ESC
Essential StaffCARE

# Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

Certified
EMPLOYMENT GROUP

- Complete the Enrollment Form for the New Hire Process
- Elect or Decline Medical Coverage on the Enrollment Form
- You **MUST** Sign and Date the Bottom of the Form, even if you Decline Coverage
- Return the Enrollment Form to your Branch Manager

**THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. YOU AND ANY DEPENDENT TO BE INSURED UNDER THIS COVERAGE MUST HAVE MINIMUM ESSENTIAL COVERAGE UNDER AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE. PERSONS ELIGIBLE FOR MEDICARE SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM BCS INSURANCE COMPANY.**

**NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

The Essential StaffCARE Fixed Indemnity Medical, Dental and Vision Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.212, and 26.213. The Term Life and Accidental Death and Dismemberment Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

VSI 208700-CEG | OFFICE USE ONLY LOCATION _____ Rehire Date __ __/__ __/__ __ __ __

# ENROLLMENT FORM

ESC-NAY P1 v25.1.CA

## 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 |

## 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(s) of Covered Person(s):

1.

2.

3.

## SELECT COVERAGE LEVEL

You **MUST** select a coverage level before adding any benefits. Your coverage level will be identical for each benefit.

☐ Employee Only ☐ Employee + Family

☐ Employee + 1 ☐ **NO** to all Benefits

## BENEFIT BUNDLE

Payroll Deducted Weekly Rates

The benefit bundle includes **dental, vision, and term life** benefits

☐ **YES**

☐ **NO**

**$8.42** Employee Only

**$16.62** Employee + 1

**$26.18** Employee + Family

## FIXED INDEMNITY PLAN

Payroll Deducted Weekly Rates

☐ **YES**

☐ **NO**

**$19.58** Employee Only

**$39.73** Employee + 1

**$53.06** Employee + Family

## BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.
Accidental Death & Dismemberment is part of the Term Life Benefit.

Name Relationship

## REQUIRED DEPENDENT INFORMATION

| | |
|---|---|
| Name DOB / / | Name DOB / / |
| Social Security # Gender M F | Social Security # Gender M F |
| Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner | Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner |
| Name DOB / / | Name DOB / / |
| Social Security # Gender M F | Social Security # Gender M F |
| Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner | Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner |

**Do you or any dependent to be enrolled currently have comprehensive health benefits from either an individual or group health insurance policy or an HMO or employer plan providing for essential health benefits?**

☐ **YES** ☐ **NO** **(If No, you are not eligible for this plan.)**

If you did not answer YES to having comprehensive health benefits from either an individual or group health insurance policy, you may still enroll in dental, vision, or term life coverage.

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans 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.

▶ SIGNATURE _____ Date __ __/__ __/__ __ __ __

**BENEFITS AT A GLANCE*** **Policy Number** 208700-CEG

## Network Information

| | | | |
|---|---|---|---|
| **Fixed Indemnity Medical Plan** | First Health Network | 1-800-226-5116 | www.myfirsthealth.com |
| **Vision Network** | EyeMed Vision Care | 1-866-559-5252 | www.eyemedvisioncare.com |
| **Dental Network** | DenteMax | 1-800-752-1547 | www.dentemax.com |

## Fixed Indemnity Medical Benefits

| **Inpatient Benefits** | | **Outpatient Benefits**[1] | |
|---|---|---|---|
| Standard Care | $300 per day | Annual Outpatient Maximum | $2,200 |
| Intensive Care Unit Maximum[2] | $400 per day | Physician Office Visit (Virtual or In-Person) | $115 per day |
| Inpatient Surgery | $2,000 per day | Diagnostic (Lab) | $90 per day |
| Anesthesia | $400 per day | Diagnostic (X-Ray) | $250 per day |
| First Hospital Admission (1 per year) | $300 | Ambulance Services | $350 per day |
| **Wellness Care** | | Emergency Room Benefit - Sickness | $250 per day |
| Wellness Care (one per year) | $100 | Emergency Room Benefit - Accident[3] | $500 per day |
| | | Outpatient Surgery | $500 per day |
| | | Anesthesia | $200 per day |
| | | Physical Therapy, Speech Therapy, Occupational Therapy | $50 per day |

**Teladoc Health**
As an enrollee in the Fixed Indemnity medical plan, you have the option to obtain telehealth, primary care or mental health services through Teladoc Health. Please see the Summary Plan Description for additional details.

*[1] all outpatient benefits are subject to the outpatient maximum [2] pays in addition to standard care benefit [3] covers treatment for off the job accidents only*

## Dental Benefits

| | **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 Benefits

| | **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%, + $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%, + $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 Benefits

| | | | |
|---|---|---|---|
| **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

| | | | |
|---|---|---|---|
| **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 |

## Weekly Premium

| **Tier Level** | **Medical** | **Benefit Bundle: Dental, Vision, Term Life** |
|---|---|---|
| **Employee Only** | $19.58 | $8.42 |
| **Employee + 1** | $39.73 | $16.62 |
| **Employee + Family** | $53.06 | $26.18 |

*For more details, please see your Summary Plan Description.

## 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 or

**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.

### TERM LIFE WITH 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.

**Member Services:**

**For questions regarding when and how you can enroll/make changes, as well as additional frequently asked questions, please go to *www.essentialstaffcare.com/FAQCA* for this information.**

**PLEASE NOTE:** 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."