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Fixed Indemnity Medical Insurance Plan, Ancillary Products, and Self-Funded Minimum Essential Coverage (MEC) Enrollment Guide

Complete the Enrollment Form to Elect or Decline Coverage

IMPORTANT PLAN INFORMATION: You have one medical plan option. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Insurance 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 Summary of Benefits pages for your records.

Not available in all states. Some provisions, benefits, exclusions or limitations herein may vary by state.

The Essential StaffCARE Fixed Indemnity Medical Insurance Plan, Prescription Drug, Dental, Vision, and Term Life Plans are underwritten by Fidelity Security Life Insurance Company®, Kansas City, MO; Policy/Form Numbers: LM-162, DT-239, VC-151, TL-149, SD-36.

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

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/. For questions or assistance, please call Essential StaffCARE Customer Service at 1-888-208-1998.

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

While you may have other health plans, this is the link for your 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 1-888-208-1998.

VSI **3126902-BUA2** OFFICE USE ONLY LOCATION _____ Rehire Date __ __ /__ __ /__ __ __ __

BENEFIT ELECTION FORM

F-ESC/MEC 4USDVTW P2M v3.0

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. ENROLL IN LIMITED BENEFIT PLANS

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

SELECT COVERAGE LEVEL
Weekly Payroll Deducted Rates

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family
- ☐ **NO** to ALL Benefits

FIXED INDEMNITY MEDICAL INSURANCE PLAN[1]

☐ **YES**
☐ **NO**

Weekly Payroll Deducted Rates

$20.91	Employee Only
$34.71	Employee + Child(ren)
$39.73	Employee + Spouse
$52.90	Employee + Family

[1] *This coverage is not available to residents of **NH, HI,** or **PR***

Coverage Level	DENTAL	VISION	TERM LIFE
Employee Only	**$5.40**	**$1.68**	**$0.60**
Employee + Child(ren)	**$14.58**	**$4.53**	**$0.90**
Employee + Spouse	**$10.80**	**$3.36**	**$0.90**
Employee + Family	**$20.52**	**$6.37**	**$1.80**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

E. BENEFICIARY INFORMATION

If you have selected the Benefit Bundle, please write in your beneficiary information for the Term Life Benefit.

Name

Relationship

F. ENROLL IN MEC WELLNESS/PREVENTIVE BENEFIT

MEC PLAN [1]
Weekly Payroll Deducted Rates

83126902-M-BUA2

- ☐ **$14.46** Employee Only
- ☐ **$20.48** Employee + Child(ren)
- ☐ **$19.17** Employee + Spouse
- ☐ **$25.18** Employee + Family
- ☐ **NO to MEC Plan**

[1] *This coverage is not available to residents of HI or PR*

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 with a valid SSN.

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

SUMMARY OF BENEFITS

Fixed Indemnity Medical Insurance Plan

Group Number: **3126902-BUA2**

The Fixed Indemnity Medical Insurance 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	Per Day	Plan Year Maximum	Inpatient Benefits	Per Day	Plan Year Maximum
Physician Office visit	$105	8 days	Hospital Admission	$250	1 day
Outpatient Surgery[1]	$500	1 day	Daily Hospital Confinement	$500	3x (unlimited days)
Anesthesia	$125	—	Intensive Care Unit Maximum[9]	$600	30 days
Diagnostic Labs[2]	$75	6 days	Skilled Nursing Facility[10]	$100	60 days (no lifetime max)
Diagnostic Tests[3]	$200	3 days	Inpatient Surgery	$3,000	1 day
Ambulance Services[4]	$300[5]/$900[6]	1 day	Anesthesia	$750	—
Emergency Room (Injuries)[7]	$500	2 days	**Wellness Care[11]**		
Emergency Room (Sickness)	$200	2 days	Persons age 1+	$100	1 Day
Prescription Drugs[8]	$20	30 days	Persons under age 1	$100	4 Days
Telemedicine Services*	No Cost	Unlimited			

*You will have access to a national Telemedicine program called 1.800MD. This program connects members to board certified physicians around the clock (24/7/365) via telephone or secure video. 1.800MD doctors can answer questions, give advice, and even diagnose and treat illnesses by calling 1-800-530-8666.

MEC Wellness/Preventive Plan

Group Number: **83126902-M-BUA2**

Your second option for medical coverage is the MEC Wellness/Preventive Plan. This plan provides coverage for preventive services such as immunizations and routine health screenings.

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

PREMIUM	Fixed Indemnity Medical Insurance Plan (Weekly)	MEC Plan (Weekly)
Employee Only	$20.91	$14.46
Employee + Child(ren)	$34.71	$20.48
Employee + Spouse	$39.73	$19.17
Employee + Family	$52.90	$25.18

[1] benefits are not payable for surgical operations performed in a Physician's office [2] routine or wellness lab screens and tests are not covered [3] laboratory tests and routine wellness screens and tests not covered [4] transportation must occur within 72 hours of the accident or onset of the sickness [5] benefit is for ground/water services [6] benefit is for air services [7] treatment must be within 72 hours of the accident [8] To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. [9] pays in addition to daily hospital confinement [10] must be under age 65 and admitted to the Skilled Nursing Facility within 14 days following a Hospital stay of at least three consecutive days [11] benefit is payable for each day an insured person has any one of the health screenings, exams, or tests listed in the policy

SUMMARY OF BENEFITS

Dental

Benefits are payable for dental treatment services and supplies performed by or prescribed by a Dentist or Dental Hygienist.

Benefits	Waiting Period/ Coinsurance	Annual Maximum Benefits: $750	Deductible: $50 (per insured person)
Coverage A	None / 80%	Exams, Cleanings, Fluoride, Bitewings, Tests & Labs, Space Maintainers, and Sealants	
Coverage B	3 Months / 60%	Fillings, Oral Surgery, Anesthesia, and Repairs for Crowns, Bridges and Dentures	
Coverage C	12 Months / 50%	Periodontics and Endodontics Including Root Canal, Crowns, Bridges, and Dentures	

Vision

Helps offset the cost of covered procedures performed by an optometrist.

VISION BENEFIT	In-Network	Out-of-Network
Eye exam with dilation as necessary [1]	$10 Copay; plan pays 100%	Plan pays $45; you pay remaining
Exam Options		
Retinal Imaging	You pay up to $39	You pay 100% of the price
Standard Contact Lens Fit [2]	You pay up to $55	You pay 100% of the price
Premium Contact Lens Fit [2]	10% off retail price; you pay remaining	You pay 100% of the price
Frames [3, 4]	Plan pays 20% after $110 allowance	$90; you pay remaining
Standard Plastic Lenses [1,4, 5]		
Single Vision	$25 Copay	Plan pays $40; you pay remaining
Bifocal	$25 Copay	Plan pays $60; you pay remaining
Trifocal / Lenticular	$25 Copay	Plan pays $80; you pay remaining
Progressive–Standard	$90 Copay	Plan pays $60; you pay remaining
Progressive–Premium	$90 Copay; plan pays 20% after $120 allowance	Plan pays $60; you pay remaining
Lens Options		
UV Treatment / Tint (Solid and Gradient) / Standard Plastic Scratch Coating	$15	You pay 100% of the price
Standard Polycarbonate	$40	You pay 100% of the price
Standard Anti-Reflective Coating	$45	You pay 100% of the price
Non-Glass Photochromatic / Other Add-ons and Services	20% off retail price	You pay 100% of the price
Contact Lenses [1,6]		
Conventional	Plan pays 15% after $110 allowance	Plan pays $90; you pay remaining
Disposable	Plan pays 100% after $110 allowance	Plan pays $90; you pay remaining
Medically Necessary	Plan pays 100%	Plan pays $210; you pay remaining
Lasik [7]	15% off retail price or 5% off promotional price	You pay 100% of the price

[1] Per insured; once every 12 months [2] Includes follow up; contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed [3] once every 24 months [4] in lieu of contact lenses [5] 40% off additional pairs of glasses and 15% off conventional lenses once funded benefit is used [6] Contact lens allows covers materials only; in lieu of regular lenses [7] Lasik or PRK from US Laser Network

Term Life

Provides coverage to your family in the event of your passing. Don't forget to name a beneficiary on the enrollment form to receive this benefit.

Benefit Amounts			
Employee Amount	$10,000 (reduces to $5,000 at 70; $2,500 at 75)	Dependent (6 mos +)	$2,500
Spouse Amount	$5,000	Dependent (14 days to 6 mos)	$250
Accidental Death & Dismemberment (AD&D is part of the Term Life Benefit.)			
Employee Only	Death / Loss of two limbs / Sight in both eyes / One limb and sight in one eye ($10,000)	Loss of one limb or sight in one eye ($5,000)	

PREMIUM	Dental (Weekly)	Vision (Weekly)	Term Life (Weekly)
Employee Only	$5.40	$1.68	$0.60
Employee + Child(ren)	$14.58	$4.53	$0.90
Employee + Spouse	$10.80	$3.36	$0.90
Employee + Family	$20.52	$6.37	$1.80

FIXED INDEMNITY MEDICAL INSURANCE PLAN LIMITATIONS AND EXCLUSIONS

Limitations

Recurrent Confinements. If the Company pays benefits for a period of Confinement, and the Insured Person is readmitted within 30 days of that Confinement for the same condition, the later Confinement will be treated as a continuation of the prior Confinement. If more than 30 days have passed between periods of Confinement for the same condition or the successive Confinement is for an unrelated cause, the Company will treat the later Confinement as a new Confinement.

Exclusions

The Policy does not provide any benefits for the following:

1. suicide or any attempt of suicide, while sane or insane (in Colorado, Missouri or Montana, while sane);
2. any intentionally self-inflicted Injury or Sickness or any attempt thereat (in Colorado, Missouri or Montana, while sane);
3. rest care or rehabilitative care and treatment, except as specifically provided in the Skilled Nursing Facility Confinement benefit;
4. dependent child Pregnancy, except Complications of Pregnancy;
5. routine newborn care, except as specifically provided for in the Wellness benefit;
6. voluntary abortion, except where Medically Necessary to save the Insured Person's life;
7. participation in a Riot, insurrection, rebellion, civil commotion, civil disobedience or unlawful assembly. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law. This does not include a loss that occurs while acting in a lawful manner within the scope of authority;
8. committing, attempting to commit or taking part in a felony, battery, assault or engaging in an illegal occupation;
9. any Injury occurring while the Insured Person is intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Injury took place);
10. treatment for the voluntary taking of any poison or inhalation of gas, or voluntary taking of any drug, sedative or narcotic, unless prescribed by a Physician and taken according to the prescribed dosage;
11. dental care or treatment, except:
12. care or treatment due to an Injury to sound, natural teeth treated within 12 months of the Accident;
13. treatment necessary due to congenital defects or birth abnormalities;
14. excision of impacted third molars, or
15. closed or open reduction of fractures or dislocation of the jaw;
16. sex changes;
17. the reversal of tubal ligation or the reversal of vasectomies;
18. flying or descending from any aircraft or air conveyance, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route;
19. accidental bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by the Company pro rata for any period of active duty);
20. declared or undeclared war or acts thereof;
21. injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit or benefits that he Insured Person is entitled to under any Occupational Disease Law or similar law, whether or not application for such benefits have been made;
22. medical care, services or supplies provided outside of the United States of America or its territories;
23. treatment of obesity, weight reduction or dietetic control; except morbid obesity or disease etiology;
24. confinement, care or services incurred prior to the Insured Person's Effective Date or that begin after termination of coverage;
25. confinement, care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law;
26. confinement or treatment that is not Medically Necessary; or
27. any Confinement or treatment not specifically covered in the Schedule of Benefits.

Extension of Benefits. This provision applies if an Insured Person is Hospital Confined on the termination date of the Policy, unless termination is due to nonpayment of premiums. The Company will pay the same benefits for the duration of any Hospital Confinement or 90 days, whichever occurs first. No further premium payment is required to qualify for this extension of benefits.

DENTAL BENEFIT

The Policy does not provide any benefits for the following charges, services or supplies:

1. that, in the absence of insurance, the Insured Person would not be required to pay;
2. related to self-inflicted injuries (in Colorado, Missouri or Montana, while sane);
3. related to war or an act of war, whether or not declared;
4. related to the Insured Person's commission of a felony or an assault on another person;
5. related to a riot, nuclear accident or a major disaster;
6. caused by, related to, or as a condition of employment, including self-employment. This exclusion applies even if charges are not covered under any Workers' Compensation, Occupational Disease, group, group-type and individual automobile "No-Fault" coverage or similar law;
7. that are more than Usual and Customary Charges;
8. that are incurred, or for which treatment began, before the Insured Person's effective date of coverage or after the Insured Person's termination of coverage;
9. related to congenital or development malformations existing when the Insured Person's coverage became effective under the Policy (unless the procedure is performed on an Insured Person who was covered immediately following birth;
10. that are Experimental/Investigational;
11. appliances, services or procedures relating (i) the change ormaintenance of vertical dimension; (ii) restoration of occlusion (iv) correction of attrition or abrasion; or (vi) bite analysis or registration; occlusion (iv) correction of attrition or abrasion; or (vi) bite analysis or registration;
12. related to orthognathic surgery;
13. for replacement of bridges unless the bridge cannot be made serviceable;
14. for replacement of partial or full dentures unless the prosthetic appliance is more than five years old and cannot be made serviceable;
15. for replacement of crowns, inlays or onlays unless the prior placement is more than seven years old and cannot be made serviceable;}
16. related to lost, stolen, missing or duplicate dentures, bridges or space maintainers;
17. charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
18. related to fixed or removable bridgework involving replacement of a natural tooth or teeth that were lost prior to the Insured Person's effective date of coverage under the Policy. Benefits may be payable for bridgework required for loss of teeth while insured under the Policy, if such bridgework is not an abutment for non-covered bridgework;
19. related to prescription drugs and analgesia pre-medication;
20. related to charges for telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending physician statements and any other services or supplies that are not part of the direct treatment of the Insured Person;
21. that are not made by a Dentist;
22. related to counseling on diet and nutrition, oral hygiene or plaque control;
23. received from a provider who is member of the Insured Person's Immediate Family;
24. caused by or related to an Insured Person's military service, including service in a military reserve unit;
25. for services and supplies not included in a Covered Procedure;
26. related to orthodontia;
27. any prosthodontic dental appliance installed or delivered more than 30 days after the Insured Person's insurance terminates;
28. that are payable under any medical insurance;
29. made by any government entity unless the Insured Person is required to pay; or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made;

30. related to treatment, services or supplies which are not rendered in accordance with generally accepted standards of dental practice;
31. related to cosmetic dentistry, including but not limited to veneers and teeth whitening or bleaching;
32. related to cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
33. for treatment of malignancies, cysts and neoplasms; or
34. replacement of third molars.

VISION BENEFIT

Fees charged by a provider for services other than a covered benefit and any local, state or federal taxes must be paid in full by the insured to the provider. Such fees, taxes or materials are not covered under the policy. Allowances provide no remaining balance for future use within the same benefit frequency.

The plan does not provide any vision examination or vision materials benefits for treatment, services or supplies that are for othoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye or supporting structures (except for the Lasik benefit); safety eyewear; plano (non-prescription) lenses or contact lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals or lost, broken lenses, frames or contact lenses.

Some provisions, benefits, exclusions or limitations listed herein may vary by state.

Providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

Exclusions:

No benefits will be paid for services or materials connected with or charges arising from:

1. medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
5. any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
6. safety eyewear;
7. solutions, cleaning products or frame cases;
8. non-prescription sunglasses;
9. plano (non-prescription) lenses; plano (non-prescription) contact lenses;
10. two pair of glasses in lieu of bifocals;
11. electronic vision devices;
12. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
13. lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

Member Services:

For frequently asked questions and network information for the Fixed Indemnity Medical Insurance Plan, visit *www.esc-enrollment.com/FSLIND*. 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/FSLMECW*. A paper copy is also available, free of charge, by calling Essential StaffCARE Customer Service 1-888-208-1998.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Use pin code **408** + _ _ _ _ (last four digits of your SSN) for your **Fixed Indemnity Medical Insurance Plan** (see gray section above for benefits covered). Use pin code **648** + _ _ _ _ (last four digits of your SSN) for your **MEC** plan. Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-888-208-1998

- 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.