



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, 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/Accidental Death and Dismemberment 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.



2912500-KAY



ENROLLMENT FORM

ESC/MEC 4S PVM v23.1

A. HIRED EMPLOYEE INFORMATION

B. MEDICARE INFORMATION

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

Name	Phone	Do you or any of your dependents receive Medicare Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes:	
Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Medicare Health Insurance Claim Number (HICN)
Address	Apt. #	Medicare Effective Date	
City	Zip	State	Name of Covered Person(s): 1. _____ 2. _____

C. LIMITED BENEFIT PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only	<input type="checkbox"/> \$15.98	<input type="checkbox"/> \$5.40	<input type="checkbox"/> \$2.42	<input type="checkbox"/> \$0.60	<input type="checkbox"/> \$4.20
Employee + Child(ren)	<input type="checkbox"/> \$26.54	<input type="checkbox"/> \$14.58	<input type="checkbox"/> \$6.54	<input type="checkbox"/> \$0.90	
Employee + Spouse	<input type="checkbox"/> \$30.36	<input type="checkbox"/> \$10.80	<input type="checkbox"/> \$4.84	<input type="checkbox"/> \$0.90	
Employee + Family	<input type="checkbox"/> \$40.44	<input type="checkbox"/> \$20.52	<input type="checkbox"/> \$9.20	<input type="checkbox"/> \$1.80	
	<input type="checkbox"/> NO to ALL Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹This coverage is not available to residents of NH, HI, or PR. ²STD is not available to persons who work in CA, HI, 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 <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
Name	Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

82912500-M-KAY

Direct Payment Monthly 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 monthly.

\$58.19 Employee Only \$65.79 Employee + Child(ren) \$71.00 Employee + Spouse \$80.87 Employee + Family

NO to MEC Wellness/Preventive



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.

DATE ___/___/_____

▶ SIGNATURE _____


LIMITED BENEFITS SUMMARY

Policy Number **2912500-KAY**

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 Benefits¹	
Physician Office Visit (Virtual or In-Person)	\$60 per day
Diagnostic (Lab)	\$75 per day
Diagnostic (X-Ray)	\$150 per day
Ambulance Services	\$300 per day
Physical, Speech, or Occupational Therapy	\$50 per day
Emergency Room Benefit—Sickness	\$100 per day
Emergency Room Benefit—Accident ²	\$300 per day
Outpatient Surgery	\$500 per day
Anesthesia	\$200 per day
Annual Outpatient Maximum	\$2,000

Inpatient Benefits	
Standard Care	\$300 per day
Intensive Care Unit Maximum ⁵	\$400 per day
Inpatient Surgery	\$2,000 per day
Anesthesia	\$400 per day
Skilled Nursing ⁶	\$100 per day
Annual Inpatient Maximum ⁷	No Limit

Prescription Drugs (via reimbursement)^{3,4}	
Annual Maximum	\$600
Generic Coinsurance / Brand Coinsurance	70% / 50%

Accidental Loss of Life, Limb & Sight

Employee/Spouse	\$20,000
Dependent (6 months to 26 years)	\$5,000
Dependent (15 days to 6 months)	\$2,500


Wellness Care

Wellness Care (one per year)	\$75
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¹all outpatient benefits are subject to the outpatient maximum ²covers treatment for off the job accidents only ³not subject to outpatient maximum ⁴To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. ⁵pays in addition to standard care benefit ⁶for stays in a skilled nursing facility after a hospital stay ⁷subject 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, Endodontics, Bridges and Dentures

VISION BENEFIT


	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay ³	Plan Pays
 Eye Exam¹ (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) ¹	\$0 Copay	100%	100%	\$200

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

GROUP TERM LIFE BENEFIT


 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

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT ¹

Policy Number **82912500-M-KAY**

 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	MONTHLY MEC PREMIUM	MEC
Preventive Services for Adults	100%	40%	Employee Only	\$58.19
Preventive Services for Women	100%	40%	Employee + Child(ren)	\$65.79
Covered Preventive Services for Children	100%	40%	Employee + Spouse	\$71.00
			Employee + Family	\$80.87

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

WEEKLY LIMITED BENEFITS PREMIUM

	Medical	Dental	Vision	Term Life	STD
Employee Only	\$15.98	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	\$26.54	\$14.58	\$6.54	\$0.90	-
Employee + Spouse	\$30.36	\$10.80	\$4.84	\$0.90	-
Employee + Family	\$40.44	\$20.52	\$9.20	\$1.80	-

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

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

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.

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.

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.

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 AND ACCIDENTAL DEATH & DISMEMBERMENT

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.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self-inflicted injury; bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; 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, your spouse or domestic partner; you, your spouse's or domestic partner'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; work-related injury or sickness.

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 is also available, free of charge, by calling Essential StaffCARE Customer Service 1-866-798-0803.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is 400 + ____ (last four digits of your SSN). 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 and to add, change, or cancel coverage.
- 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."