



# C.S.T. Connection

## Employee Benefits Proposal

### Benefit Coverages

- Hospital Indemnity Plans (sickness and accident coverage)
- Preventive Coverage
- Preventive Coverage Plus
- Dental
- Vision
- Short Term Disability



This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

# 2019 HEALTH BENEFITS OVERVIEW

## ▶ MEC (MINIMUM ESSENTIAL COVERAGE)

All preventative services in this plan are 100% covered when received in the FirstHealth Network. This plan provides no coverage for sickness/hospitalization/surgical benefits.

WEEKLY PREMIUMS			
Employee	Employee+ Spouse	Employee+ Children	Family
\$16.38	\$36.05	\$32.77	\$54.07

## ▶ TELADOC

**This benefits is included with the MEC Plan.**

**Teladoc gives you 24/7/365 access to U.S. board-certified doctors** through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

**GET THE CARE YOU NEED:** Teladoc doctors can treat many medical conditions including: Cold & Flu symptoms, Allergies, Bronchitis, Skin Problems, Respiratory infection, and MORE!

## ▶ MEC PLUS

All preventative services in this plan are 100% covered when received in the FirstHealth Network. This plan provides also Provides coverage for Physicians visits and Pharmacy Benefits.

WEEKLY PREMIUMS			
Employee	Employee+ Spouse	Employee+ Children	Family
\$19.85	\$43.66	\$39.69	\$65.49

## ▶ HOSPITAL INDEMNITY INSURANCE

**You have two plan options for this coverage**

**The HIP Plan:**

- No deductible before your benefits kick in!
- Offers benefits for sickness, pharmacy, and hospitalization
- No Pre-existing Condition Restrictions

WEEKLY PREMIUMS PLAN 1			
Employee	Employee+ Spouse	Employee+ Children	Family
\$15.90	\$36.87	\$30.86	\$47.64

## ▶ DENTAL INSURANCE

For as little as \$4.96 per week, participants receive comprehensive coverage to control out-of-pocket expenses— MAX of \$1,000

WEEKLY PREMIUMS			
Employee	Employee+ Spouse	Employee+ Children	Family
\$4.96	\$11.76	\$9.78	\$15.88

## ▶ ADDITIONAL BENEFITS

There is also benefits for Vision and Short Term Disability. Details & Rates for these benefits can be found on page 8.

**Enroll Online at [www.mybenefitservices.com/cst](http://www.mybenefitservices.com/cst)**

**Call our service center at 1-888-820-5687 with any questions.**

# Preventive Only Coverage: Minimum Essential Coverage

**24/7/365 access to a doctor at no cost (Telemedicine) is included in this plan**

## 20 PREVENTIVE SERVICES COVERED FOR ADULTS (AGES 18 AND OLDER)

1	Abdominal Aortic Aneurysm one time screening for age 65-75	12	He
2	Alcohol Misuse screening and counseling	13	HIV
3	Aspirin use for men ages 45 - 79 and women ages 55-79 to prevent CVD when prescribed by a physician	14	Immunization vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella) screening
4	Blood Pressure screening	15	Lung cancer screening for adults age 55-80 who smoke 30 packs/year
5	Cholesterol screening for adults	16	Obesity screening and counseling
6	Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years	17	Sexually Transmitted Infection (STI) prevention counseling
7	Depression screening	18	Skin cancer behavioral counseling for adults to age 24 with fair skin
8	Type 2 Diabetes screening	19	Tobacco Use screening, counseling and cessation interventions
9	Diet counseling	20	Syphilis screening
10	Fall prevention to include physical therapy and vitamin D supplementation to prevent fall in community dwellings age 65+		
11	Hepatitis B screening		

## 24 PREVENTIVE SERVICES COVERED FOR WOMEN (INCLUDING PREGNANT WOMEN)

1	Anemia screening on a routine basis for pregnant women	12	Folic acid supplements for women who may become pregnant when prescribed by a physician.
2	Aspirin for pregnant women at high risk for preeclampsia	13	Gestational diabetes screening
3	Bacteriuria Urinary Tract or other infection screening for pregnant women	14	Gonorrhea screening
4	BRCA counseling and genetic testing for women at higher risk	15	Hepatitis B screening for pregnant women
5	Breast Cancer Mammography screenings every year for women age 40 and over	16	Human Immunodeficiency Virus (HIV) screening and counseling
6	Breast Cancer Chemo Prevention counseling as well as breast cancer testing and medications for women with increased risk of breast cancer	17	Human Papillomavirus (HPV) DNA test: HPV DNA testing every three years for women with normal cytology results who are 30 or older.
7	Breastfeeding comprehensive support and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women. Non-network services will be payable as network services.	18	Osteoporosis screening over age 60
8	Cervical Cancer screening	19	Routine prenatal visits for pregnant women
9	Chlamydia Infection screening	20	Rh Incompatibility screening for all pregnant women and follow-up testing
10	Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs	21	Tobacco Use screening and interventions for all women and expanded counseling for pregnant tobacco users
11	Domestic interpersonal violence screening and counseling for all women.	22	Sexually Transmitted Infections (STI) counseling
		23	Syphilis screening
		24	Well-woman visits to obtain recommended preventive services

## 29 PREVENTIVE SERVICES COVERED FOR CHILDREN

1	Alcohol and Drug Use assessments	17	HIV screening for adolescents
2	Autism screening for children limited to two screenings up to 24 months	18	Immunization Vaccines for children from birth to age 18 - Doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Human Papillomavirus, Influenza (Flu Shot), Meningococcal, Rotavirus, Diphtheria, Tetanus, Pertussis, Hemophilus influenza type B, Inactivated Poliovirus, Measles, Mumps Rubella, Pneumococcal, Varicella
3	Behavioral assessments for children limited to five assessments up to age 17.	19	Iron supplements for children up to 12 months when prescribed by a physician
4	Blood Pressure Screening	20	Lead screening for children
5	Cervical Dysplasia screening	21	Medical History for all children throughout development Ages: 0-11 months; 1-4 years; 5-10 years; 11-14 years; 15-17 years
6	Congenital Hypothyroidism screening for newborns	22	Obesity screening and counseling
7	Depression Screening for adolescents ages 12 and older	23	Oral Health risk assessment for young children up to age 10
8	Developmental Screening for children under age 3 and surveillance throughout childhood	24	Phenylketonuria (PKU) screening in newborns
9	Dyslipidemia screening for children	25	Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
10	Fluoride Chemoprevention supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5	26	Skin Cancer behavioral counseling for adolescents age 10 and up who have fair skin
11	Gonorrhea preventive medication for the eyes of all newborns	27	Tobacco use screening, counseling and cessation interventions for children and adolescents
12	Hearing screening for all newborns	28	Tuberculin testing for children
13	Height, weight and body mass index measurements for children	29	Vision screening for all children under the age of 5
14	Hematocrit or Hemoglobin screening for children		
15	Hemoglobinopathies or Sickle Cell screening for newborns		
16	Hepatitis B screening for adolescents		

For additional information, visit: <http://healthcare.gov/what-are-my-preventive-care-benefits>.

MEC Rates	Monthly	Weekly
Employee Only	\$71.00	\$16.38
Employee + Spouse	\$156.20	\$36.05
Employee + Children	\$142.00	\$32.77
Family	\$234.30	\$54.07

# Preventive Plus Coverage

Preventive care services are covered at 100% without having to pay a co-payment, co-insurance, or being applied to a deductible. These benefits are listed on page 2 of this proposal. There are also additional benefits included in the Preventive Plus Coverage Plan that are listed below.

All of these benefit will be covered when these services are delivered by a First Health network provider.

Additional Plan Benefits	
ACA Preventive Services: 21 Adult Services 28 Women Services 31 Children Services	Covered 100% - Unlimited
Prescription Discount Program	Included
Prescription Plan	20% Copay - Generic Only 12 Scripts Max
Primary Care Physician Office Visit	\$25 Copay / 5 Visits Max
Telemedicine	Covered 100% - Unlimited
Lab & Diagnostics/X-rays	Preventative Labs & Diagnostics Covered at 100% - no additional benefits covered outside of ACA
OB/GYN - Preventive Only	Included
Pediatrics - Preventive Only	Included
PPO Network	FirstHealth

Discount Cards for services: Dental, Vision, Labs, MRI's, and Prescriptions  
PPO Network –FirstHealth

MEC Rates	Monthly	Weekly
Employee Only	\$86.00	\$19.85
Employee + Spouse	\$189.20	\$43.66
Employee + Children	\$172.00	\$39.69
Family	\$283.80	\$65.49

# Hospital Indemnity Plan 1

\*This plan can be purchased with the Preventive Plan or as a stand-alone benefit to provide coverage for Sickness and Accident.

## INPATIENT

-Day 1 hospital confinement benefit amount per day	\$200 per day x 1 day
-Day 2 + hospital confinement benefit amount per day	\$150 Thereafter
• Maximum Benefit	30 days per year
-Surgery benefit amount (including maternity) per day	\$500 per day x 1 day
-Anesthesia benefit amount per day 25% of surgery amount	\$125.00 per day x 1 day

## OUTPATIENT

Physician Office Visit Pre-pay	\$10
-- Benefit amount per day	\$50 per day x 5 days
-- Annual Physical (Wellness) benefit amount per day	\$100 per day x 1 day
Diagnostic, X-Ray, Lab Benefit amount per day:	
-- Class I: Laboratory, Blood work, CMP, Lipid Panel, ECG, Pap/PSA, urinalysis. And all other laboratory tests	\$30 per day x 2 days
--Class II: Radiology, Ultrasound, Mammogram, Sonogram. Angiogram	\$100 per day x 2 days
--Class III: Imaging CT, PET	\$100 per day x 1 day
-- Class IV: MRI	\$150 per day x 1 day

## PRESCRIPTION

Retail- Generic RX copay	\$10 co-pay
Monthly benefit maximum – INDIVIDUAL/FAMILY	\$200/\$400

## TERM LIFE INSURANCE

- Benefits reduced to 50% at age 70
- Dependent children eligible on the 15<sup>th</sup> day
- Term Life Insurance benefit is \$10,000 employee/\$5,000 spouse/\$2,000 children\*

## OTHER SERVICES

AD&D	\$10,000
Teledoc: Telephonic Doctor Office Visits	YES
Support Linc Employee Assistance Program	YES
First Health PPO Discounts	YES

## Plan 1 Hospital Indemnity Rates

	Monthly Rates	Weekly Rates
<b>Employee</b>	<b>\$68.89</b>	<b>\$15.90</b>
<b>Employee + Spouse</b>	<b>\$159.77</b>	<b>\$36.87</b>
<b>Employee + Children</b>	<b>\$133.72</b>	<b>\$30.86</b>
<b>Family</b>	<b>\$206.43</b>	<b>\$47.64</b>

(1)The Fixed Hospital Indemnity, Outpatient Accidental-Only, Critical Illness and AD&D Benefit Plans are underwritten by AXIS Insurance Company. (2)The office visit pre-pay is a service through the First Health PPO Network. (3) Prescription benefits are underwritten by an AM Best rated carrier. (4)Term Life is underwritten by an A rated carrier. (5)These services are not insurance and are not provided by the underwriting companies shown here. \*Benefit amounts listed are for: Employee/Spouse/Child(ren)

### Notice

The insurance described in this proposal provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. This insurance does not coordinate with any other insurance plan. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

# Hospital Indemnity Plan 2

\*This plan can be purchased with the MEC or as a stand-alone benefit to provide coverage for Sickness and Accident.

## INPATIENT

-Day 1 hospital confinement benefit amount per day	\$1,000 per day x 1 day
-Day 2 + hospital confinement benefit amount per day	\$500 Thereafter
• Maximum Benefit	30 days per year
-Surgery benefit amount (including maternity) per day	\$1,000 per day x 1 day
-Anesthesia benefit amount per day 25% of surgery amount	\$250.00 per day x 1 day

## OUTPATIENT

Physician Office Visit Pre-pay	\$10
-- Benefit amount per day	\$70 per day x 5 days
-- Annual Physical (Wellness) benefit amount per day	\$100 per day x 1 day
Diagnostic, X-Ray, Lab Benefit amount per day:	
-- Class I: Laboratory, Blood work, CMP, Lipid Panel, ECG, Pap/PSA, urinalysis. And all other laboratory tests	\$30 per day x 2 days
--Class II: Radiology, Ultrasound, Mammogram, Sonogram. Angiogram	\$100 per day x 2 days
--Class III: Imaging CT, PET	\$100 per day x 1 day
-- Class IV: MRI	\$500 per day x 1 day

## PRESCRIPTION

Retail- Generic RX copay	\$10 co-pay
Monthly benefit maximum – INDIVIDUAL/FAMILY	\$200/\$400

## TERM LIFE INSURANCE

- Benefits reduced to 50% at age 70
- Dependent children eligible on the 15<sup>th</sup> day
- Term Life Insurance benefit is \$10,000 employee/\$5,000 spouse/\$2,000 children\*

## OTHER SERVICES

AD&D	\$10,000
Teledoc: Telephonic Doctor Office Visits	YES
Support Linc Employee Assistance Program	YES
First Health PPO Discounts	YES

## Plan 2 Hospital Indemnity Rates

	Monthly Rates	Weekly Rates
<b>Employee</b>	<b>\$110.74</b>	<b>\$25.56</b>
<b>Employee + Spouse</b>	<b>\$258.96</b>	<b>\$59.76</b>
<b>Employee + Children</b>	<b>\$216.17</b>	<b>\$49.89</b>
<b>Family</b>	<b>\$340.36</b>	<b>\$78.54</b>

(1)The Fixed Hospital Indemnity, Outpatient Accidental-Only, Critical Illness and AD&D Benefit Plans are underwritten by AXIS Insurance Company. (2)The office visit pre-pay is a service through the First Health PPO Network. (3) Prescription benefits are underwritten by an AM Best rated carrier. (4)Term Life is underwritten by an A rated carrier. (5)These services are not insurance and are not provided by the underwriting companies shown here. \*Benefit amounts listed are for: Employee/Spouse/Child(ren)

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# DENTAL COVERAGE

<b>Dental Plan</b>	No Deductibles; Reimburses 100% of usual amounts listed.	<b>Dental \$1,000</b>
Maximum Plan Year Limit		\$1,000
Periodontics Lifetime Maximum		\$500
Orthodontics Lifetime Maximum		\$500
<b>Type 1: Preventive &amp; Diagnostic</b>		
-Oral Exams, Including Prophylaxis		\$36
-Bitewings, per film		\$5
-X-ray, panoramic or cephalometric		\$36
-Sealants/topical fluoride		\$11
-Space maintainers		\$108
<b>Type 2: Major Restorative</b>		
-Crowns, Bridges, & Dentures		\$180
-Pre-fabricated crowns		\$60
-Crown build-up procedures		\$48
<b>Type 3: Minor Restorative</b>		
-Fillings		\$42
-Crowns, Bridges, & Denture Repair		\$24
-Relining or rebasing dentures		\$60
<b>Type 4: Endodontics</b>		
-Root canals, apicoectomies		\$192
-Root amputation		\$96
-Therapeutic pulpotomy, retrograde, fillings, apexification, hemisection		\$48
<b>Type 5: Periodontics</b>		
-Lifetime Maximum		\$500
-Tissue grafts or bone surgery		\$96
-Gingivectomy (per quadrant)		\$60
-Gingivectomy (per tooth)		\$34
-Periodontal scaling, periodontal splinting, root planning, gingival curettage (per quadrant)		\$36
<b>Type 6: Oral Surgery</b>		
-Surgeries Level 1 (example: Removal of exostosis)		\$120
-Surgeries Level 2 (example: Removal of impacted tooth)		\$66
-Surgeries Level 3 (example: Simple extraction)		\$36
<b>Type 7: General Anesthesia &amp; IV</b>		
- IV, first ½ hour general, each additional ¼ hour general		\$72
<b>Type 8: Orthodontia</b>		
- Per course treatment (Lifetime Maximum)		\$500

- **Types 1 through 7 Subject to the \$1,000 annual maximum**
- **Types 2,5,6,8 Subject to a 12 month waiting period**

Dental Rates	Monthly	Weekly
Employee	\$21.50	\$4.96
Employee + Spouse	\$50.96	\$11.76
Employee + Children	\$42.36	\$9.78
Family	\$68.80	\$15.88

# VISION & SHORT TERM DISABILITY COVERAGE

## Vision Indemnity Benefit

-Examination benefit- once per plan year	\$100
-Materials benefit- once per plan year	\$500

Vision Rates	Monthly	Weekly
Employee	\$17.80	\$4.11
Employee + Spouse	\$36.76	\$8.48
Employee + Children	\$36.76	\$8.48
Family	\$55.72	\$12.86

## Short Term Disability

- Total disability due to non-occupational accident or sickness
- Weekly benefits for up to 26 weeks of disability
- 50% of base pay, up to a maximum of \$125 per week
- Elimination period: 7 days sickness, 0 days if accident or hospitalized
- Not available to employees that reside in CA, HI, NJ, RI, and PR
- STD coverage is only available to eligible employees.
- There is no dependent coverage available

Short Term Disability Rates	Monthly	Weekly
Employee Only	\$15.86	\$3.66

The Vision Indemnity and Short Term Disability Plans are underwritten by AXIS Insurance Company. This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy is delivered. The policy is subject to the laws of the state in which it is issued. Coverage may not be available in all states or certain terms may be different if required by state law. This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

### Notice

The insurance described in this proposal provides limited benefits. Limited benefits plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. This insurance does not coordinate with any other insurance plan. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.



# BENEFITS FOR 2019

## Value of Pre-Tax Benefits

### Section 125 Plan

E3 HR, Inc. operates a Premium Only Section 125 Plan, which allows you to reduce your total taxable income by your portion of group insurance premiums. In effect, this is just like getting a raise - your withholding taxes are reduced, and your take-home pay increases!

**Example: Employee earning \$30,000 annually, paying \$200/month for benefits**

	Without Pre-Tax Benefits	With Pre-Tax Benefits
Gross Pay	\$30,000	\$30,000
Insurance Deductions/Payments	\$0	\$2,400
<b>Taxable Income</b>	<b>\$30,000</b>	<b>\$27,600</b>
Taxes at 25%	\$7,500	\$6,900
<b>After-Tax Income</b>	<b>\$22,500</b>	<b>\$20,700</b>
After-Tax Payment for Benefits	\$2,400	\$0
<b>Take-Home Pay</b>	<b>\$20,100</b>	<b>\$20,700</b>
<b>INCREASE IN TAKE HOME PAY</b>		<b>+\$600</b>

**ONCE YOU ENROLL IN BENEFITS YOU CAN ONLY TERMINATE YOUR BENEFITS DURING A DESIGNATED OPEN ENROLLMENT OR IF YOU HAVE A QUALIFY LIFE EVENT.**

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.



## **First Health PPO Medical Network**

Access to Network discounts to more than 5,000 hospitals and 590,000 physicians and health care professionals. Service provides members affordable access to physicians by allowing them to pay a \$25 Office Co-Pay before insurance benefits are applied. To find a provider in network please visit [www.firsthealthbp.com](http://www.firsthealthbp.com) For more information on locating an in-network provider, please see page 11.



## **Prescription Savings**

With ScriptSave® members enjoy instant savings for their entire household on brand name and generic medications. Savings average 22%, with potential savings of up to 50% on brand name and generic prescription drugs at over 50,000 participating pharmacies.



## **Need Help??**

For Questions, Concerns, or Claims on any of your benefits please contact the service center at 1-888-820-5687 option 2



## **Need Help??**

For Questions or Concerns on who to contact for your benefits please contact First Staff Benefits at [kdunn@firststaffbenefits.com](mailto:kdunn@firststaffbenefits.com)



## **WellCard Health Prescription Benefits**

To access your prescription benefits discount on generic drugs, please find a pharmacy or provider by calling 1- 800-562-9625 or visit their website. [www.WellCardHealth.com](http://www.WellCardHealth.com) Please see page 12 for more information.



## **SupportLinc Employee Assistance**

The SupportLinc Employee Assistance Program (EAP) helps you deal with life's challenges and the demands that come with balancing home and work. SupportLinc provides confidential, professional referrals and up to three (3) face-to-face counseling sessions for a wide array of personal and work-related concerns.



## **DenteMax Network**

With DenteMax, members have access to network discounts averaging 20% - 40% below normal costs. In addition, members have access to over 137,000 providers in all 50 states.

[www.dentemax.com](http://www.dentemax.com)

\* These services are not insurance and are not provided by the underwriting companies shown.



Do you need to find a provider in-network? Please follow the steps below to locate a First Health Network Provider.

Step 1: Go to [www.firsthealthlbp.com](http://www.firsthealthlbp.com)

Step 2: Click on  in the middle of the screen.

Step 3: Choose the Type of Provider and Zip code

Type of provider

What type of provider are you looking for?

\* Provider type:  Physician  Hospital  Urgent care center  Lab and radiology  All providers

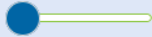
Search by

Do you want to search by ZIP or state?

\*Select ZIP or state :  Search by ZIP code  Search by state

\*ZIP code:   
Please enter a valid ZIP code. [Find a Zip code.](#)

within:  miles  
Adjust slider to increase or decrease distance

Distance:   
Minimum 5 miles  
Maximum 100 miles

Step 4: Choose  and you will be provided with a list of providers.

# “When I show my



# my pharmacist shows me the savings!”



Just show your WellCard and Save...

- Prescriptions
- Doctor Visits
- Dental Care
- Vision Care
- Lab & Imaging Tests
- 24/7 Doctor
- Hearing Care
- Medical Bill Help
- Diabetic Care Services, Vitamins & Daily Living Products
- WellCard Rewards



Keep more money in your pocket!

## Start saving today...

1. Find a pharmacy or provider by visiting [www.WellCardHealth.com](http://www.WellCardHealth.com) or calling 800-562-9625.
2. Keep this card in your wallet and present it at your pharmacy or provider's office to save.

Show the pharmacy your WellCard, and they'll show you the savings on your prescriptions.

**A PRESCRIPTION SAVINGS PROGRAM**  
Present this card to your pharmacy and provider.

Group ID: CBS2  
Member ID: Enter member's 10-digit phone #, then add 2-digit person code.  
01 - Member, 02 - Spouse, 03 - Dependent, etc.  
Processor: NetCard Systems  
BIN #: 008878

**WellCard Health**  
Smart. Simple. Savings.

**MEMBER:**  
To find a provider: visit [www.WellCardHealth.com](http://www.WellCardHealth.com) or call 800-562-9625.

**PHARMACY:**  
Add 2-digit person code to Member ID  
01 - Member  
02 - Spouse  
03 - Dependent, etc.  
**Pharmacist Help Desk:**  
888-886-5822

**PROVIDER:**  
**Physician & Dental Provider:**  
To verify eligibility & for patient responsibility call 888-203-6714. The patient is responsible for the entire discounted cost at the time of service.  
**Walon Provider:**  
To verify eligibility call 888-203-6662.

This is Not Insurance. It is a discount medical program. It does not replace COBRA or any other medical insurance program nor is it a Medicare Part D prescription drug plan. WellCard Health does not qualify for essential coverage under the Affordable Care Act (ACA-Obamacare). Cardholders are responsible for paying the discounted cost at the time of service from participating providers. WellCard Health is a PACE WellCard Health will not release or sell your personal information. The discount plan organization is Access One Consumer Health, Inc., 84 Villa Road, Greenville, SC 29615, [www.accessonehealth.com](http://www.accessonehealth.com). This program is not available to residents of Montana, but may be used at participating Montana providers. Other state residents: visit [www.WellCardHealth.com](http://www.WellCardHealth.com) for full disclosure statement.

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# Plan Provisions

<b>Pre-existing Condition Limitation</b>	<p><b>Limited Medical Plans</b> 6 Month Treatment Period/12 Month Limitation Period on Hospital Confinement and Surgery Benefits only</p> <p><b>Critical Illness</b> Benefit Waiting Period- 90 Days Survival Period –30 Days State variations apply</p>
<b>Continuation of Coverage When Employment Ends</b>	<ul style="list-style-type: none"> <li>Continuation of coverage provision in policy</li> </ul>
<b>Issue Ages</b>	<ul style="list-style-type: none"> <li>Employee/Spouse: 18+</li> <li>Dependent Child: to 26</li> <li>For Critical Illness benefit, Covered Person must be under age 65</li> </ul>
<b>Coordination of Benefits</b>	Coordination of Benefits
<b>Rate Guarantee</b>	<ul style="list-style-type: none"> <li>1 year</li> </ul>
<b>Rate Contingency</b>	<ul style="list-style-type: none"> <li>Rates are subject to the Employer Contribution level defined above.</li> </ul>
<b>Situs State</b>	<ul style="list-style-type: none"> <li>Policy will be issued in the situs state of client.</li> </ul>

\* Coverage may not be available in all U.S. states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on state laws. If applicable, state specific Exclusions and Limitations pages will be provided at the end of the proposal.

## Limitations and Exclusions

### Pre-existing Condition Limitation

#### **For Hospital Confinement or Surgery Benefits on all plans:**

6 Month Treatment Period /12 Month Limitation Period

#### **Pre-Existing Condition Limitation:**

The Insurance Company will not pay Hospital Confinement Benefits for any Pre-existing Condition. A “Pre-existing Condition” means a disease or physical condition for which the Employee received medical treatment, during the treatment period shown above before his or her most recent effective date of insurance. The Pre-existing Condition Limitation will apply to any added benefits or increase in benefits. It will not apply after the Limitation Period shown above.

#### **For Short Term Disability Benefits on all Plans:**

12-Month Treatment Period/12-Month Limitation Period

#### **Pre-Existing Condition Limitation**

The Insurance Company will not pay Disability Benefits for any period of Disability caused by or contributed to by, or resulting from, a Pre-existing condition. A “Pre-existing Condition” means an Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within 12 months before his or her most recent effective date of insurance. The Pre-existing Condition Limitation will apply to any added benefits or increase of benefits. It will not apply to a period of Disability that begins after an Employee is in Active Service for at least 12 months after his or her most recent effective date of insurance or the effective date of any added or increased benefits.

The Pre-Existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the Pre-existing Condition Limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the Pre-existing Condition Limitation of that plan, credit will be given for any time that was satisfied. Time will not be credited for any day an Employee is not actively at work due to his or her Injury or Sickness. The Pre-existing Condition Limitation will be extended by the number of days the Employee is not actively at work due to his or her Injury or Sickness.

\* Coverage may not be available in all U.S. states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on state laws. If applicable, state specific Exclusions and Limitations pages will be provided at the end of the proposal.

# Limitations and Exclusions

- **Under the Group Hospital Indemnity Policy we will not pay benefits for any loss, injury or sickness that is caused by, or results from:**
    - Intentionally self-inflicted injury, suicide or any attempt while sane or insane;
    - Commission or attempt to commit a felony or an assault;
    - Commission of or active participation in a riot or insurrection;
    - Declared or undeclared war or act of war;
    - Release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
    - An injury or sickness that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon our receipt of proof of service, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
    - Travel or activity outside the United States, Canada or Mexico, except for a Medical Emergency;
    - Flight in, boarding or alighting from an Aircraft except as:
      - a fare-paying passenger on a regularly scheduled commercial or charter airline;
      - a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
    - Travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be “controlled” by the Policyholder, if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
    - Bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
    - Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
    - The Insured Person’s intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in his blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer’s report, or similar items will be considered proof of the Insured Person’s intoxication;
    - An Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator’s license, unless:
      - (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver’s education instructor;
    - Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Physician unless specifically provided herein;
    - Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration;
    - Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses;
    - Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
    - Mental and nervous disorders;
    - Elective surgery or cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury or Covered Sickness;
    - Experimental or Investigational drugs, services, supplies. For the purposes of this exclusion, “Experimental or Investigational” means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II, or III). The covered service will also be considered Experimental or Investigational if the Insured Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption;
    - Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications;
    - Sexual reassignment surgery, sexual transformation surgery, sexual trans gendering surgery;
    - Services related to sterilization, reversal of a vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a Covered Injury or Covered Sickness;
    - Treatment or services provided by a private duty nurse;
    - Organ or tissue transplants and related services;
    - Personal comfort or convenience items;
    - Rest or custodial cures;
    - Hearing aids.
    - An Injury or Sickness for which the Insured Person is paid benefits under any Workers’ Compensation or occupational disease law or under any insurance policy that provides benefits to the Insured Person for injuries resulting from an occupational accident.
- In addition, benefits will not be paid for services or treatment rendered by any person who is:
- employed or retained by the Policyholder; Subscriber;
  - living in the Insured Person’s household;
  - an Immediate Family Member of either the Insured Person or the Insured Person’s Spouse;
  - the Insured Person.

# Limitations and Exclusions

## No Prescription Drug Benefits will be paid for:

- All over-the-counter products and medications, including, but not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications.
- Blood glucose meters; insulin injecting devices.
- Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
- Biologicals (including allergy tests); blood products; growth hormones; hemophilic factors; MS injectables; immunizations; and all other injectables unless shown in the definition of Prescription Drug.
- Medical supplies and durable medical equipment unless shown in the definition of Prescription Drug.
- Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid, and Niacin – used in treatment verses as a dietary supplement; and all other Legend Drug vitamins and nutritional supplements.
- Anorexiants; any cosmetic drugs including, but not limited to, Renova and skin pigmentation preps; any drugs or products used for the treatment of baldness; and topical dental fluorides.
- Refills in excess of that specified by the prescribing Doctor, or refills dispensed after one year from the original date of the prescription.
- Any drug labeled “Caution – limited by Federal Law for Investigational Use” or experimental drugs.
- All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication.
- Drugs needed due to conditions caused, directly or indirectly, by a Insured Person taking part in a riot or other civil disorder; or the Insured Person taking part in the commission of a felony.
- Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or any act of war; or drugs dispensed to a Insured Person while on active duty service in any armed forces.
- Any expenses related to the administration of any drug.
- Drugs or medicines taken while in or administered by a Hospital or any other health care facility or office.
- Drugs covered under Worker’s Compensation, Medicare, Medicaid or other governmental program.
- Drugs, medicines or products which are not medically necessary.
- Diaphragms; erectile dysfunction Legend Drugs; and infertility Legend Drugs.
- Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; and Imitrex-auto injection.
- Smoking deterrents, Legend or over-the-counter drugs.
- Replacement of stolen medication (except under circumstances approved by us), or lost, spilled, broken or dropped Prescription Drugs.
- Vacation supplies of Prescription Drugs (except under circumstances approved by us).

## Under the Dental Policy, benefits will not be paid for the following:

- For services and supplies not listed in the Schedule of Benefits or not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
- For cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
- For services related to, performed in conjunction with, or resulting from a non-covered procedure.
- For charges in excess of the Usual and Customary rate.
- For any treatment program which began prior to the date the Insured Person is covered under the Policy.
- For crowns, inlays and onlays on teeth that can be restored by direct placement materials.
- For the replacement of crowns, bridges, dentures, inlays or onlays that can be restored to normal function.
- For the replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
- For service or supplies payable under any medical expense portion of an auto or no-fault plan.
- For any condition paid under any Worker’s Compensation Act or similar law.
- For services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence or insurance.
- During any Waiting Period the Company requires. When the Insured Person voluntarily ends this insurance without a qualifying event and re-enrolls at a later date, the Waiting Period is 2 years and begins on the date coverage first ended.
- For services that are applied toward the satisfaction of a Deductible, if any.
- For services subject to a Waiting Period that were incurred during the Waiting Period.
- For charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
- For Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, Hospital confinement.
- For drugs or the dispensing of drugs.
- For oral hygiene instruction; plaque control; acid etch; prescription or take-home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
- For implants; myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.
- For orthodontia, unless included within the Schedule of Benefits.
- For services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on Our Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits.
- For composite, resin, or white fillings on posterior primary teeth. Benefits will be reduced to that of an amalgam or silver filling.
- For the replacement of a filling within 24 months of placement, unless for specific health reasons.
- For the replacement of retainers.
- For sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.
- For lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.



# Limitations and Exclusions

## The Insurance Company will not pay Short Term Disability Benefits for a Disability that results, directly or indirectly, from any of the following events:

[Please note, STD is Not offered in NJ, NY, RI, CA, HI]

- Attempted suicide, or whenever an Insured Person injures Himself on purpose.
- War or any act of war, whether or not declared.
- Serving on full-time active duty in any armed forces. If the Insured Person sends proof of military service, the Company will refund the portion of the premium paid to cover the Insured Person during a period of such service.
- Active participation in a riot.
- Commission of a felony.
- Incarceration in a penal or corrections institution.
- Participation in an activity or event while under the influence of a controlled substance (unless administered by a Physician or taken according to a Physician's instructions) or Intoxicated. Intoxicated means that condition as defined by the law of the jurisdiction in which the activity or event occurred.
- Any cosmetic surgery or surgical procedure that is not Medically Necessary.
- An Injury or Sickness for which the Employee is paid benefits under any Workers' Compensation or occupational disease law or under any insurance policy that provides benefits to the Insured Person for injuries resulting from an occupational accident.
- The Insured Person's refusal to participate in rehabilitation efforts as required by the Company.
- The Insured Person is not receiving Appropriate Care by a Physician.
- The Insured Person fails to cooperate with the Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.
- The revocation, restriction or non-renewal of an Insured Person's license, permit or certification necessary to perform the duties of His occupation unless due solely to Injury or Sickness otherwise covered by the Certificate/Policy.
- An Injury or Sickness that is work related.

## Vision Benefits will not be paid for:

- Broken or lost or stolen lenses contact or frames.
- Medical or surgical treatment of the eye.
- Services or materials which are payable under any Workers' Compensation Act or similar law or public program other than Medicaid.
- Services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of their license.
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when vision material ordered before coverage ended are delivered and the services rendered to Insured Person(s) within 31 days of such order.
- Services rendered or material ordered before the date coverage began for a Insured Person under the Policy.
- Regardless of Optical Necessity, benefits are not available more frequently than that which is specified in the Schedule of Benefits

The insurance coverage provided herein may be considered a welfare benefit plan pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). If ERISA applies the plan sponsor has certain responsibilities. Please consult with your legal or tax counsel for guidance as to whether ERISA would apply to this coverage and the responsibilities of a plan sponsor.

\* Coverage may not be available in all U.S. states and jurisdictions. Product availability and plan design features, including eligibility requirements, descriptions of benefits, exclusions or limitations may vary depending on state laws. If applicable, state specific Exclusions and Limitations pages will be provided at the end of the proposal.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit AXIS Insurance Company from providing insurance, including, but not limited to, the payment of claims.

Payment of claims under any insurance policy issued shall only be made in full compliance with all United States economic or trade and sanction laws or regulation, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC").

### NOTICE

The insurance described in this proposal provides limited benefits. Limited benefits plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.