Health Plan Options
Employee KEEPS this page

Two great plans to choose from!

SIGN UP IS AVAILABLE DURING YOUR
FIRST 30 DAYS OF EMPLOYMENT

Enhanced MEC_Plan 1

- MEC wellness/preventive plans starting at $24.00/week
- Covers 63 mandated benefits AND $20 office visit copay, $10 generic prescription drug copay, $10 CVS Minute Clinic copay and more!
- Eliminates employee individual mandate tax for those enrolled
- Options for family coverage
- Weekly payroll deduction – month by month coverage
- Visit www.essghealth.com for info and tools
- PHCS Network

Fixed Indemnity_Plan 2

- ESC Fixed Indemnity plans starting at $20.25 per weekly payroll deduction
- Medical, Rx, vision and dental benefits
- Doctor office visit benefit of $100 per day
- Wellness benefit of $100
- No pre-existing condition limitations
- No waiting period or deductibles on medical
- First Health Network
- Unbundled choices-you do not need to have medical to choose the vision, dental, term life, or short term disability

ESSG offers a **Enhanced Minimum Essential Coverage (Plan 1)** which is administrated by Health EZ. The Minimum Essential Coverage (MEC) plan is ACA qualifying. There are copays for services like doctor's visits, x-rays, and generic prescription drugs. Please note - hospitalization is **not** a covered benefit.

ESSG offers a **Fixed Indemnity Plan (Plan 2)** which is administrated by Planned Administrators Inc. (PAI). The Fixed Indemnity Plan offers limited benefits at an affordable price, specifically for the staffing industry. Premiums will be automatically deducted from your weekly paycheck. This means you are buying it with pre-tax dollars. What does pre-tax dollars mean? It simply means the premium comes out before taxes are taken out, which means you're taxed on less income. Affordable medical, dental, vision, disability, and life insurance benefits are available.

You have **30 days** from the start of your employment to change your benefit elections.

The 3rd plan is offered to only qualifying employees*. It's an ACA qualifying **Bronze Plan** with Essential StaffCARE (ESC). Once you qualify, you will be notified by ESC that you are eligible, and will be given the opportunity to enroll. You should receive this after you have been on assignment for approximately 35 - 45 days. The offer will be mailed to the address we have on file. It is your responsibility to update your address if needed.

If you have any questions, please contact the Health Benefits Team at Employer Solutions Staffing Group.

An employee will be deemed qualifying any time after 30 days on assignment(s), and their status is working 30+ hours per week or more than 1560 total hours in a calendar year. They must be ESSG employees.

Health Benefits Team
Employer Solutions Staffing Group
PO Box 46270 | Minneapolis, MN 55344
Phone: 952-767-9519 | Fax: 952-767-9515
health@employersolutionsgroup.com
http://ESSGHealth.com

Enhanced MEC_Plan 1

Summary of Medical Benefits		
MEC EZ Plan		
	In-Network	**Out-of-Network**
Calendar Year Deductible	None	None
Coinsurance	None	None
Out-of-Pocket Maximum	None	None
Preventative Care	100% Covered	No Coverage
HealthiestYou Telemedicine Services	100% Covered	100% Covered
Primary Physician Office Visit	$20 Copay	No Coverage
Specialist Office Visit	$50 Copay	No Coverage
CVS Minute Clinic	$10 Copay	No Coverage
Urgent Care	$50 Copay	No Coverage
Emergency Services	No Coverage	No Coverage
Hospital Services – Inpatient & Outpatient Care	No Coverage	No Coverage
Mental Health / Chemical Dependency	No Coverage	No Coverage
Durable Medical Equipment	$50 Copay	No Coverage
Labs & Scans		
Diagnostic Lab & X-Ray – In Office	$60 Copay	No Coverage
CT/MRI or Outpatient Testing	$200 Copay	No Coverage
Prescription Drug Coverage	**Retail 30 Day Supply**	**Mail Order 90 Day Supply**
Generic	$10 Copay	No Coverage
Preferred Brand	100% Copay	No Coverage
Non-Preferred Brand	No Coverage	No Coverage
Specialty	No Coverage	No Coverage

Weekly Premiums

Employee Only	$24.00
Employee + Spouse	$38.00
Employee + Child(ren)	$36.00
Family	$63.00

NOTES: This serves as a summary of your benefit plan only. Please refer to your Summary Plan Description for actual coverage, limitation and exclusion provisions.

Fixed Indemnity Medical Benefits_Plan 2

LIMITED BENEFITS SUMMARY

Policy Number **219301-ESG-1**

FIXED INDEMNITY MEDICAL BENEFIT

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 [2]	$500 per day
Diagnostic (X-Ray)	$200 per day	Inpatient Surgery	$3,500 per day
Ambulance Services	$300 per day	Anesthesiology	$700 per day
Physical, Speech, or Occupational Therapy	$50 per day	Skilled Nursing [3]	$100 per day
Emergency Room Benefit - Sickness	$200 per day	First Hospital Admission (1 per year)	$250
Emergency Room Benefit - Accident	$750 per day	Annual Inpatient Maximum [4]	No Limit
Outpatient Surgery	$750 per day	**Wellness Care**	
Anesthesiology	$300 per day	Wellness Care (one per year)	$100
Annual Outpatient Maximum	$2,250	**Prescription Drugs (via reimbursement)** [5,6]	
		Annual Maximum	$600
		Per Day	$30

[1] all outpatient benefits are subject to the outpatient maximum [2] pays in addition to standard care benefit [3] for stays in a skilled nursing facility after a hospital stay [4] Subject to internal limits of plan [5] not subject to outpatient maximum [6] 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 / 100%	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, Bridges, Endodontics and Dentures

VISION BENEFIT	**In-Network**		**Out-of-Network**	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Examination [1] (including dilation)	$10 Copay	100%	100%	$35
Exam Options (Standard or Premium Contact Lens Fit)	Up to $55 or 10% off Retail Price	$0	100%	up to $40
Frames [2]	$0 Copay, 80%, after $100 allowance	$100 allowance, 20% off	100%	$45
Standard Plastic Lenses (single, bifocal, trifocal) [1]	$10 Co-pay	20% off retail	100%	$25-$55
Lens Options	$15 Copay	-	100%	$0
Contact Lenses (Conventional) [1]	$0 Copay, 85% of remaining	$80, plus 15% off	100%	$64
Disposable Contact Lenses [1]	$0 Copay	$80 allowance	100%	$0
Medically Necessary Contact Lenses [1]	$0 Copay	100%	$0	$200

[1] Once every 12 months [2] Once every 24 months

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 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 Salary up to $150 per week
Waiting Period/Maximum Benefit Period	7 days, up to 26 weeks

WEEKLY LIMITED BENEFITS PREMIUM	**Medical**	**Dental**	**Vision**	**Term Life**	**STD**
Employee Only	$20.25	$6.17	$2.42	$0.60	$4.20
Employee + 1	$41.10	$12.34	$4.92	$0.90	-
Employee + Family	$54.88	$20.36	$6.56	$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.

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

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 are payable for services or materials connected with, or charges arising from:

- Orthoptic or vision training, sub-normal vision aids, and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structure;
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan;
- Services provided as a result of any Worker's Compensation law;
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount);
- Services or materials provided by any other group benefit providing for vision care;
- Two pair of glasses in lieu of bifocals.

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.

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 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.

Member Services:

For frequently asked questions and network information for the the Fixed Indemnity Medical Plan, please go to *www.essentialstaffcare.com/FAQVSI*.

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your pin code for enrolling/making changes is **140** + _ _ _ _ (last four digits of your SSN). Your Company has chosen to take some/all of your payroll deductions on a **Pre-Tax basis.** Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

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 "Your Plan" and enter your group number.

Frequently Asked Questions

When can I enroll in a plan?

As a part-time or full-time employee, you are able to enroll within 30 days of your hire date, or during the annual open enrollment for the plan. If you do not enroll in one of those periods, you can only enroll if you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Loss of dependent status
- Loss of prior coverage

When can I cancel off of the plan?

As our plans are pre-tax, you are only allowed to make changes/enroll/cancel during certain times of the year. The above listed times (your first 30 days of employment, during open enrollment, or within 30 days of a qualifying life event) are the only times you are able to change/enroll/cancel.

If I fill out a form, and do not get placed on assignment right away, do I need to fill out a new form?

Your form will stay valid for 6 months. If you are placed on assignment after 6 months of the signature date, you will need to fill out a new form to enroll in the plans. If you worked for a period of time and had deductions, and then stopped working for 6 consecutive weeks, you are considered a re-hire, and would need to fill out a new form to re-enroll. If you miss less than 6 consecutive weeks, the Fixed Indemnity insurance will continue without penalty or the need to re-enroll. After 3 missed weeks the Enhanced MEC coverage will be cancelled.

When will my deductions start and coverage begin?

Fixed Indemnity Plan – Deductions will begin about 2 weeks after we at ESSG receive the form, coverage will begin the Monday following the first deduction

Enhanced MEC Plan – Deductions will begin the first of the month after we at ESSG receive the form, coverage will begin on the first of the month following one month of deductions

When will I receive my insurance card?

Fixed Indemnity Plan – It should come about a week after your first deduction.

Enhanced MEC Plan – It should come about 10 days prior to your effective date.

Additional Fixed Indemnity Plan Information:

This plan does not qualify as minimum essential coverage as defined under the Affordable Care Act (ACA). This plan is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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, Prescription Drug, and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.1204, 26.1801, 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 Vision Plan is underwritten by Companion Life Insurance Company.

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

Essential StaffCARE

HealthEZ

employer solutions staffing group

employer solutions group — You have the employees. We have the solutions.

ESNG — employer solutions nationwide group — You have the employees. We have the solutions.

Enhanced MEC_Plan 1

Benefits Enrollment Form ☑ New Employee_ ☐ Rehire Rehire Date__________________

Employee Information

Name (First and Last)			**Social Security Number**
Samantha Tennison			340889441
Address 3011 kinley blvd	**City** mchenry	**State** illinois	**Zip Code** 60050
Gender ☐ **Male** ☑ **Female**	**Marital Status** ☑ Single ☐ Married ☐ Divorced	**Date of Birth** 02/08/1993	**Date of Hire** 6/11/2018
Phone Number: 8153552035	**Email Address:** sammit900@gmail.com		

Please Select Desired Coverage:

☑ **Employee Only - $24.00/Week** ☐ **Employee+Spouse - $38.00/Week** ☐ **Employee+Child(ren) - $36.00/Week** ☐ **Family - $63.00/Week**

Dependent

First Name M.I. Last Name	Social Security #	**Birth Date**	**Sex**	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	**Birth Date**	**Sex**	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Dependent

First Name M.I. Last Name	Social Security #	**Birth Date**	**Sex**	Relationship
			☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Domestic Partner

Other coverage information including Medicare/Medicaid

NAME OF PERSON COVERED (FIRST, LAST):

	EFF. DATE
	EFF. DATE
	EFF. DATE

Employee Acknowledgement and Authorization - I hereby apply for the group benefit(s) as indicated. I acknowledge that all entries are true and complete and that any misstatements or failure to report information may be used as the basis for cancellation of coverage for me and my dependent(s), if any, from the original effective date. Further, I authorize my employer to make the necessary payroll deduction of premiums for coverages I have elected.

IF ENROLLING - YOU MUST SIGN HERE

Employee Signature Samantha Tennison
Samantha Tennison (Jun 19, 2018) **Date** 6/19/2018

EMPLOYEES DECLINING ☐ **I am DECLINING coverage**

I understand that I and/or my dependents, if any, waive any coverage and desire to participate in the plan at a later date. I/we may be considered a late enrollee and must meet the requirements defined in the Certificate of Coverage for the company's medical or dental plans. If I decline enrollment for myself or my dependents (including my spouse) because of other coverage, I may, in future be able to enroll myself or my dependents in this plan, provided I request enrollment within 31 days after the other coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, placement for adoption of parting suit of adoption, I may be able to enroll myself or my dependent, provided I request enrollment within 31 days of the event.

IF DECLINING- YOU MUST SIGN HERE

Employee Signature **Date**

Employer Solutions Staffing Group Health Benefits Team
PO Box 46270
Minneapolis, MN 55344
Phone: 952-767-9519 Fax: 952-767-9515
Email: Health@employersolutionsgroup.com

Fixed Indemnity Medical Benefits_Plan 2

VSI **219301-ESG-1** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __/__ __/__ __ __ __

ENROLLMENT FORM

ESC CU(UNAC-MN) P1 v18.2

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name: Samantha Tennison	Social Security #: 340889441	Home Phone: 8153552035	Sex: ☐ M ☑ F
Address: 3011 kinley blvd			Apt. #
City: mchenry	State: illinois	Zip: 60050	Date of Birth: 02/08/1993

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?

☐ Yes ☑ No. If Yes, please continue.

Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date

Name of Covered Person (s): 1.	2.	3.

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** select a coverage level before any benefits in Section C. Your coverage level for the all benefits in Section C will be identical. The Fixed Indemnity Medical Plan, Dental Plan, Term Life Plan, and Short-Term Disability plans are underwritten by BCS Insurance Company. The Vision plan is underwritten by Companion Life Insurance Company.

SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL [1]	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY [2]
Employee Only ◉	**$20.25**	**$6.17**	**$2.42**	**$0.60**	**$4.20**
Employee + 1 ○	**$41.10**	**$12.34**	**$4.92**	**$0.90**	
Employee + Family ○	**$54.88**	**$20.36**	**$6.56**	**$1.80**	
NO to ALL Benefits ○	☑ Yes ☐ No	☑ 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 work in CA, HI, NJ, NY, or RI.

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

Name _____ Relationship _____

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Sex	Relationship
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

DATE 06/19/2018/__ __ __ __ ▶ **SIGNATURE** Samantha Tennison

Samantha Tennison (Jun 19, 2018)

This Plan DOES NOT Alleviate the Individual Mandate Penalty

Signature: Samantha Tennison
Samantha Tennison (Jun 19, 2018)

Email: sammit900@gmail.com

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Employee KEEPS
this page

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ESNG

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Health Benefits Team
Employer Solutions Staffing Group
PO Box 46279 | Minneapolis, MN 55344
Phone 952-767-9959 | Fax 952-767-9958
health@employersolutionsgroup.com
http://ESSGHealth.com

2018 CMG Insurance Enrollment

Adobe Sign Document History 06/19/2018

Created:	06/18/2018
By:	Jamie Ready (jamie@corpmgmtgroup.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAeFHMf7Ku7k7maqB2ltVUiNeHvCiAnDCx

"2018 CMG Insurance Enrollment" History

Document created by Jamie Ready (jamie@corpmgmtgroup.com)
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Document e-signed by Samantha Tennison (sammit900@gmail.com)
Signature Date: 06/19/2018 - 9:31:23 AM MDT - Time Source: server- IP address: 216.75.211.7

Signed document emailed to Jamie Ready (jamie@corpmgmtgroup.com) and Samantha Tennison (sammit900@gmail.com)
06/19/2018 - 9:31:23 AM MDT