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 employer policies: In order to enroll in the Fixed Indemnity Medical Benefit, you must 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 OR MINIMUM ESSENTIAL COVERAGE AS DEFINED UNDER THE AFFORDABLE CARE ACT (ACA).**


**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/what-are-my-preventive-care-benefits/](https://www.healthcare.gov/what-are-my-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**

Copies of the Summary of Benefits and Coverage (“SBC”) and Summary Plan Description (“SPD”) from Essential StaffCARE (“ESC”) are available at the following link: [www.essentialstaffcare.com/mec-sbc-spd](http://www.essentialstaffcare.com/mec-sbc-spd)

While you may have other health plans, this is the link for your specific MEC plan SPD with ESC. These important documents explain 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.
A. REQUIRED EMPLOYEE INFORMATION
PRINT USING BLACK or BLUE INK (Must Be Filled Out)
Name ____________________________ Home 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 ____________________________

C. LIMITED BENEFIT PLAN SELECTION
You MUST select a coverage level before any benefits in Section C. Your coverage level for the all 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 | VISION | TERM LIFE | SHORT-TERM DISABILITY ²
----------------- | ----------------- | ------- | ------- | --------- | ------------------
Employee Only     | $20.91            | $5.40   | $2.42   | $0.60     | $4.20              
Employee + 1      | $42.44            | $10.80  | $4.92   | $0.90     |                    
Employee + Family | $56.67            | $17.82  | $6.56   | $1.80     |                    
NO to ALL Benefits| No [ ] Yes [ ]    | No [ ]  Yes [ ] | No [ ] Yes [ ] | No [ ] Yes [ ] | No [ ] Yes [ ] |

¹ This coverage is not available to residents of NH, HI, or PR. ² STD 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 M F Relationship Spouse Child Domestic Partner
Name ____________________________ Social Security # ____________________________ Date of Birth __ / __ / __________ Gender M F Relationship Spouse Child Domestic Partner
Name ____________________________ Social Security # ____________________________ Date of Birth __ / __ / __________ Gender M F Relationship Spouse Child Domestic Partner

E. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION
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. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

List Bill Monthly Rates
82341000-M-EFX

[ ] $58.19 Employee Only [ ] $69.53 Employee + 1 [ ] $80.87 Employee + Family [ ] NO to MEC Wellness/Preventive

F. REQUIRED SIGNATURE
YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE
I have read the Benefits Summary and the Limitations and Exclusions for the Fixed Indemnity Medical Plan. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE __ / __ / __________ SIGNATURE __________
**LIMITED BENEFITS SUMMARY**

**FIXED INDEMNITY MEDICAL BENEFIT**

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.

<table>
<thead>
<tr>
<th>Outpatient Benefits ¹</th>
<th>Inpatient Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit</td>
<td>$100 per day</td>
</tr>
<tr>
<td>Diagnostic (Lab)</td>
<td>$75 per day</td>
</tr>
<tr>
<td>Diagnostic (X-Ray)</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>$300 per day</td>
</tr>
<tr>
<td>Physical, Speech, or Occupational Therapy</td>
<td>$50 per day</td>
</tr>
<tr>
<td>Emergency Room Benefit - Sickness</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Emergency Room Benefit - Accident ²</td>
<td>$500 per day</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$500 per day</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>$200 per day</td>
</tr>
<tr>
<td>Annual Outpatient Maximum</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**Children 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

**Prescription Drugs (via reimbursement)³, ⁴**

- Annual Maximum: $600

**DENTAL BENEFIT**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Waiting Period/Coinsurance</th>
<th>Annual Maximum Benefit</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>None / 80%</td>
<td>$750</td>
<td>$50</td>
</tr>
<tr>
<td>B</td>
<td>3 Months / 60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>12 Months / 50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**VISION BENEFIT**¹

<table>
<thead>
<tr>
<th>Eye Exam² (including dilation)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams, Cleanings, Intraoral Films, and Bitewings</td>
<td>$10 Copay 100%</td>
<td>$35</td>
</tr>
<tr>
<td>Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures</td>
<td>Up to $55 100%</td>
<td>$0</td>
</tr>
</tbody>
</table>

**TERM LIFE BENEFIT**

<table>
<thead>
<tr>
<th>Employee Amount</th>
<th>$10,000 (reduces to $7,500 at 65; $5,000 at 70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Amount (6 mos to 26 yrs old)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Infant Amount (15 days to 6 mos)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**SHORT-TERM DISABILITY BENEFIT**

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>60% of base pay up to $150 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Period/Maximum Benefit Period</td>
<td>7 days for injury or sickness / up to 26 weeks</td>
</tr>
</tbody>
</table>

**OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT**¹

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.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Non-Network</th>
<th>MEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Preventive Services for Adults</td>
<td>100%</td>
<td>40%</td>
<td>Employee Only</td>
</tr>
<tr>
<td>22 Preventive Services for Women</td>
<td>100%</td>
<td>40%</td>
<td>Employee + 1</td>
</tr>
<tr>
<td>26 Covered Preventive Services for Children</td>
<td>100%</td>
<td>40%</td>
<td>Employee + Family</td>
</tr>
</tbody>
</table>

**WEEKLY LIMITED BENEFITS PREMIUM**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>234100-EFX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>$20.91</td>
</tr>
<tr>
<td>Dental</td>
<td>$10.80</td>
</tr>
<tr>
<td>Vision</td>
<td>$6.56</td>
</tr>
<tr>
<td>Term Life</td>
<td>$4.20</td>
</tr>
</tbody>
</table>

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

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.

Member Services:
For frequently asked questions and network information for the Fixed Indemnity Medical Plan, visit www.esc-enrollment.com/FAQIND. For questions and a full list of preventive services covered by the MEC Wellness/Preventive Plan, as well as the MEC SBC, please visit www.esc-enrollment.com/FAQMEC. A paper copy of the SBC 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 142 + _ _ _ (last four digits of your SSN). Your Company has chosen to take some/all of your payroll deductions on a Pre-Tax basis. Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

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” and enter your group number.