Fixed Indemnity Medical, 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 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.

VSI **2934600-LSL** | OFFICE USE ONLY LOCATION _____ | Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

ESC/MEC 4NA PVM 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 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 [1]	VISION [1]	TERM LIFE [1]	SHORT-TERM DISABILITY [1, 2]
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**	
	☐ **NO** to ALL Benefits	☐ 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 Death & Dismemberment please write in your beneficiary information. Accidental Death & Dismemberment is part of the Group Term Life Benefit.

Name Relationship

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship
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 [1]

82934600-M-LSL **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

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

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**

LIMITED BENEFITS SUMMARY

Policy Number **2934600-LSL**

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 (Virtual or In-Person)	$70 per day	Standard Care	$300 per day
Diagnostic (Lab)	$90 per day	Intensive Care Unit Maximum[3]	$400 per day
Diagnostic (X-Ray)	$200 per day	Inpatient Surgery	$2,000 per day
Ambulance Services	$350 per day	Anesthesia	$400 per day
Physical, Speech, or Occupational Therapy	$50 per day	Skilled Nursing[4]	$100 per day
Emergency Room Benefit—Sickness	$150 per day	Annual Inpatient Maximum[5]	No Limit
Emergency Room Benefit—Accident[2]	$300 per day	**Wellness Care**	
Outpatient Surgery	$500 per day	Wellness Care (one per year)	$75
Anesthesia	$200 per day	**Prescription Drugs (via reimbursement)**[6, 7]	
Annual Outpatient Maximum	$2,200	Annual Maximum	$600
		Generic Coinsurance / Brand Coinsurance	70% / 50%

[1]all outpatient benefits are subject to the outpatient maximum [2]covers treatment for off the job accidents only [3]pays in addition to standard care benefit [4]for stays in a skilled nursing facility after a hospital stay [5]subject to internal limits of plan [6]not subject to outpatient maximum [7]To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc.

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 Exam[1] (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

[1]Once every 12 months [2]$15 higher in AK, CA, HI, OR, WA [3]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

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D is part of the Group Term Life Benefit.)

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

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 [1,2]

Policy Number: **82934600-M-LSL**

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. [2] This coverage is not available to residents of HI, or PR

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.

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.

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.

The fixed indemnity medical/Rx, dental, term life, and accidental death and dismemberment plans are not available to residents of Hawaii, New Hampshire, or Puerto Rico.

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 reside in California, Hawaii, New Hampshire, New Jersey, New York, or Rhode Island.

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."

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact **PAI at 1-866-798-0803** or visit **www.paisc.com**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform, www.paisc.com.com** or call **1-866-798-0803** to request a copy

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. **Preventive Services.**	For example, this **plan** covers certain **Preventive Services** without **cost-sharing** and before you meet your **deductible**. See a list if covered **Preventive Services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This **plan** does not have an **out-of-pocket limit** on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This **plan** does not have an **out-of-pocket limit** on your expenses.
Will you pay less if you use a network provider?	Yes. See **www.myfirsthealth.com** or call First Health toll free at 1(800)226-5116 for a list of network providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays **(balance billing)**. Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

[Type text]

(DT – OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL-OMB Control Number: 1210-0147/Expiration date: 5/31/2022)
(HHS – OMB control number : 0938-1146/Expiration Date: 10/31/2022)

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	Benefits are provided only for **Preventive care** services as outlined by the Patient Protection and Affordable Care Act (PPACA). There is no coverage for services to treat an injury or illness. You may have to pay for services that aren't **Preventive.** Ask your provider if the services needed are preventive. Then check what your plan will pay for. Only ACA approved **Preventive care** benefits are covered. .
	Specialist visit	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance.** Treatment of an injury or illness: Not covered.	
	Preventive care/screening/ immunization	No charge for **Preventive Services** outlined by the Affordable Care Act (ACA)	**Preventive care**: 60% **coinsurance**.	
If you have a test	**Diagnostic test** (x-ray, blood work)	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	
	Imaging (CT/PET scans, MRIs)	Not covered.	Not covered.	
If you need drugs to treat your illness or condition	**Generic drugs**	Not covered.	Not covered.	Oral birth control, immunizations, select supplements and aspirin are covered under this plan in accordance with ACA **Preventive care**.* More information about **prescription drug coverage** is available by calling 1-866-798-0803.
	Preferred brand drugs	Not covered.	Not covered.	
	Non-preferred brand drugs	Not covered.	Not covered.	
	Specialty drugs	Not covered.	Not covered.	

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	This **plan** provides benefits for **Preventive care services** as outlined by the Affordable Care Act. You may have to pay for services that aren't **Preventive.** Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.* Treatment of an injury or illness: Not covered.
	Physician/surgeon fees	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	
If you need immediate medical attention	Emergency room care	Not covered.	Not covered.	
	Emergency medical transportation	Not covered.	Not covered.	
	Urgent care	Not covered.	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	
	Physician/surgeon fees	Not covered.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	
	Inpatient services	Not covered.	Not covered.	
If you are pregnant	Office visits	**Preventive care**: No charge. Other maternity treatment: Not covered.	**Preventive care**: 60% **coinsurance**. Other maternity treatment: Not covered.	
	Childbirth/delivery professional services	**Preventive care**: No charge. Other maternity treatment: Not covered.	**Preventive care**: 60% **coinsurance**. Other maternity treatment: Not covered.	Only ACA approved **Preventive care** benefits are covered.* This **plan** provides benefits for **Preventive care services** as outlined by the Affordable Care Act.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				You may have to pay for services that aren't **Preventive.** Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.* Treatment of an injury or illness: Not covered.
	Childbirth/delivery facility services	Not covered	Not covered	Not covered
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	This **plan** provides benefits for **Preventive care services** as outlined by the Affordable Care Act. You may have to pay for services that aren't **Preventive.** Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for.* Treatment of an injury or illness: Not covered.
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	**Preventive care**: No charge. Treatment of an injury or illness: Not covered.	**Preventive care**: 60% **coinsurance**. Treatment of an injury or illness: Not covered.	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	**Preventive care:** No charge.	**Preventive care:** 60% **coinsurance.**	Covers only an oral health risk assessment for young children: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years and Fluoride Chemoprevention Supplements for children without fluoride in their water source.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Habilitation Services
- Hearing aids
- Infertility treatment
- Inpatient care
- Long-term care
- Non–emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Routine eye care (children only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform/ Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov/ Planned Administrators Inc. at 1-866-798-0803 or **www.paisc.com**. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or / Planned Administrators Inc. at 1-866-798-0803 or **www.paisc.com**.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available thru the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-798-0803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-798-0803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-798-0803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-798-0803.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist	$0
Hospital (facility) *Not covered*	%N/A
Other *Not covered*	%N/A

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	100%
What isn't covered	
Limits or exclusions	$12,617
The total Peg would pay is	**$12,617**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist	$0
Hospital (facility) *Not covered*	%N/A
Other *Not covered*	%N/A

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	100%
What isn't covered	
Limits or exclusions	$7,217
The total Joe would pay is	**$7,217**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist	$0
Hospital (facility) *Not Covered*	%N/A
Other *Not covered*	%N/A

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	100%
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)