



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

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: <https://www.healthcare.gov/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

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.



VSI 2960300-AQL

OFFICE USE ONLY LOCATION _____

Rehire Date ___/___/_____

ENROLLMENT FORM

ESC/MEC 4SW P1DM v20.1

A. REQUIRED EMPLOYEE INFORMATION**PRINT USING BLACK or BLUE INK (Must Be Filled Out)**

Name	Home Phone	
Social Security #	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 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"/> \$22.76	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	<input type="checkbox"/> \$37.78	\$14.58	\$6.54	\$0.90	
Employee + Spouse	<input type="checkbox"/> \$43.24	\$10.80	\$4.84	\$0.90	
Employee + Family	<input type="checkbox"/> \$57.58	\$20.52	\$9.20	\$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
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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

82960300-M-AQL

Payroll Deducted Weekly 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. Rates for the MEC Wellness/Preventive Benefit are billed weekly.

\$13.42 Employee Only \$15.18 Employee + Child(ren) \$16.38 Employee + Spouse \$18.66 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

For more details, please see your Summary Plan Description.

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

Outpatient Benefits ¹		Inpatient Benefits	
Physician Office Visit	\$100 per day	Standard Care	\$300 per day
Diagnostic (Lab)	\$75 per day	Intensive Care Unit Maximum ⁴	\$400 per day
Diagnostic (X-Ray)	\$200 per day	Inpatient Surgery	\$2,000 per day
Ambulance Services	\$300 per day	Anesthesiology	\$400 per day
Physical, Speech, or Occupational Therapy	\$50 per day	Skilled Nursing ⁵	\$100 per day
Emergency Room Benefit - Sickness	\$200 per day	First Hospital Admission (1 per year)	\$250
Emergency Room Benefit - Accident ²	\$500 per day	Annual Inpatient Maximum ⁶	No Limit
Outpatient Surgery	\$500 per day	Accidental Loss of Life, Limb & Sight	
Anesthesiology	\$200 per day	Employee/Spouse	\$20,000
Annual Outpatient Maximum	\$2,000	Dependent (6 months to 26 years)	\$5,000
Prescription Drugs ³		Dependent (15 days to 6 months)	\$2,500
Annual Maximum	\$600	Wellness Care	
Generic Copay / Brand Copay	\$10/\$50	Wellness Care (one per year)	\$100


¹ all outpatient benefits are subject to the outpatient maximum ² covers treatment for off the job accidents only ³ not subject to outpatient maximum ⁴ pays in addition to standard care benefit ⁵ for stays in a skilled nursing facility after a hospital stay ⁶ Subject to internal limits of plan

DENTAL BENEFIT


Waiting Period/Coinsurance

Annual Maximum Benefit \$750

Deductible \$50


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

VISION BENEFIT ¹

	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay ⁴	Plan Pays
 Eye Exam ² (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) ^{2,3}	\$25 Copay	100%	100%	\$25-\$55
Contact Lenses (Conventional) (materials only) ²	85%, after \$110 allowance	15% plus \$110 allowance	100%	\$88
Contact Lenses (Disposable) (materials only) ²	100%, after \$110 allowance	\$110 allowance	100%	\$88
Contact Lenses (Medically Necessary) (materials only) ²	\$0 Copay	100%	100%	\$200

¹ For complete plan details, visit www.essentialstaffcare.com/vision ² Once every 12 months ³ \$15 higher in AK, CA, HI, OR, WA ⁴ After plan payment

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 **82960300-M-AQL**

 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	WEEKLY MEC PREMIUM	MEC
15 Preventive Services for Adults	100%	40%	Employee Only	\$13.42
22 Preventive Services for Women	100%	40%	Employee + Child(ren)	\$15.18
26 Covered Preventive Services for Children	100%	40%	Employee + Spouse	\$16.38
			Employee + Family	\$18.66

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

WEEKLY LIMITED BENEFITS PREMIUM

	Medical	Dental	Vision	Term Life	STD
Employee Only	\$22.76	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	\$37.78	\$14.58	\$6.54	\$0.90	-
Employee + Spouse	\$43.24	\$10.80	\$4.84	\$0.90	-
Employee + Family	\$57.58	\$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 AND ACCIDENTAL LOSS OF LIFE, LIMB OR SIGHT BENEFIT

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

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

No benefits will be paid for:

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

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

PRESCRIPTION DRUGS

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

DENTAL

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

VISION

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

SHORT-TERM DISABILITY

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

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

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

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/FAQ/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 www.esc-enrollment.com/FAQMECW. 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 **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" and enter your group number.