essential StaffCARE.

**Q: What if I want to cancel or make changes to my coverage?**

**A:** Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. To make changes or cancel coverage by telephone call (800) 269-7783 within 30 days of the date of your first paycheck.

Toll Free Customer Service Hotline: 1-866-798-0803
8:30 a.m. to 8:00 p.m. EST

ESC
Essential StaffCARE

# Reference Manual

## Information for Branch Managers on **MEC Wellness/Preventive Plan**

# MEC Wellness/Preventive Benefits

| Adults—MEC Plan covers 100% of the allowed amount in network; 40% out of network | |
|---|---|
| **Abdominal Aortic Aneurysm** | One time screening for men of specified ages who have ever smoked |
| **Alcohol Misuse** | Screening and counseling |
| **Aspirin** | Use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk |
| **Blood Pressure** | Screening for all adults |
| **Cholesterol** | Screening for adults of certain ages or at higher risk |
| **Colorectal Cancer** | Screening for adults over 50 to 75 |
| **Depression** | Screening for adults |
| **Type 2 Diabetes** | Screening for adults 40 to 70 years who are overweight or obese |
| **Diet** | Counseling for adults at higher risk for chronic disease |
| **Falls Prevention** | (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting |
| **HIV** | Screening for everyone 15 to 65, and other ages at increased risk |
| **Hepatitis B Screening** | for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence |
| **Hepatitis C Screening** | for adults at increased risk, and one time for everyone born 1945–1965 |
| **Immunization** | Vaccines for adults—doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella |
| **Lung Cancer** | Screening for adults 55–80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years |
| **Obesity** | Screening and counseling for all adults |
| **Sexually Transmitted Infection (STI)** | Prevention counseling for adults at higher risk |
| **Statin Preventive Medication** | for adults 40 to 75 at high risk |
| **Syphilis** | Screening for all adults at higher risk |
| **Tobacco Use** | Screening for all adults and cessation interventions for tobacco users |
| **Tuberculosis Screening** | for certain adults without symptoms at high risk |

# MEC Wellness/Preventive Benefits

| Women, Including Pregnant Women—MEC Plan covers 100% of the allowed amount in network; 40% out of network | |
|---|---|
| **Anemia** | Screening on a routine basis for pregnant women |
| **Bacteriuria** | Urinary tract or other infection screening for pregnant women |
| **BRCA** | Counseling about genetic testing for women at higher risk |
| **Breast Cancer Mammography** | Screenings every 1 to 2 years for women over 40 |
| **Breast Cancer Chemoprevention** | Counseling for women at higher risk |
| **Breastfeeding** | Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women |
| **Cervical Cancer Screening** | Pap test (also called a Pap smear) every 3 years for women 21 to 65; Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years |
| **Chlamydia Infection** | Screening for younger women and other women at higher risk |
| **Contraception** | Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers." |
| **Diabetes** | Screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before |
| **Domestic and Interpersonal Violence** | Screening and counseling for all women |
| **Folic Acid** | Supplements for women who may become pregnant |
| **Gestational Diabetes** | Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes |
| **Gonorrhea** | Screening for all women at higher risk |
| **Hepatitis B** | Screening for pregnant women at their first prenatal visit |
| **Human Immunodeficiency Virus (HIV)** | Screening and counseling for sexually active women |
| **Osteoporosis** | Screening for women over age 60 depending on risk factors |
| **Preeclampsia Prevention and Screening** | for pregnant women with high blood pressure |
| **Rh Incompatibility** | Screening for all pregnant women and follow-up testing for women at a higher risk |
| **Sexually Transmitted Infections (STI)** | counseling for sexually active women |

# MEC Wellness/Preventive Benefits

| | |
|---|---|
| **Syphilis** | Screening for all pregnant women or other women at increased risk |
| **Tobacco Use** | Screening and interventions for all women, and expanded counseling for pregnant tobacco users |
| **Urinary Incontinence Screening** | for women yearly |
| **Well-Woman Visits** | To get recommended services for women under 65 |
| **Children—MEC Plan covers 100% of the allowed amount in network; 40% out of network** | |
| **Alcohol, Tobacco, and Drug Use Assessments** | for adolescents |
| **Autism** | Screening for children at 18 and 24 months |
| **Behavioral Assessments** | for children of all ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Bilirubin Concentration Screening** | for newborns |
| **Blood Pressure** | Screenings for children: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Blood Screening** | for newborns |
| **Cervical Dysplasia** | Screening for sexually active females |
| **Depression** | Screening for adolescents beginning routinely at age 12 |
| **Developmental Screening** | for children under age 3 |
| **Dyslipidemia** | Screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders. Ages: 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years |
| **Fluoride Chemoprevention** | Supplements for children without fluoride in their water source |
| **Fluoride Varnish** | for all infants and children as soon as teeth are present |
| **Gonorrhea** | Preventive medication for the eyes of all newborns |
| **Hearing** | Screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years |
| **Height, Weight, and Body Mass Index** | Measurements for children ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Hematocrit or Hemoglobin** | Screening for children |
| **Hemoglobinopathies** | Or Sickle Cell screening for newborns |

# MEC Wellness/Preventive Benefits

| | |
|---|---|
| **Hepatitis B Screening** | for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S. -born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11–17 years |
| **HIV** | Screening for adolescents at higher risk |
| **Hypothyroidism Screening** | for newborns |
| **Immunization** | Vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis (Whooping Cough), Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella |
| **Iron** | Supplements for children ages 6 to 12 months at risk for anemia |
| **Lead** | Screening for children at risk of exposure |
| **Maternal Depression** | Screening for mothers or infants at 1, 2, 4, and 6-month visits |
| **Medical History** | For all children throughout development: Ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years |
| **Obesity** | Screening and counseling |
| **Oral Health** | Risk assessment for young children: Ages: 0 to 11 months; 1 to 4 years; 5 to 10 years |
| **Phenylketonuria (PKU)** | Screening for newborns |
| **Sexually Transmitted Infection (STI)** | Prevention counseling and screening for adolescents at higher risk |
| **Tuberculin** | Testing for children at higher risk of tuberculosis: Ages 0 to 11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years |
| **Vision** | Screening for all children |

| MEC Biweekly Rates | |
|---|---|
| Employee Only | $26.84 |
| Employee + Child(ren) | $30.36 |
| Employee + Spouse | $32.76 |
| Employee + Family | $37.32 |

# MEC Wellness/Preventive Plan Questions & Answers

**Q: How do I enroll?**
**A:** Enrolling in the MEC Wellness/Preventive Plan is easy. You can enroll by completing an Essential StaffCARE MEC Wellness/Preventive Plan application and returning it to your manager.

**Q: When can I enroll in the plan?**
**A:** You are eligible to enroll in the MEC Wellness/Preventive Plan program within 30 days of your hire date or during your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

**Q: What is a qualifying life event?**
**A:** A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Medicare entitlement
- Employer bankruptcy
- Loss of dependent status
- Loss of prior coverage
- Reduction of work hours (under 30)

In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this benefit.

**Q: Are dependents covered?**
**A:** Yes. Eligible dependents include your spouse and your children up to age 26 (this may vary by state).

**Q: When does coverage begin?**
**A:** Coverage begins the Monday following receipt of your first payment.

**Q: Can I make changes or cancel coverage?**
**A:** You will only have 30 days from your hire date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

**Q: How can I make changes or enroll if I initially decline?**
**A:** If making changes during the annual open enrollment period or within 30 days from your hire/rehire date, complete and submit a new Enrollment Form. If making changes outside of these periods, complete and submit a Change Form. Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. If deductions are taken on a pre-tax basis, changes can only be made due to a QLE and should be submitted using a Change Form.

**Q: Is there a pre-exisiting clause for the medical benefit?**
**A:** There are no restrictions for pre-existing conditions in this plan. Even if you were previously diagnosed with a condition, you can receive coverage for related services as soon as your coverage goes into effect.

**Q: How can managers and employees get the MEC Summary of Benefits and Coverage (SBC)?**
**A:** Employees may contact Essential StaffCARE Customer Service at 1-866-798-0803 to request a printed or emailed copy of your group-specific MEC SBC. At the time of your annual MEC renewal, the main point of contact from your company will receive an updated PDF of the SBC via email. A sample version of the SBC is available at the following link: www.enrollment.care/resources/sbcmec.