2019 Employee Benefit Program

Welcome! As an employee, you are eligible to enroll in our benefits program. Below is a summary of the different types of insurance you are eligible to purchase. A list of all coverage and exclusions are in the plan document that is available at choosebettercare.com.

Although you are making your election at the time of application, coverage will not become effective until you start work (subject to any allowable waiting period). **You have four options for 2019**:

1. You can decline health insurance. <u>If you decline, you will not have any money deducted from your check for health insurance.</u>

2. For $65.40 per month you can purchase **Minimum Essential Coverage Plan (MEC). MEC** provides ***Preventative Screening & Immunization Services only***. For example, it covers blood pressure screening. However it does not cover treatment for high blood pressure if a medical issue is found during the screening. If you enroll in the **MEC** plan, you will fulfill your Affordable Care Act obligation to have insurance coverage and you will not be subject to the Individual Mandate tax penalty.

MEC coverage is $65.40 and is payroll deducted in one lump sum from your first pay check each month.

NOTE: If you elect to enroll in any coverage you (and your dependents if they also enroll) will be ineligible to enroll in subsidized coverage through a public insurance exchange or marketplace even if you would otherwise qualify.

3. For $100.65 - $214.23 per month you can purchase **MEC Heavy.** The **MEC Heavy** incorporates the benefits of the **MEC**, plus co pays for in-network coverage for certain medical benefits such as Telemedicine calls, Generic Prescription Drugs ($15 co pay generic), non- emergency room outpatient X-rays and laboratory services ($75 co pay), non- emergency room outpatient MRIs ($500 co pay).

MEC Heavy EXCLUSIONS: The MEC Heavy has many exclusions. The following is a *<u>partial list</u>* of services *<u>not</u>* covered by the MEC Heavy - All inpatient services; mental/behavioral health and substance abuse outpatient services; rehabilitative speech therapy; rehabilitative occupational and physical therapy; skilled nursing facility services; outpatient facility fees and surgery; all brand drugs, specialty drugs; drugs related to mental health and substance abuse.

If you purchase MEC Heavy coverage, $100.65 - $214.23 per month would be payroll deducted in one lump sum from your first pay check each month. The actual amount of the deduction would depend on your pay rate. Listed below are examples of pay rates and the corresponding monthly costs:

Pay Rate	$8.15	$9.00	$10.00	$11.00	$12.00	$13.00	$14.00	$15.00	$16.00
Monthly Cost	$100.65	$111.15	$123.50	$135.85	$148.20	$160.55	$172.90	$185.25	$197.60

4. For $100.65 - $496.11 per month you can purchase a **Bronze Medical Plan** that provides **Minimum Value Coverage.** To enroll in the **Bronze Medical Plan** you must call 1(888)525-7206 and complete a health care application with medical questions within 30 days of your start date. If you do not submit the completed Bronze Application within 30 days of my start date, you will be automatically enrolled in the MEC Plan (single coverage).

NOTE: If you elect to enroll in any coverage, you (and your dependents, if they also enroll) will be ineligible to enroll in subsidized coverage through a public insurance exchange or marketplace even if you would otherwise qualify.

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Group Name: Intellichoice Staffing, LLC			
Last Name:		SS #:	
First Name:		Date of Birth (DOB):	
Sex: • M • F	Home Phone #:		
Street Address:			
City:		State:	Zip:

Plan Selection Or Waiver Choose One:	
	• I Decline Coverage $ 0.00
	• MEC Employee Only $65.40
	• MEC EE + Dependants $163.30
	• MEC Heavy Employee Only $100.65 to $214.23 depending on my pay rate
	• MEC Heavy EE + Dependants $275.72 to $389.30 depending on my pay rate
	• I will call 1(888) 525-7206 to enroll in the Bronze Plan. $100.65 - $496.11 depending on my pay rate. If I do not submit the completed Bronze Application within 30 days of my start date, I will be automatically enrolled in the MEC Plan (single coverage).

ONLY if you chose MEC Heavy: Please provide the following for Beneficiary of Life Insurance

Full name, address and phone number:	Relationship:

2. Dependent Information

I would like to covered the following dependents under this plan: Child, Court Ordered or Disabled

Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[1] ❑Court Ordered[2]				

[1]For disabled dependents; SUBMIT appropriate documentation as proof of disabled status with this enrollment form.
[2]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

I hereby apply for or waive participation in health care for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I agree that no benefits will be effective until the date specified by the plan. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

Employee Signature: ____Date:________________________________