

BENEFITS ACKNOWLEDGEMENT

Please review all Essential StaffCARE Benefits being offered to Gage Personnel employees. By agreeing to this policy, you acknowledge that you have been offered health benefits by Gage Personnel and have reviewed the Benefits Information and Enrollment information attached.

- If you would like to opt **IN** for benefits, please select your benefits by completing the attached **Enrollment Form** and return it to one of our Gage Office Locations or by emailing JOBS@GAGEPERSONNEL.COM to ensure proper completion of your benefits packet within 30 days.
- If you would like to opt **OUT** of benefits at this time, you may simply complete this Benefits Acknowledgement Policy with no additional follow up required, or you may select **NO to all benefits** and return your form. You will have the opportunity to enroll in benefits 30 days after the start of your first assignment by contacting Gage Personnel at any time.

BENEFITS ACKNOWLEDGMENT FORM

This is to acknowledge that I have been given the opportunity to enroll for health insurance benefits. I have been informed and received benefit-related materials, including coverage descriptions and enrollment instructions for the benefit plans being offered by Gage Personnel.

I understand that:

Coverage is entirely voluntary;

I must enroll or decline coverage within 30 days of receiving my first paycheck or during the annual open enrollment window. If I do not enroll by the deadline, I will not be eligible to elect coverage until the next annual open enrollment period unless I experience a qualifying event;

My failure to complete my enrollment within 30 days of receiving my first paycheck or during the annual open enrollment window will be determined to be a declination of coverage;

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if I elect coverage I may have the right to continue receiving benefits even if I am no longer employed by Gage Personnel. If I elect to continue coverage under COBRA, I am responsible to pay the total cost for coverage and Gage Personnel is permitted to cancel my coverage in certain circumstances. If I choose to decline coverage now, I will not be able to obtain coverage under COBRA after my employment ends.

I am NOT AUTOMATICALLY ENROLLED in coverage. If I want coverage I must make an active election and complete my enrollment within 30 days of receiving my first paycheck. My failure to do so will constitute a declination of coverage.

YOUR SOCIAL SECURITY NUMBER: - -
Protected Health Information (PHI) that will not be disclosed by Gage Personnel without your written authorized consent.

EMPLOYEE FIRST NAME(Print):

EMPLOYEE LAST NAME(Print):

EMPLOYEE SIGNATURE: _____

DATE: / /

Branch Staff:

Please collect this signed form and complete this section.

Branch _____

Employee Name (rewrite here if illegible above) _____

BENEFITS PLAN DESCRIPTION & OVERVIEW



ESC 5500 PLAN

The Essential StaffCARE 5500 plan is a fully insured plan that provides comprehensive coverage as outlined under the Affordable Care Act ("ACA") to full-time employees working a minimum of 130 hours per month. This plan meets the ACA individual mandate for health insurance coverage. The ESC 5500 Bronze Plan will be effective on the 1st of the month following your 59-day waiting period.

In accordance with ACA regulations, this offer of the Essential StaffCARE 5500 plan disqualifies you and your dependent children from subsidized coverage on the government exchange. You may still decline coverage under the Essential StaffCARE 5500 plan and purchase coverage on the government exchange, but you will pay the full cost of that coverage yourself without any subsidy from the government or your employer.

ABOUT THE ESSENTIAL STAFFCARE 5500 PLAN:

- This plan has an individual deductible of \$5,500 in-network/\$11,000 out-of-network!
- The plan has an individual/children deductible of \$11,000 in-network/\$22,000 out-of-network!
- The plan pays 80% for in-network services and 60% for out of network services (excluding prescription coverage) after the deductible is met!
- To learn more about the cost and coverage of the Essential StaffCARE 5500 plan and to view the Summary of Benefits and Coverage, please visit !
- You can also view your Summary of Benefits and Coverage (SBC) at www.paisc.com under the Your Plan tab at the top!
- If you wish to enroll, you may visit the Gage Personnel office for details for eligibility and accessing the enrollment link.

WHAT IS MY COST?

According to ACA guidelines a plan is considered affordable if you pay no more than 9.50% of your income for Employee Only coverage. Gage Personnel uses these guidelines to determine the amount you will pay for Employee Only coverage. If your cost is less than the Employee Only rate (\$943.13), Gage Personnel contributes the difference between the amount you pay and the total cost. If you enroll dependents you are responsible for the additional cost for coverage. Please visit to your local Gage Personnel office for assistance with calculating your rate and for enrollment details.

MONTHLY RATES PRIOR TO ANY APPLICABLE EMPLOYER CONTRIBUTION:

- Employee Only: \$943.13
- Employee+ Child(ren): \$1,730.30

FOR NEW ENROLLMENT:
CONTACT YOUR LOCAL GAGE PERSONNEL OFFICE

ESC

GAGE PERSONNEL CORPORATE OFFICE

CALL OR TEXT: 610-376-1771

EMAIL: JOBS@GAGEPERSONNEL.COM

BENEFITS ENROLLMENT PACKET



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 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.



ATY ESC/MEC 4USW P2M v21.0

BENEFITS PACKET SUMMARY

Policy Number **2965100-ATY**

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	\$105 per day	Standard Care	\$500 per day
	Diagnostic (Lab)	\$75 per day	Intensive Care Unit Maximum ⁵	\$600 per day
	Diagnostic (X-Ray)	\$200 per day	Inpatient Surgery	\$3,000 per day
	Ambulance Services	\$300 per day	Anesthesiology	\$600 per day
	Physical, Speech, or Occupational Therapy	\$50 per day	Skilled Nursing ⁶	\$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 ⁷	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 (via reimbursement) ^{3,4}		Dependent (15 days to 6 months)	\$2,500
	Annual Maximum	\$600	Wellness Care	
	Generic Coinsurance / Brand Coinsurance	70% / 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 To file a claim for reimbursement, save your receipt and remit to Planned Administrators, Inc. ⁵ pays in addition to standard care benefit ⁶ for stays in a skilled nursing facility after a hospital stay ⁷ 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

GROUP 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 **82965100-M-ATY**

 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	\$20.91	\$5.40	\$2.42	\$0.60	\$4.20
Employee + Child(ren)	\$34.71	\$14.58	\$6.54	\$0.90	-
Employee + Spouse	\$39.73	\$10.80	\$4.84	\$0.90	-
Employee + Family	\$52.90	\$20.52	\$9.20	\$1.80	-

BENEFITS ENROLLMENT FORM

IF ELECTING TO ENROLL IN BENEFITS, PLEASE COMPLETE AND RETURN THIS FORM TO GAGE PERSONNEL AT JOBS@GAGEPERSONNEL.COM OR TO ONE OF OUR OFFICE LOCATIONS.

PLEASE CALL OUR COPORATE OFFICE WITH ANY QUESTIONS: 610-376-1771

	VSI 2965100-ATY	OFFICE USE ONLY	LOCATION _____	Rehire Date ____/____/____
ENROLLMENT FORM				ESC/MEC 4USW P2M v21.0
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	Medicare Health Insurance Claim Number (HICN) _____	
Address _____		Apt. # _____	Medicare Effective Date _____	
City _____	Zip _____	State _____	Name of Covered Person(s): 1. _____ 2. _____	


C. LIMITED BENEFIT PLAN SELECTION					Payroll Deducted Weekly Rates
<small>You MUST select a coverage level before any benefits in Section C. Your coverage level for all the benefits in Section C will be identical. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.</small>					
SELECT COVERAGE LEVEL	FIXED INDEMNITY MEDICAL ¹	DENTAL	VISION	TERM LIFE	SHORT-TERM DISABILITY ²
Employee Only <input type="checkbox"/>	\$20.91 	\$5.40 	\$2.42 	\$0.60 	\$4.20 
Employee + Child(ren) <input type="checkbox"/>	\$34.71	\$14.58	\$6.54	\$0.90	
Employee + Spouse <input type="checkbox"/>	\$39.73	\$10.80	\$4.84	\$0.90	
Employee + Family <input type="checkbox"/>	\$52.90	\$20.52	\$9.20	\$1.80	
NO to ALL Benefits <input type="checkbox"/>	<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	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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 _____

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			82965100-M-ATY	Payroll Deducted Weekly Rates
<small>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 Federal Affordable Care Act (ACA) individual mandate no longer imposes a penalty; however, please check your state for any individual mandate requirements or penalties. Rates for the MEC Wellness/Preventive Benefit are billed weekly.</small>				
<input type="checkbox"/> \$13.42 Employee Only	<input type="checkbox"/> \$15.18 Employee + Child(ren)	<input type="checkbox"/> \$16.38 Employee + Spouse	<input type="checkbox"/> \$18.66 Employee + Family	
<input type="checkbox"/> NO to MEC Wellness/Preventive				

F. REQUIRED SIGNATURE		YOU MUST SIGN AND DATE EVEN IF YOU DECLINE COVERAGE
<small>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.</small>		
DATE ____/____/____	▶ SIGNATURE _____	