SUMMARY PLAN DESCRIPTION

FOR

Employer Solutions Group, LLC

LIMITED GROUP BENEFITS PLAN

Effective: July 28, 2013

Premium Payment Method: Payroll Deduction

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ADMINISTRATIVE INFORMATION

Name of Plan	Essential StaffCARE Limited Group Benefit Plan
Employer / Plan Sponsor	Employer Solutions Group, LLC 7301 Ohms Lane # 405 Edina, MN 55439
Plan Sponsor's Employer Identification Number	20-2301006
Plan Number	510
Group Number	219301
Type of Plan	A welfare benefit plan providing group health benefits. A medical plan with optional dental, term life insurance/accidental death & dismemberment and short term disability coverage.
Type of Plan Administration	This plan is fully insured. Benefits are provided under group insurance contracts entered into between **Employer Solutions Group, LLC** and BCS Insurance Company as well as 4 Ever Life Insurance Company.
Plan Administrator/ Named Fiduciary/ Insurance Companies	BCS Insurance Company 4 Ever Life Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181 1(630)472-7700
Third Party Administrator (TPA):	Planned Administrators, Inc. (PAI) P.O. Box 6702 Columbia, SC 29260 1(866)798-0803 (Toll Free) 8:30 a.m. – 8:00 p.m. Eastern Standard Time(EST)
Original Plan Effective Date:	July 28, 2013
Plan Year/Policy Year:	Begins July 28th of each year and continues for 12 consecutive months, ending on July 27th of the following year.

DISCLAIMER

Benefits under the Plan are provided pursuant to insurance contracts between the Employer/Plan Sponsor and the Insurance Companies. If the terms of this SPD conflict with the terms of the Plan or the insurance contracts, the terms of the Plan and the insurance contracts will control, unless superseded by applicable law.

CONFORMITY WITH THE LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in this Plan is intended to replace or affect any requirements for coverage by workers compensation insurance.

NOTICES TO EMPLOYEES

NOTICE: Preferred Provider Organizations (PPOs)

- Medical – **First Health Network**
- Dental – **Dente*Max* Network**

As a selective consumer concerned with health care costs, it would benefit you through added discounts to visit providers who **participate within the First Health Network for medical services** and the **Dente*Max* Network for dental services**. However, in order to realize these potential discounts, before you receive services or supplies, you should verify whether or not your provider is participating by:

ALWAYS asking the provider the following questions:

For Medical Services:

- **"Do you participate within the First Health Network PPO?"; and**
- **"Will you honor network discounts for Limited Group Benefit Plans?"**

For Dental Services:

- **"Do you participate within the Dente*Max* Network PPO?"**

**You can also verify whether or not your provider is participating by:

- Accessing the provider directory online at www.myfirsthealth.com (medical services), www.Dente*Max*.com (dental services) or by visiting PAI's Essential StaffCARE Website at www.essentialcare.com/staffcare.
- Calling Planned Administrators, Inc. (PAI) Toll Free 1(866)798-0803 8:30 a.m. to 8:00 p.m. EST.
- Calling First Health Toll Free at 1(800)226-5116.
- Calling Dente*Max* Toll Free at 1(800)752-1547.

****Since there are timing differences between when a provider is approved for enrollment into the network and terminates from the network, the most accurate member information can be obtained by asking your provider directly.**

INTRODUCTION, LIMITED BENEFITS MEDICAL PLAN, Essential StaffCARE

Employer Solutions Group, LLC (the "Employer") is pleased to sponsor a welfare benefit plan (the "Plan") for you and your fellow eligible employees. References to "you" and "your" throughout this SPD refer to you as the employee who may be entitled to benefits under the Plan.

The Plan provides the following benefits:

Medical (including prescription drugs) with the option to include the following benefits:

- Dental;
- Term Life/Accidental Death & Dismemberment; and
- Short Term Disability (Employee Only).

In addition, if you enroll for coverage, you are eligible to participate in the Plan's Prescription discount program.

Each of these is summarized in the respective sections within this SPD.

Summary Plan Description

This document is a summary plan description ("SPD"). It provides a summary of the major provisions and benefits of the Plan. It is also intended to inform you of some of the Plan's limitations and exclusions and your rights as a participant. Because this is only a summary, it has not been written with all of the technical words and legal phrases used in the official Plan documents, insurance contracts and other Plan materials. For full details about the Plan and any of the insurance contracts that provide benefits under the Plan, please consult your human resource representative, the Plan Administrator or Planned Administrators, Inc. (PAI).

Employee Welfare Benefit Plan

The Plan is intended to be a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

Use of Third Party Administration

Your Employer has selected limited benefit coverage underwritten by BCS Insurance Company and 4 Ever Life Insurance Company and administered by Planned Administrators, Incorporated (PAI) - experienced in processing and paying medical claims and providing consulting services in connection with the operation of these benefits. Your Third Party Administrator (TPA), PAI, is located in Columbia, South Carolina. PAI is a TPA who provides record keeping and claims processing services for BCS Insurance Company and 4 Ever Life Insurance Company. As a TPA, PAI has no discretionary powers under the Plan and, in particular, has no discretionary power in the paying or denying of claims.

PAI is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call between 8:30 a.m. and 8:00 p.m. Eastern Standard Time (EST) or write PAI at the following:

Planned Administrators, Inc.
Attn: Claims
P.O. Box 6702
Columbia, SC 29260
1(866)798-0803
www.essentialcare.com/staffcare

MAKING CHANGES TO HEALTH INSURANCE BENEFITS

If you need to update or cancel your coverage, the Interactive Voice Response (IVR) line is a convenient way for you to do so by telephone. However, using the IVR line to update or cancel your coverage is limited to certain times. At other times, you can only update or cancel your coverage by mailing or faxing your information to Essential StaffCARE.

Please read the information below carefully to determine how and when you may make changes to your health insurance benefits.

- When may I use the IVR line to update or cancel my health insurance benefits?
  The timeframes for updating or canceling your health insurance benefits using the IVR line are limited to the following:
  - **I enrolled during the Initial Open Enrollment Period**. You have sixty (60) days from the Original Plan Effective Date, found on the ADMINISTRATIVE INFORMATION page of this SPD to make changes. NOTE: You may also make changes during subsequent open enrollment periods, as defined by your employer.
  - **I enrolled when I was hired.** You have up to thirty (30) days from the date you were hired to make changes.
  - **I enrolled when I was hired but did not have an assignment until my first thirty (30) days of employment were up.** Then you have an additional thirty (30) days from the date of your first paycheck, for your first assignment, to make changes.

If you have medical, dental and vision coverage, you may add coverage, cancel coverage, drop individual benefits or change the level of coverage (such as move from Family coverage to Employee only) if you experience a **Qualifying/life change event**, such as birth, marriage, death, divorce, adoption, termination of employment, loss of dependent status, Medicare entitlement, employer bankruptcy or loss of prior coverage. If a **qualifying/life change event** occurs outside of the timeframes referenced for using the IVR line, proof of the event must be provided to Essential StaffCARE in writing via mail or fax and the enrollment or change must occur within thirty-one days of the event.

In addition, you may request a special enrollment (for yourself, your spouse and/or eligible dependents) within 60 days (1) of termination of overage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

If you have group term life insurance and/or short term disability coverage, you may cancel coverage, drop individual benefits or levels of coverage (such as move from Family group term life insurance coverage to Employee Only) at any time. However, if you previously declined group term life insurance and/or short term disability coverage, you may only enroll during an open enrollment or by requesting a special enrollment as described under the ELIGIBILITY AND PARTICIPATION IN THE PLAN section of this SPD.

- How do I make changes to my health insurance benefits?

  1. If you would like to update or cancel coverage during the timeframes the IVR line is available, call the IVR line's toll free number **1(800)269-7783.** The IVR attendant will prompt you to enter your personal identification (PIN) code. Your Essential StaffCARE PIN code begins with the numbers 140 followed by the last four digits of your social security number.
     Example:

If your social security number is:	XXX-XX-0000
Your personal identification number (PIN) code is:	1400000

Make changes or cancel coverage according to the instructions provided by the IVR attendant.

2. If you would like to update or cancel coverage outside of the timeframes referenced for using the IVR line or you have a **qualifying/life change event,** you must complete a Change Form and attach supporting documentation, such as a marriage certificate, birth certificate, etc. and send them to Essential StaffCARE.

Mail or fax changes to Essential StaffCARE at the following:

Essential StaffCARE
Attention: Eligibility
P.O. Box 6702
Columbia, SC 29260
1(803)264-0772 (fax)

NOTE: To obtain a Change Form, call Essential StaffCARE at the toll free number 1(866)798-0803.

It takes two (2) to three (3) weeks for premiums to stop being deducted from your paycheck after the changes are submitted through the VIR line, or mailed or faxed to Essential StaffCARE. These premiums will not be refunded to you, but coverage will continue for the periods for which these paycheck deductions are taken.

PLAN ADMINISTRATION

Plan Funding/Administration

All Plan benefits are provided on a fully insured basis through group insurance contracts between BCS Insurance Company as well as 4 Ever Life Insurance Company and the Plan Sponsor (identified under **Administrative Information**). Participants are responsible for all required premiums. BCS Insurance Company is the insurance underwriter of the Medical and Dental Plans. 4 Ever Life Insurance Company is the underwriter of the Term Life Insurance, Accidental Death & Dismemberment and Short Term Disability Plans.

Claims for benefits are sent to Planned Administrators, Incorporated in accordance with the Plan's claims procedures. BCS Insurance Company and 4 Ever Life Insurance Company are responsible for paying claims, not the Employer. BCS Insurance Company and 4 Ever Life Insurance Company are responsible for determining eligibility for and the amount of benefits payable under the Plan and for prescribing, implementing and complying with claims procedures established to determine benefits under the Plan.

If you have any questions regarding eligibility or benefits provided under the insurance contracts, please contact Planned Administrators, Incorporated.

Contributions to the Plan

Contributions to the Plan are:

- 0% by the Employer and 100% by the employee for employee only, employee plus one and family coverage.

The Plan will notify you in writing of any changes to contributions.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

Eligibility for medical, accidental death and dismemberment and dental benefits includes all hourly-paid employees not receiving any other insurance benefits from the Employer. Also, eligible to receive benefits are the employee's:

- Spouse; and
- Dependent children, who are less than age twenty-six (26).

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

Your coverage will become effective after all of the following is complete:

(1) when you become eligible for this plan;
(2) when you have enrolled, no more than 30 days from your date of hire and/or no more than 30 days following your first pay date; and
(3) when the appropriate premiums for benefits are paid.

Once complete, your benefits will begin on the first Monday following the date your premium payment is deducted.

Please consult with your human resource personnel or PAI to determine how many days after becoming eligible, acquiring a new dependent, or during an open enrollment period that you may enroll.

Your spouse's and/or eligible dependents' coverage will become effective after all of the following is complete:

(1) when they become eligible for this plan;
(2) when they have enrolled; and
(3) when the appropriate premiums for benefits are paid.

Once complete, dependent benefits will begin on the first Monday following the date the premium payment for dependents is deducted.

In no case will coverage for your spouse and/or eligible dependents take effect before yours. The insurance company reserves the right to approve or disapprove your late application to cover a spouse and/or eligible dependents.

There are certain exceptions to the annual enrollment requirement. If you declined coverage (for yourself, your spouse and/or eligible dependents) at a time of eligibility due to the fact that you, your spouse and/or eligible dependents were covered under another plan, and that health coverage is terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated, you can request a special enrollment within 31 days of the loss. In addition, you may request a special enrollment (for yourself, your spouse and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit. Please consult with your human resource personnel, the Plan Administrator, or Third Party Administrator (PAI) if you are interested in obtaining medical benefits and think one of these situations may apply to you.

Newborn Child Coverage: A child of the Insured born while the policy is in force and grandchildren who are financially dependent on the covered grandparent and who reside with the covered grandparent from the moment of birth, are covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and prematurity), as well as routine newborn care. Upon receipt of a maternity claim we will notify the Insured if any additional dependent premium is required. If additional premium is required, any past due premium will be deducted from the benefits payable to the Insured.

Adopted Children: a child placed with the Insured while this coverage is in force as to the Insured will be covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. Premium is payable for the period of time such premium would have been collected had the Company been aware of such child. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this policy.

If you have questions concerning eligibility for benefits, please contact your human resource personnel or PAI.

TERMINATION OF COVERAGE

Your benefits will terminate, except for COBRA continuation coverage, as described below. In addition, benefits will also terminate the date the employee becomes eligible for another group health benefit program sponsored by the Employer, other than the Plan, regardless of whether the employee participates in such program.

Your spouse's and/or eligible dependents' coverage will terminate, except for any COBRA continuation coverage, as described below. In addition, benefits will terminate the date your spouse and/or eligible dependents become eligible as a covered employee for another group health benefit program.

Except for those benefits that provide COBRA continuation coverage and the Conversion of Benefits Provision referenced within this SPD:

A. Your coverage will terminate:

- on the last day for which premium payment is made following termination of employment or you otherwise cease to be eligible for coverage;
- on the last day for which a premium payment was made if you fail to remit, when due, the required premium payment for your coverage;
- on the termination date of the benefit;
- on the date that you enter into an armed service on full-time active duty. For information on continuing benefits after entering into an armed service on active duty, refer to the Uniformed Services Employment and Re-Employment Rights Act (USERRA) on the following page; or

- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

B. Coverage for your covered Dependents will also terminate on the day:

- on which your coverage is terminated;
- following the last day for which required premium payments are made for Dependent coverage;
- that you cease to be in a class eligible for Dependent coverage;
- that a covered Dependent ceases to meet the definition of a Dependent;
- coverage for your Dependents is discontinued under the Plan;
- the termination date of the benefit; or
- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

In no case will Dependent coverage terminate later than the coverage of the employee.

Certain requirements must be met to continue coverage beyond the age limit for a child. Please consult your human resource representative or PAI for more information concerning these requirements.

Extension of Coverage, Other than COBRA

In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA (or when your COBRA continuation ends). At such time, you should contact the ERISA Plan Administrator to determine what rights, if any, you might have.

Uniformed Services Employment and Re-Employment Rights Act (USERRA)

USERRA requires employers to offer continuation of coverage for Plan participants when called to serve in the military. If you are called to military duty for more than thirty (30) days, you may elect to continue Employer-sponsored health care for yourself and your eligible dependents for up to twenty-four (24) months, but you may be required to pay up to 102% of the applicable premium. The Employer shall be required to provide coverage for you as though you had remained on the job if you are out on military service for less than thirty-one (31) days. In this case, you will be charged only your share of the premium. Upon your return to work, you will be reinstated with no new waiting periods. However, pre-existing condition waiting periods can be imposed for any condition that occurred as a direct result of the military service.

Missed Premium Payments

For any given pay period, if you haven't worked enough hours to pay your premium via payroll deduction, you may pay your premium by check or money order after completing a *Missed Premium Direct Payment Form* found at the end of this SPD. You should make a photocopy of the sample form and complete it. Mail the completed form and a check or money order, payable to Planned Administrators, Inc., to:

Planned Administrators, Inc.
Attn: MISSED PREMIUMS
P.O. Box 6839
Columbia, SC 29260

If no deduction has ever occurred for an elected coverage or you are no longer eligible, coverage may not be maintained by direct payments. Additionally, manual payments will not be accepted for a period greater than six consecutive weeks and after 6 weeks of missed payment of premiums by payroll deduction your coverage will be terminated.

You must pay the full premium for all consecutive missed premium payment periods. Partial payments will not be accepted. Your check or money order must be mailed within 45 days after the date on the paycheck from which the payroll deduction would have been taken from your pay. If you miss more than one payroll deduction, you must make up all missed premiums within this 45-day period or claim benefits will not be paid.

EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act (ERISA) of 1974.

ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operations of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done. You have the right to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your claim. Certain time schedules apply to these decisions.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal court so long as you have exhausted the Plans claims procedures. No such action can be brought against the Employer more than three years after it receives a claim. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

You may be eligible to continue health coverage for yourself, spouse, or eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may be eligible to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have had creditable coverage under a previous plan. A certificate of creditable coverage should be provided to you, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date.

If you have any questions about your Plan, you should contact the Plan Administrator or PAI. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER PROVISIONS

Employment Rights

Under no circumstances does the maintenance of the Plan, the provision of benefits under the Plan or under any insurance contract or agreement, or this SPD constitute a contract of employment or modify, alter or affect the terms of employment of any participant or employee of the Employer. In addition, the provisions of this SPD do not constitute a contractual agreement as to the terms and conditions of your employment.

Plan Amendment or Termination

Although it is the intent of the Employer to continue the Plan indefinitely, the Employer reserves the right to modify, amend or terminate the Plan or any benefit programs or coverage under the Plan, any group insurance contract, and/or any other agreement or contract associated with the Plan at any time.

Misstatement of Age

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amount of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

Women's Health And Cancer Rights Act Of 1998

The Plan provides, in the case of a participant or covered Dependent who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.

The Plan's Benefit Limitations as outlined in the benefit summaries will apply to these benefits.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan and the insurance company may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance company for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order (QMCSO)

The term Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

A. Provides for child support with respect to a child of a participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan, or
B. Enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

For further information on QMCSOs please contact Essential StaffCARE at 1(866)798-0803 between 8:30 a.m. and 8:00 p.m. EST. A copy of the QMCSO procedures for the Plan is available without charge from the Plan Administrator.

MEDICAL SCHEDULE OF BENEFITS, Essential StaffCARE

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact the Employer's Human Resource Benefit Department.

INPATIENT HOSPITAL BENEFIT (Payable benefits require a minimum 24 hour stay)	
Maximum Benefit Period	No annual maximum
First Hospital Admission (This benefit is payable once per year per covered person when admitted to a hospital and continuously confined for a minimum of 24 continuous hours or more and is charged for room and board. Admissions to a hospital observation unit or emergency room are excluded.)	$250
Hospital Confinement Daily Income – Per Day	$500
Intensive Care Unit Confinement Daily Income – Per Day (Paid in addition to Hospital Confinement Daily Benefit)	$600
Surgical Procedure --Per Day	$3,000
Administration of Anesthesia – Per Day	$600
Skilled Nursing – Per Day (Payable for stays in a skilled nursing facility after a hospital stay)	$100

OUTPATIENT BENEFITS	
Annual Maximum (Applies to all outpatient benefits except Wellness)	$2,000
Physician Office Visits – Per Day	$100
Diagnostic Lab – Per Testing Day	$75
Diagnostic X-Ray – Per Testing Day	$200
Ambulance Services – Per Day	$300
Emergency Room for Sickness – Per Day	$200
Emergency Room for Accident – Per Day (For off-the-job accidents only)	$500
Surgical Procedure --Per Day	$500
Administration of Anesthesia – Per Day	$200
Physical Therapy- Per Day	$50
Speech Therapy- Per Day	$50
Occupational Therapy- Per Day	$50
Prescription Drugs Annual Maximum Per Day	 $600 $20
Wellness (One benefit payment per calendar year for a routine examination or other preventive testing)	$100

Benefit Descriptions:

Ambulance Services

This benefit is payable at the reflected fixed dollar amount for the use of ground or air ambulance transportation service, to or from a hospital as a result of an accident or illness.

Diagnostic Lab

This benefit includes all diagnostic lab tests ordered or performed by a licensed practitioner when hospital confinement is not required. It is paid at a preselected fixed dollar amount. This benefit is not payable if test(s) are ordered or performed during an emergency room visit.

Diagnostic X-ray

This benefit includes all diagnostic x-ray ordered or performed by a licensed practitioner when hospital confinement is not required and is paid at a preselected fixed dollar amount. This benefit is not payable if test(s) are ordered or performed during an emergency room visit.

Emergency Room

This benefit is payable at a preselected fixed dollar amount for eligible services or supplies received in an emergency room when the visit results from an accident or illness.

Intensive Care Hospital Benefit

This benefit is payable per day for confinement in an intensive care unit. This benefit is paid in addition to the daily standard care hospital benefit, per covered person per policy year at the plan defined daily rate.

Physical Therapy, Speech Therapy, Occupational Therapy

This benefit is payable as a per visit fixed amount.

Physician Office Visits

This benefit is payable for visits to a doctor's office, urgent care or outpatient hospital facility for diagnosis, consultation or treatment for wellness, injury or illness services provided by a licensed practitioner. It is paid at a preselected fixed dollar amount. Diagnostic and X-ray services performed during a physician office visit are payable separately as per the benefit schedule.

Skilled Nursing

This benefit is payable per day after a hospital stay for a facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services that would not otherwise be offered in a hospital.

Standard Care Hospital Benefit

Payable when a covered person is confined in a hospital as a result of an accident or sickness unrelated to a work injury. This benefit is payable per day to the insured after 24 hours confinement in a hospital.

Surgical and Anesthesia

This benefit pays a preselected fixed dollar amount for surgeries performed by a licensed practitioner and provides for anesthesia administered by an anesthesiologist or anesthetist in connection with a covered surgical procedure. The benefits for surgery and anesthesia are paid at a preselected fixed dollar benefit plan amount.

Wellness

This is a one-time payable benefit for all routine examinations, preventive testing and well-child care for outpatient services provided by a licensed practitioner. This benefit is paid in addition to any other benefit allowed under the policy and is payable per covered person per policy year.

Standard Prescription Plan

For generic and brand prescriptions, the plan pays you $20 per day up to the annual maximum for drugs dispensed by a pharmacist. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. You will then use the Medical/Rx Claim Form at the back of this SPD to file your claim for reimbursement with PAI.

MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

A. No benefits will be paid for loss caused by or resulting from:

1. Intentionally self-inflicted injuries, suicide or any attempt thereat while sane or insane;
2. Declared or undeclared war or any act thereof;
3. Serving on full-time active duty in the Armed Forces of any country or international authority;
4. The Covered Person's commission of a felony;
5. Flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country;
6. Work-related Injury or Sickness.

B. In addition to the above exclusions, no benefits will be paid for:

1. Eye examinations for glasses; any kind of eye glasses, or prescriptions therefore;
2. Hearing examinations or hearing aids;
3. 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;
4. Reading or interpreting the results of any diagnostic laboratory or X-ray;
5. 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;
6. Services provided by a member of the Covered Person's immediate family or services provided by the Employer.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Preferred Provider Organization (PPO) for the participants with medical benefits under the Plan is:

- **First Health Network**

PPO Providers are hospitals, skilled nursing facilities, home health agencies, hospice, doctors and other providers of medical services and supplies who have a written agreement with the above referenced network.

The PPO Providers will file all claims for covered services or supplies with PAI for you.

You will receive discounted rates when you use PPO Providers for services. **You will pay more if you do not use PPO Providers.** You will receive Non-PPO rates for providers (such as the radiologist, anesthesiologist, etc.) who are not in the preferred network, even if the hospital is a preferred provider. It is in your best interest for you to make sure that all of your providers are participating providers within the appropriate PPO Network referenced by state above. The **NOTICE** on Page 1 has additional information on how to find out if your provider is a PPO Provider.

Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies and you will have to file your own claims.

CLAIM FILING PROCEDURES

How to file your claims

- If you receive healthcare or dental services or supplies from a PPO Provider, the Provider will file your claims for you.
- If you receive healthcare services or supplies from a Non-Network Provider, you will have to file your own claims using the Medical Claim Form.
- If you receive dental services or supplies from a Non-Network Provider, you will have to file your own claims using the Dental Claim Form.
- If you receive prescription drug benefits, please follow the directions outlined on page 10 of this Plan Document.

Please follow the instructions below when you have claims for expenses. When filing your own claims, here are some things you will need:

1. Limited Benefits Claim Form for each patient. You can get these forms from your Employer's benefits department, in the FORMS section at the end of this SPD, or you may print them from the Essential StaffCARE website at www.essentialcare.com/staffcare.
2. Itemized bills from the providers. These bills should include:
   A. Provider's name and address and Tax Identification number;
   B. Patient's name and date of birth;
   C. Your ID number;
   D. Description (applicable CPT, dental or NDC drug procedure code) and charge/cost for each service;
   E. Date that each service took place; and
   F. Description of the illness or injury (ICD-9 diagnosis code).

Complete the front of each claim form and attach the itemized bills to it.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Send your claims to PAI at the address found on the bottom of the claim form.

Authorized Representative

Unless expressly permitted under the protection of the ERISA regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your protected health information (PHI) cannot be released to an individual without your consent. There are instances when a family member or representative needs to discuss your protected health information or receive an explanation of benefits to help manage your care. In order to comply with these regulations and to protect your privacy, a written authorization or a completed Authorized Representative Form is required. Please visit the Essential StaffCARE website at www.essentialcare.com/staffcare and click FORMS on the left. You can print this form and mail to the PAI address. You can also call 1(866)798-0803 for a form to complete.

Time Limits to File a Claim

Claims must be filed no later than ninety (90) days from the incurred date of service you or your spouse and/or eligible dependents receive services or supplies. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given within one (1) year after it is due, unless you are legally incapable of doing so.

Denial of Claims

If we deny any part or all of a claim, you will receive an adverse benefit determination notice known as an explanation of benefits (EOB) explaining the reasons for the claim denial.

If you do not understand why we denied your claim, you can:

- Read the information in this SPD. It outlines the terms and conditions of your health coverage; and
- Contact PAI at 1(866)798-0803 between 8:30 a.m. and 8:00 p.m. Eastern Standard Time (EST).

Appeal Procedures	Legal Actions
If you wish to file a formal appeal, you must write to: **Essential StaffCARE** **Attention: Claims Appeal** **P.O. Box 6702** **Columbia, SC 29260** The letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter.	**No action at law or in equity can be brought for denial of benefits until sixty (60) days after we receive a claim (proof of loss) and you have exhausted the appeal process. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.**

DENTAL CARE BENEFITS

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact your Employer's Human Resources Benefit Department.

Except in an emergency, you should discuss dental charges with your dentist before treatment begins. If you, your covered spouse and/or covered eligible dependents need dental treatment which the dentist estimates will cost $200 or more, ask your dentist to file for predetermination of benefits with the Third Party Administrator (TPA), PAI. By doing so, you and your dentist will know in advance the amount that the Plan will pay for the course of treatment your dentist recommends.

This predetermination process is not a pre-service claim requirement. A pre-service claim means any claim for a benefit if the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining care. The predetermination process is simply to assist you in knowing the cost of dental treatment that you are undertaking.

In order to obtain predetermination of benefits, your dentist should list, on a claim form, the treatment he or she plans to perform and the charges for that treatment. The dentist should then send the form to PAI. PAI will let you and your dentist know the amount of money that can be paid under your coverage for the recommended treatment. If treatment costs $200 or more and your dentist does not ask for predetermination of benefits, your claim will be paid according to the information contained on the claim form when submitted. Predetermination of benefits is not necessary for treatment that costs less than $200 or for emergency care, routine oral examinations, x-rays, fluoride treatments, cleaning, and scaling.

Alternate Dental Benefit Plan

Recognizing that many dental problems can be solved in more than one way, the Plan will pay an amount equal to that applicable for generally accepted treatment which will provide you, your covered spouse and/or eligible dependents with adequate dental care at the lowest cost. The Plan will be guided by nationally established standards of the dental profession in determining the amount of dental benefits coverage or expense reimbursement.

If you, your spouse and/or eligible dependents pursue a more expensive course of treatment, the Plan may pay the equivalent of the less expensive treatment that adequately treats the dental issue. This payment may be applied toward the more expensive course of treatment.

Termination of Dental Benefit

Your, your spouse's and eligible dependents' dental coverage will terminate, except for COBRA continuation coverage, in accordance with the Termination of Coverage section appearing earlier in this SPD.

Dente*Max*, Preferred Provider Organization

Dente*Max* Network participating providers have agreed to accept a Dente*Max* fee as payment in full, less applicable co-payments, deductibles and amounts exceeding benefit maximums for covered procedures performed. For more information on who participates in the Dente*Max* Network, please reference the NOTICES TO EMPLOYEES section of this SPD.

DENTAL SCHEDULE OF BENEFITS
Maximum Benefit Amount, per Plan year, per participant, all dental benefits: $750.00. **Dental Deductible, per Plan year, per participant: $50.00.**

CLASSES OF EXPENSES	PERCENT (%) PLAN PAYS
See details on following pages	
CLASS A - Diagnostic and Preventive Dental Benefits **No waiting periods apply to Class A**	**100%**
CLASS B - Basic Dental and Oral Surgery **Three Month Waiting Period for all Class B expenses applies**	**60%**
CLASS C - Endodontic, Periodontic and Prosthodontic Services **Twelve Month Waiting Period for all Class C expenses applies**	**50%**

Dental Benefits

The following chart provides a list of the benefits provided under the Plan's dental coverage. Read this information carefully as there are a number of maximums and other limitations referenced with an (a-h) following the benefit code description. These limits are further explained following the chart.

Choose any qualified dental provider for your dental care.

Dental Claim Procedures

For general claims procedure information, refer to the *Claim Filing Procedures* section of this SPD.

COVERED DENTAL EXPENSES

LIMITATIONS AND MAXIMUMS THAT APPLY ARE INDICATED FOLLOWING THE DESCRIPTION WITH REFERENCE FOLLOWING THIS SECTION

Code	Description
	CLASS A
D0120	Periodic oral exam (a)
D0140	Limited oral evaluation – problems focused
D0150	Comprehensive oral exam (a)
D0160	Detailed and extensive oral evaluation-problem focused
D0170	Re-evaluation – limited, problem focused
D0180	Comprehensive periodontal evaluation
D9110	Palliative (emergency) treatment of dental pain, minor procedure
D0330	Panoramic film (b) or
D0210	Intraoral – complete series (b)
D0220	Intraoral – perapical, first film
D0230	Intraoral – perapical, each additional film
D0240	Intraoral – occlusal film
D0250	Extraoral – first film
D0260	Extraoral – each additional film
D0270	Bitewing – single film (f)
D0272	Bitewing – two films (f)
D0274	Bitewing – four films (f)
D0277	Vertical bitewings – 7 to 8 films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0321	Other temporomandibular joint films, by report
D0322	Tomographic survey
D0340	Cephalometric film
D0350	Oral/facial images
D0415	Bacteriologic studies for determination of pathologic agents
D0425	Caries susceptibility tests
D0460	Pulp vitality tests
D0470	Diagnostic casts
D0472	Accession of tissue, gross exam
D0473	Accession of tissue, gross and microscopic exam
D0474	Accession of tissue, gross and microscopic exam w/surgical margins
D0480	Processing and interpretation of cytologic smears
D0502	Other oral pathology procedures, by report
D1110	Prophylaxis – adult (a)
D1120	Prophylaxis – child (a) (e), or
D1201	Topical application of fluoride – child (including prophylaxis) (c) (e) or
D1203	Topical application of fluoride – child (no prophylaxis) (a) (e)
D1204	Topical application of fluoride – adult (no prophylaxis) (a)
D1205	Topical application of fluoride – adult (including prophylaxis) (c)
D1351	Sealant – per tooth (c) (e)
D1510	Space maintainer – fixed – unilateral (c) (e)
D1515	Space maintainer – fixed – bilateral (c) (e)
D1520	Space maintainer – removable – unilateral (c) (e)
D1525	Space maintainer – removable – bilateral (c) (e)
D1550	Re-cementation of space maintainer
	CLASS B
	Fillings
D2140	Amalgam – one surface, primary or permanent
D2150	Amalgam – two surfaces, primary or permanent
D2160	Amalgam – three surfaces, primary or permanent
D2161	Amalgam – four + surfaces, primary or permanent
D2330	Resin-based composite – one surface, anterior
D2331	Resin-based composite – two surfaces, anterior
D2332	Resin-based composite – three surfaces, anterior
D2335	Resin-based composite – four +surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior
D2410	Gold foil – one surface
D2420	Gold foil – two surfaces
D2430	Gold foil – three surfaces
D2510	Inlay – metallic – one surface
D2520	Inlay – metallic – two surfaces
D2530	Inlay – metallic – three or more surfaces
D2542	Onlay – metallic – two surfaces
D2543	Onlay – metallic – three surfaces
D2544	Onlay – metallic – four or more surfaces
D2610	Inlay – porcelain/ceramic – one surface
D2620	Inlay – porcelain/ceramic – two surface
D2630	Inlay – porcelain/ceramic – three of more surfaces
D2642	Onlay – porcelain/ceramic – two surfaces
D2643	Onlay – porcelain/ceramic – three surfaces
D2644	Onlay – porcelain/ceramic – four or more surfaces
D2650	Inlay – resin-based composite – one surface
D2651	Inlay – resin-based composite – two surfaces
D2652	Inlay – resin-based composite – three of more surfaces
D2662	Onlay – resin-based composite – two surfaces
D2663	Onlay – resin-based composite – three surfaces
D2664	Onlay – resin-based composite – four or more surfaces
	Crowns & Bridges Repair
D2910	Recement inlay
D2920	Recement crown
D2940	Sedative filling
D2950	Core buildup, including any pins
D2951	Pin retention – per tooth, in addition to restoration
	Dentures Repair
D5510	Repair broken complete denture base (c)
D5520	Replace missing or broken teeth – complete denture (each tooth) (c)
D5610	Repair partial resin denture base (c)
D5620	Repair partial cast framework (c)
D5630	Repair or replace broken clasp (c)
D5640	Replace broken teeth – per tooth (c)
D5650	Add tooth to existing partial denture (c)
D5660	Add clasp to existing partial denture (c)
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)
D5730	Reline complete maxillary denture (chairside) (b)
D5731	Reline complete mandibular denture (chairside) (b)
D5740	Reline maxillary partial denture (chairside) (b)
D5741	Reline mandibular partial denture (chairside) (b)
D5750	Reline complete maxillary denture (lab) (b)
D5751	Reline complete mandibular denture (lab) (b)
D5760	Reline maxillary partial denture (lab) (b)
D5761	Reline mandibular partial denture (lab) (b)
D6930	Recement fixed partial denture
	Oral Surgery
D7111	Coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

Code	Description
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7310	Alveoloplasty in conjunction with extractions – per quadrant
D7320	Alveoloplasty not in conjunction with extractions – per quadrant
D7510	Incision and drainage of abscess – intraoral soft tissue

CLASS C

Endodontics

Code	Description
D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3230	Pulpal therapy – anterior, primary tooth
D3240	Pulpal therapy – posterior, primary tooth
D3310	Root canal – anterior (excluding final restoration) (c), or
D3320	Root canal – bicuspid (excluding final restoration) (c), or
D3330	Root canal – molar (excluding final restoration) (c)
D3331	Treatment of root canal obstruction; non-surgical access
D3332	Incomplete endodontic therapy; inoperable or fractured tooth
D3333	Internal root repair of perforation defects
D3346	Retreatment of previous root canal therapy – anterior
D3347	Retreatment of previous root canal therapy – bicuspid
D3348	Retreatment of previous root canal therapy – molar
D3351	Apexification/recalcification – initial visit
D3352	Apexification/recalcification – interim medication replacement
D3353	Apexification/recalcification – final visit
D3410	Apicoectomy/periradicular surgery – anterior (c), or
D3421	Apicoectomy/periradicular surgery – bicuspid (first root) (c), or
D3425	Apicoectomy/periradicular surgery – molar (first root) (c)
D3426	Apicoectomy/periradicular surgery – (each additional root)
D3430	Retrograde filling – per root
D3450	Root amputation – per root
D3460	Endodontic endosseous implant
D3470	Intentional reimplantation (including necessary splinting)
D3910	Surgical procedure for isolation of tooth with rubber dam
D3920	Hemisection (including any root removal), not including root canal therapy
D3950	Canal preparation and fitting of preformed dowel or post

Periodontics

Code	Description
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant (g)
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant (h)
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant
D4245	Apically positioned flap
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery – four or more contiguous teeth or bounded teeth spaces per quadrant (h)
D4261	Osseous surgery – one to three teeth, per quadrant
D4263	Bone replacement graft – first site in quadrant
D4264	Bone replacement graft – each additional site in quadrant
D4265	Biologic materials to aid in soft and osseous tissue regeneration
D4266	Guided tissue regeneration – resorbable barrier, per site
D4267	Guided tissue regeneration – nonresorbable barrier, per site
D4268	Surgical revision procedure, per tooth
D4270	Pedicle soft tissue graft procedure
D4271	Free soft tissue graft procedure (including donor site surgery)
D4273	Subepithelial connective graft procedures
D4274	Distal or proximal wedge procedure
D4275	Soft tissue allograft
D4276	Combined connective tissue and double pedicle graft
D4320	Provisional splinting – intracoronal
D4321	Provisional splinting – extracoronal
D4341	Periodontal scaling & root planing – four or more contiguous teeth or bounded teeth spaces per quadrant (h)
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis (b)
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased tissue, per tooth, by report
D4910	Periodontal maintenance procedures (following active therapy) (a)
D4920	Unscheduled dressing change (by someone other than treating dentist)

Crowns & Bridges

Code	Description
D2710	Crown – resin (indirect)
D2720	Crown – resin w/high noble metal (d)
D2721	Crown – resin w/predominantly base metal (d)
D2722	Crown – resin with noble metal (d)
D2740	Crown – porcelain/ceramic substrate (d)
D2750	Crown – porcelain fused to high noble metal (d)
D2751	Crown – porcelain fused to predominantly base metal (d)
D2752	Crown – porcelain fused to noble metal (d)
D2780	Crown – 3/4 cast high noble metal (d)
D2781	Crown – 3/4 cast predominantly base metal
D2782	Crown – 3/4 cast noble metal
D2783	Crown – 3/4 porcelain/ceramic
D2790	Crown – full cast high noble metal (d)
D2791	Crown – full cast predominantly base metal (d)
D2792	Crown – full cast noble metal (d)
D2930	Prefabricated stainless steel crown – primary tooth (d)
D2931	Prefabricated stainless steel crown – permanent tooth (d)
D2932	Prefabricated resin crown (d)
D2952	Cast post and core in addition to crown (d)
D2953	Each additional cast post – same tooth
D2954	Prefabricated post and core in addition to crown (d)
D2955	Post removal
D2957	Each additional prefabricated post – same tooth
D2960	Labial veneer (resin laminate) – chairside
D2961	Labial veneer (resin laminate) – lab
D2962	Labial veneer (porcelain laminate) – lab
D2970	Temporary crown (fractured tooth)
D2980	Crown repair – by report
D6210	Pontic – cast high noble metal (d)
D6211	Pontic – cast predominantly base metal (d)
D6212	Pontic – cast noble metal (d)

D6240	Pontic – porcelain fused to high noble metal (d)	D5140	Immediate denture – mandibular (d)
D6241	Pontic – porcelain fused to predominantly base metal (d)	D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth) (d)
D6242	Pontic – porcelain fused to noble metal (d)	D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth) (d)
D6250	Pontic – resin with high noble metal (d)	D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) (d)
D6251	Pontic – resin with predominantly base metal (d)	D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth) (d)
D6252	Pontic – resin with noble metal (d)	D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth) (d)
D6720	Crown – retainer – resin with high noble metal (d)	D5410	Adjust complete denture – maxillary (d)
D6721	Crown – retainer – resin with predominantly base metal (d)	D5411	Adjust complete denture – mandibular (d)
D6722	Crown – retainer – resin with noble metal (d)	D5421	Adjust partial denture – maxillary (d)
D6750	Crown – retainer – porcelain fused to high noble metal (d)	D5422	Adjust partial denture – mandibular (d)
D6751	Crown – retainer – porcelain fused to predominantly base metal (d)	D5710	Rebase complete maxillary denture (d)
D6752	Crown – retainer – porcelain fused to noble metal (d)	D5711	Rebase complete mandibular denture (d)
D6780	Crown – retainer – 3/4 cast high noble metal	D5720	Rebase maxillary partial denture (d)
D6790	Crown – retainer – full cast high noble metal (d)	D5721	Rebase mandibular partial denture (d)
D6791	Crown – retainer – full cast predominantly base metal (d)	D5850	Tissue conditioning – maxillary (d)
D6792	Crown – retainer – full cast noble metal (d)	D5851	Tissue conditioning – mandibular (d)
D6970	Cast post and core in addition to fixed partial denture retainer (d)		
D6972	Prefabricated post and core in addition to fixed partial denture retainer (d)		
D6973	Core build up for retainer, including any pins (d)		
	Dentures		
D5110	Complete denture – maxillary (d)		
D5120	Complete denture – mandibular (d)		
D5130	Immediate denture – maxillary (d)		

Limitations and Maximums referenced above are as follows:

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 1 procedure per 12 months
(d) Maximum of 4 procedures of this class per 12 months
(e) Limited to dependent children under 14
(f) Maximum of 4 films per 12 months
(g) Maximum of once each quadrant per 36 months
(h) Maximum of once each quadrant per 6 months

DENTAL EXCLUSIONS AND LIMITATIONS

Coverage is not provided for services or supplies for which a charge is not customarily made in the absence of insurance. No dental benefits are payable under the Plan for the procedures listed below. Additionally, the procedures listed below will not be recognized toward satisfaction of any deductible.

1. service or supply not shown on the Covered Dental Expenses Chart;
2. any procedure begun after your, your spouse's and/or eligible dependents' dental coverage under the Plan date terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty days after your, your spouse's and/or eligible dependents' dental coverage under the Plan terminates;
3. any procedure that begins or appliance installed before becoming covered for dental benefits under the Plan;
4. any treatment that is elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association;
5. the correction of congenital malformations (unless the procedure is performed on a child who was covered immediately following birth);
6. the replacement of lost or stolen appliances;

7. initial placement of any prosthetic appliance or fixed bridge unless such placement is necessitated by the extraction of one or more functioning natural teeth while covered for dental benefits under the Plan, provided such tooth was not an abutment for a prosthetic appliance installed during the preceding five years or a fixed bridge installed during the preceding seven years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of the extracted tooth or teeth;
8. replacement of bridges unless the bridge cannot be made serviceable;
9. replacement of full or partial dentures unless the prosthetic appliance is more than five years old and cannot be made serviceable;
10. replacement of crowns, inlays or onlays unless the prior placement is more than seven years old and cannot be made serviceable;
11. appliances, services or procedures relating to: (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) correction of attrition or abrasion; (iv) bite registration or (v) bite analysis;
12. orthognathic surgery;
13. prescribed drugs, pre-medication, analgesia or general anesthesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means;
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment unless otherwise listed as a covered procedure;
20. charges for failure to keep a scheduled visit or for the completion of any claim forms;
21. any procedure which the Plan determines is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to you, your spouse and/or eligible dependents by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of that person’s household;
23. any procedure, service or supply that is included as covered medical expenses under a group health benefit plan;
24. expenses compensable under workers' compensation or employers' liability laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage); and
25. expenses provided or compensable for by any governmental program or law, except as to charges that the person is legally obligated to pay.

MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE."

11.822-MN (2/11)

TERM LIFE INSURANCE BENEFIT PLAN

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact your Employer's Human Resource Benefit Department.

All hourly-paid employees not receiving any other insurance benefits from the Employer are eligible to participate in the Term Life Insurance Benefit Plan. The employee may also obtain life insurance for his or her spouse and/or eligible dependents who live with the employee or who rely upon the employee for the majority of his or her support.

Your term life insurance will become effective on the first Monday following the date your premium payment is deducted. Coverage for your spouse and eligible dependents will begin on the latest of the following:

- the effective date of the group term life coverage, if the employee applies for family life insurance coverage prior to the coverage effective date;
- the employee's effective date if application for family life insurance is made within 31 days of the employee's eligibility date;
- the Monday following the date the applicable premium payment is deducted following the date the insurance company approves the application for family life insurance, subject to proof of evidence of insurability, if application is made more than 31 days after the employee's eligibility date;
- the Monday following the date the applicable premium payment is deducted following the date the insurance company approves the application for family life insurance, if application is made within 31 days of the employee acquiring a new spouse or child; or
- the Monday following the date the applicable premium payment is deducted following the date the insurance company approves the application for family life insurance, subject to proof of evidence of insurability, if application is made more than 31 days after acquiring a new spouse or child.

If you or your spouse are eligible for coverage both as an employee and a spouse (e.g., both you and your spouse work for the Employer), each of you will only be eligible for coverage as an employee. If you and your spouse both work for the Employer, only one of you will be able to maintain coverage for the child.

Termination of Term Life Benefits

Your, your spouse's and eligible dependents' term life insurance will terminate in accordance with the Termination of Coverage section appearing earlier in this SPD. In addition term life insurance will terminate for your spouse when your spouse attains age 70.

TERM LIFE INSURANCE SCHEDULE OF BENEFITS		
Life Benefit	Employee	$ 10,000.00
The Employee Life Benefit Reduces at the following ages:		
75% at age 65 to 70	50% at age 70 or over	
Life Benefit	Dependents	
Spouse *(Note: This Life Benefit ends at age 70)*		$ 5,000.00
Dependents (6 months old to 26 years)		$ 5,000.00
Dependents (15 days to 6 months)		$ 1,000.00
Dependents (under 15 days)		$ 0.00

Term Life Insurance Limitation

Term Life benefits are not payable for any loss during the first two years of coverage if death is caused by or results from suicide.

Conversion of Term Life Coverage

If your employment is terminated or you become ineligible for life insurance benefits you, your spouse and/or eligible dependents, in some instances, have the right to convert the group term life coverage (not including the matching accidental death benefit) to an ordinary life policy. Conversion must occur within 31 days of the end of the group term life coverage.

The cost of coverage, based on age and other factors, will usually increase with the conversion from your Employer's Plan. For a preliminary price quote or assistance with the application process contact customer service at 1(866)798-0803, Monday through Friday between 8:30 a.m. and 8:00 p.m. EST. The quote is not binding and may change prior to receipt of the conversion policy.

Premiums must be paid directly to the insurance company yearly, two or four times per year.

Beneficiary

At enrollment, you will name a beneficiary to receive this benefit in the event of your death. You may change the beneficiary at any time by writing to PAI. The change will become effective once PAI receives the written notification of the change of beneficiary. You are always the beneficiary for dependent benefits.

Life Insurance Claim Procedures

If a covered person dies as the result of an accident or illness, you or your beneficiary should apply for the insurance benefit as soon as possible. A copy of the Life Claim Form is located in the back of this SPD. You or your beneficiary can obtain the appropriate forms and details about the claims procedure by calling the PAI/Essential StaffCARE Claims Customer Service Area at 1(866)798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. EST.

If all or a part of your claim is denied, you will be notified in writing. This notice will include detailed reasons why the claim was denied and an explanation of how to appeal for reconsideration of the decision. Please also refer to the *Claim Filing Procedures* section of this SPD.

Legal Actions

No action at law or in equity can be brought for denial of benefits until sixty (60) days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Claim Filing Procedures* section of this SPD. No such action can be brought for denial of benefits more than three (3) years after we receive a claim.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Employee	$20,000
Spouse	$20,000
Dependent (6 months to 26 years)	$5,000
Dependent (15 days to 6 months)	$2,500

Benefits are as follows:

Loss of Life	The Full Benefit
Loss of Two or More Members:	The Full Benefit
Loss of One Member:	One-Half of the Benefit
Loss of Thumb and Index Finger of the Same Hand:	One-Quarter of the Benefit

"Member" means hand, foot or eye. "Loss" means, with regard to a hand or foot, complete severance through or above the wrist or ankle joint. Loss of an eye means total and irrevocable loss of sight. Loss of a thumb and index finger means severance through or above the joint closest to the wrist.

All benefits and rates are subject to change. Your organization will be notified in advance of any change to the benefits or rates. This benefit is a part of the total limited medical benefit package.

Beneficiary

At enrollment, you will name a beneficiary to receive this benefit in the event of your death. You may change the beneficiary at any time by writing to PAI. The change will become effective once PAI receives the written notification of the change of beneficiary. You are always the beneficiary for dependent benefits.

Accidental Death & Dismemberment Claim Procedures

If a covered person dies or suffers the loss of a hand, foot or eye as the result of an accident, you or your beneficiary should apply for the insurance benefit as soon as possible. In addition to the FORMS section within this SPD, you or your beneficiary can obtain the appropriate forms and details about claims procedures by calling the PAI/Essential StaffCARE Claims Customer Service Area at 1(866)798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. EST.

If all or part of your claim is denied, you will be notified in writing. This notice will include detailed reasons why the claim was denied and an explanation of how to appeal for reconsideration of the decision. Please also refer to the *Claim Filing Procedures* section of this SPD.

ACCIDENTAL DEATH & DISMEMBERMENT EXCLUSIONS & LIMITATIONS

No benefit is payable with respect to any Total Disability caused by or resulting from:

1.) Attempted suicide or intentionally self-inflicted injury, while sane or insane;
2.) 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 a poisonous food substance;
3.) 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 the Insured; his or her spouse; a child, sibling, or parent of the Insured or of the Insured's spouse; or a person who resides in the Insured's home;
4.) Declared or undeclared war or act of war;
5.) The Insured's commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
6.) The Insured's participation in a riot;
7.) The Insured's engaging in an illegal occupation;
8.) Release of nuclear energy;
9.) Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply to the Insured while a passenger on a licensed, commercial, nonmilitary aircraft; and
10.) Injury or Sickness for which the Insured has or had a right to payment under any workers' compensation or similar law.

SHORT TERM DISABILITY (STD) PLAN

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact your Employer's Human Resources Benefit Department.

Eligibility for Short Term Disability Benefit Plan

All hourly-paid employees not receiving any other insurance benefits from the Employer are eligible to participate in the Short Term Disability Plan. Enrollment in this coverage is only available for the employee. No benefits are available for your spouse or eligible dependents.

Your short term disability benefit will become effective on the first Monday following the date your premium payment is deducted.

Termination of Short Term Disability Benefit

Your short term disability benefits will terminate in accordance with the Termination of Coverage section appearing earlier in this SPD.

SHORT TERM DISABILITY SCHEDULE OF BENEFITS

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact your Employer's Human Resources Benefit Department.

Weekly Benefit	60% of your average weekly base pay received for work done for the Employer (plus reported tips, but no overtime).
Maximum Benefit Amount	$150 per week
Maximum Number of Weeks	26
Waiting Period	7 days Benefits will begin paying immediately if hospitalized during the 7-day period.
General Information	To receive benefits, you must have been covered under the short term disability coverage at the time of commencement of total disability from either accidental injury or sickness. While receiving benefits under this coverage, you will not have to pay the short term disability coverage premiums.
Recurrent Disability	If a disabled employee returns to work and becomes disabled again due to the same or related causes within 14 days after the end of the prior disability during which benefits were paid, the disability is considered a resumption of the prior disability. This means the disabled employee does not need to satisfy a new elimination period to receive benefits.

If the Insured Person has successive periods of Total Disability, a new period of Total Disability begins if:

1. the later Total Disability results from causes entirely unrelated to the causes of the earlier Total Disability; or
2. the periods of Total Disability are separated by at least 14 days during which the Insured Person is not Totally Disabled.
3. Only one Disability Income benefit is payable for any one period of time.

"Total Disability/Totally Disabled" means:

1. during the Elimination Period and up to the Maximum Benefit Period, the Insured's complete inability to perform all of the Primary and Essential Duties of his or her Own Occupation, with or without accommodation, during the Insured's normal work schedule; and
2. the Insured is not working in any capacity for pay or remuneration.

SHORT TERM DISABILITY EXCLUSIONS AND LIMITATIONS

No benefits are payable under this coverage in the following instances:

1. attempted suicide or intentionally self-inflicted injury;
2. the intentional taking of poison; intentional inhalation of gas; intentional 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, your or your spouse's child, sibling or parent, or a person who resides in your home;
3. declared or undeclared war or act of war;
4. your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
5. your participation in a riot;
6. if you engage in an illegal occupation;
7. release of nuclear energy;
8. 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; and
9. work-related injury of sickness.

Availability

The short term disability benefit is not available to persons who work in California, Hawaii, New Jersey, New York and Rhode Island, and Puerto Rico. In these states (and Puerto Rico) your employer is required to provide this benefit.

Disability Claim Procedures

The following information provides specific information relating to the filing of a claim for disability benefits.

How to file your claims

If you become totally disabled while covered under the Short Term Disability coverage you should apply for the insurance benefit as soon as possible. This SPD contains a claim form for Short Term Disability coverage. Make a copy of the sample form (front and back), or get a copy of the form from your Employer or the Essential StaffCARE website at www.essentialcare.com/staffcare for use when you have a claim. Ensure that your Employer completes the first section of the form and have your physician complete the back of the form including the dates of disability. Send your completed form, along with copies of applicable medical records, to:

Essential StaffCARE CLAIMS
P.O. Box 6702
Columbia, SC 29260

You may also call Essential StaffCARE Customer Service at 1(866)798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. EST if you have questions.

Denial of Claim/Appeal Procedures

If all or a part of your claim is denied, you will be notified in writing. This notice will include detailed reasons why the claim was denied and an explanation of how to appeal for reconsideration of the decision. Please also refer to the *Claim Filing Procedures* section of this SPD.

Legal Actions

No action at law or in equity can be brought for denial of benefits until sixty (60) days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Claim Filing Procedures* section of this SPD. No such action can be brought for denial of benefits more than three (3) years after we receive a claim.

Pharmacy Discount Program

A discount for prescription drug charges will be provided to eligible persons when prescriptions are purchased through a contracted pharmacy.

DISCOUNT PROGRAM

To use the Caremark Prescription Drug Discount, visit or call a participating network location.

Caremark Prescription Drug Discounts	
Generic Drugs *You MUST present Member ID to receive discount*	**Up to 50%**
Brand Name Drugs *You MUST present Member ID to receive discount*	**Up to 15%**

To find a network location near you visit www.essentialcare.com/staffcare and utilize the FIND A PHARMACY link to access the Caremark link, call Caremark at 1(888)963-7290 or call Essential StaffCARE toll free at 1(866)798-0803.

EyeMed Vision Care Program®

Vision care and prescription eyewear discounts are provided through EyeMed Vision Care Program®, a national network.

EyeMed Vision Care Program® Discounts		
20% to 60%	possible discounts on eyewear	Providers must participate in the EyeMed Vision Care Program®
10%	possible discounts on contact lenses	

To use the EyeMed Vision Care Program® all you need to do is:

- Visit or call a participating network location
  - To find a network location near you visit www.eyemedvisioncare.com (When using the website, search the Access Network for participating providers).
  - You may also access provider location information by calling 1(866)559-5252. Automated location information is available 24 hours a day.
  - Locations are subject to change. Please call 1(866)559-5252 to verify participation.
- Identify yourself as a EyeMed Vision Care Program® member by showing your medical identification card.
  - You can access these savings at several locations including:
    - Pearle Vision;
    - Sears Optical;
    - Target Optical;
    - J.C. Penney Optical; and
    - thousands of independent providers.

EyeMed Vision Care Program® eye examinations are provided by licensed independent doctors of optometry located in or adjacent to most participating optical departments or by participating independent network providers.

If you have additional questions, you may call Essential StaffCARE toll free at 1(866)798-0803.

NOTE: When calling EyeMed regarding your discount program, please make sure to reference Plan ID# 9244278.

Allergy Control Products Inc.

Members can take advantage of preferred rates on products designed to reduce exposure to indoor allergens, including air cleaners, carpet treatments, pillow and mattress encasings and more. Visit Allergy Control Products Inc. at www.allergycontrol.com or call 1-877-362-6283. When ordering, enter or mention the discount code ACPBC20.

Bosley Hair Restoration

Bosley is a world leader in hair loss and medical hair restoration. Their process restores growing hair that can be cut and washed. Once transplanted, it continues to grow naturally. Members receive a 20 percent discount on the cost of a hair restoration procedure. To learn more about hair restoration, visit Bosley at www.bosley.com or call 1-800-510-5357.

Jenny Craig

Members can save on weight loss, including a free 30-day trial program or receive 25 percent off a Premium Program. Visit www2.jennycraig.com/CorporateChannel/affinity.aspx for more information.

QualSight LASIK

Members can receive special rates on LASIK vision correction services from participating QualSight Lasik centers. The discounted LASIK service members can receive include:

$945 per eye for Traditional /$1370 per eye for Custom / $1795 per eye for Bladeless Custom

Flexible financing options, with up to 12-month interest free, are available from participating providers for qualified applicants. Visit http://www.qualsight.com/-lasiksc.com

TruHearing Digital Hearing Aids

Members, their parents and their grandparents, can receive discounts on digital hearing aids. Three plans are available:

TruHearing Basic		TruHearing Medallion		TruHearing Ultra	
100% Digital, + 2 channels, 2 memories and microphone noise reduction		Includes all in Basic, + 6 bands, 3 memories, sensitive voice processing and adaptive feedback detection.		Includes everything in Medallion, + 16 channels, 6 compression areas, adaptive noise reduction, speech preservation and much more	
Regular Price:	$1,595	Regular Price:	$3,595	Regular Price:	$4,755
Member Price:	$ 995	Member Price:	$1,495	Member Price:	$1,995
Member SAVES:	$ 600	**Member SAVES**:	$2,100	**Member SAVES**:	$2,760

Prices may be subject to change without notice. There is a 45-day money back guarantee on TruHearing hearing aids. For more information call toll free 1-866-814-4237. Operators are available Monday through Friday, 9:00 a.m. - 9:00 p.m. Eastern Standard Time (EST) or visit their website at www.truhearing.com.

PRIVACY NOTICE

BCS Insurance Company

Privacy Practices Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Entities Covered by this Notice

The following entity is covered by this notice in so far as it provides or pays the cost of medical care as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its attendant regulations:

- BCS Insurance Company

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

The above are entities covered by this notice in so far as they provide or pay the cost of medical care as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its attendant regulations.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or entity subject to the federal Privacy Rules so they can obtain payment or engage in these payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations include:

- Rating our risk and determining our premiums for your health plan;
- Quality assessment and improvement activities;
- Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

Public Health, Auditing, Research, Emergency Purposes, and when Required by Law: We may use or disclose identifiable health information about you without your authorization for several additional reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances.

Others Involved In Your Care or Payment of Your Care: We also may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before we disclose your medical information to a person involved in your health care or payment of your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Plan Sponsors: We may disclose your medical information and the medical information of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan to permit the plan sponsor to perform plan administration functions. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.

We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the enrollees in your group health plan. The summary information will be stripped of demographic information about the enrollees in the group health plan, but the plan sponsor may still be able to identify you or other enrollees in your group health plan from the summary information.

Situations Other Than Those Above: In any situation other than those above, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $.05 (5 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. All requests for access to your medical information must be made in writing by you and directed to the contact person named below.

Additionally, you have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. We will accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan.

Finally, you may request in writing that we not use or disclose your information for treatment, payment and operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office

BCS Privacy Officer

BCS Insurance Company

2 Mid America Plaza, Suite 200

Oakbrook Terrace, IL 60181

Phone: (630)472-7752

Fax: (630)472-7754

Email: privacyofficer@bcsigroup.com

COBRA NOTICE

****CONTINUATION COVERAGE RIGHTS UNDER COBRA****

This example notice describes how your coverage can be continued under COBRA. Please review it carefully.

Introduction

You are receiving this notice because you have recently become covered under the Essential StaffCARE Limited Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should contact PAI at:

Planned Administrators, Inc.
Attn: Essential StaffCARE
P.O. Box 6839
Columbia, SC 29260
Call Toll Free: 1 (866) 798-0803
Between 8:30 a.m. to 8:00 p.m. EST

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1) Your hours of employment are reduced, or
2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

1) Your spouse dies;
2) Your spouse’s hours of employment are reduced;
3) Your spouse’s employment ends for any reason other than his or her gross misconduct;
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1) The parent-employee dies;
2) The parent-employee's hours of employment are reduced;
3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to **Employer Solutions Group, LLC**, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation to qualified beneficiaries only after PAI has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify PAI of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify PAI within 60 days after the qualifying event occurs. You must send this notice to:

Planned Administrators, Inc.
Attn: Essential StaffCARE - COBRA
P.O. Box 6839
Columbia, SC 29260

Once PAI receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to:

Planned Administrators, Inc.
Attn: Essential StaffCARE - COBRA
P.O. Box 6839
Columbia, SC 29260

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child**. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

Planned Administrators, Inc
Attn: Essential StaffCARE - COBRA
P.O. Box 6839
Columbia, SC 29260

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the PAI COBRA Unit or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

HIPAA/COBRA RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

   Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

3. If you were covered by a group health plan(s) prior to your employment with us, your previous employer's insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE AND ARE ENTITLED TO ONE, PLEASE CONTACT YOUR FORMER EMPLOYER. Once you deliver the Certificate of Creditable Coverage to us, you are exempt from any pre-existing condition exclusions in our group health plan(s), provided you had twelve months of creditable coverage (eighteen months if a late enrollment) and have not had more than a sixty-three day gap in coverage.

4. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

Sincerely,

PAI COBRA Unit

Essential StaffCARE

Medical/Rx Claim Form

BCS pai

Claim Form Instructions

1. Make a copy of this form. 2. Completely fill out Sections 1-4 (Section 5 is optional). 3. Sign and date Section 6. 4. Remember to give your Social Security Number.
5. Attach itemized bills providing complete information on:
   • Doctor's name and address • Doctor's tax identification number • Patient's name • Diagnosis Code ICD-9 • Date of service • Charges/Cost of each treatment• Procedure Codes CPT-4 • Place of service code • **Note:** Itemized bills are not balance due statements or Explanation of Benefits.
6. If your medical provider sends your bill or claim to us, make sure an itemized bill is included. 7. Sign Section 5 if you want benefits paid to your medical provider.
8. If you have a Certificate of Creditable Health Coverage from your previous health insurance plan, please attach it to your completed Medical Claim Form and send it to the address at the bottom of this form. Keep a copy for your records.

Section 1: Employee Information

Employee's Name ______________________________ SSN: _____ — _____ — _____
Last First Middle

Telephone: (______) ______ — ______ Employer Name: ______________ Group Number (obtain from ID card): ______________

Address: ______________________________
Street City State ZIP

Section 2: Patient Information

Patient's Name: ______________________________
Last First Middle

SSN: _____ — _____ — _____ Birth Date: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Relationship to employee: ☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other: (specify) ______________

If the patient is your child and over 18, is he or she dependent upon you for support? ☐ Yes ☐ No Is he or she disabled? ☐ Yes ☐ No

Is he or she a full-time student? ☐ Yes ☐ No Name of School: ______________________________
Submit documentation of school enrollment from Registrar office.

Section 3: Claim Information

Is the claim for an ☐ accident or ☐ illness Is treatment a result of occupational illness or injury? ☐ Yes ☐ No

When did the accident or illness occur? _____ / _____ / _____

Please explain what you were treated for, and if it was an accident, provide details on how, when and where it happened. (Use the back of this form or attach a sheet of paper to this form if necessary.) ______________________________

____

Section 4: Prescription Drug Information

If you have more than two medications, please use the back of this form or attach an additional sheet of paper to this form.

1. Name of Medication ______________________ Condition being treated ______________________
2. Name of Medication ______________________ Condition being treated ______________________

Section 5: Assignment of Benefits

To be completed by employee. Do not sign if fees have already been paid.

I approve the payment of benefits to the doctor or other medical provider shown on the itemized bill (whose Tax Identification Number is included). I understand that I am financially responsible for all charges not covered by this approval.

Signature of Employee: ______________________________ Date: ______________

Section 6: Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Planned Administrators, Inc. and its authorized representatives to view and obtain copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease of: ______________________________.
Print Name of Insured

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

______________________ ______________ ______________
Signed Date Relationship to insured if signed by other than insured

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

______________________ ______________________________
Name Address

Send Medical Claims to: Essential StaffCARE, Attn: Claims, PO Box 6702, Columbia, SC 29260-6702

Please note: Incomplete forms and the absence of itemized bills may delay the processing of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: 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.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** any other person.) Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Essential StaffCARE

Dental Claim Form

Mail Claims to: Essential StaffCARE, PO Box 6702, Columbia, SC 29260

Please complete both sides of this form.

Employer/Plan Name:______________________________________

Providers:________________________ Covered Person:____________________

Part 1: Employee Complete Part 1, sign the authorization and give it to the dentist.

Patient's Name:______________________________________
Last First Middle

Patient's SSN: _____ — _____ — _____ Patient's Birth Date:_____/___/_____ Sex: ☐ Male ☐ Female

Full-time Student: ☐ Yes ☐ No Patient's Relationship to Employee: ☐ Self ☐ Spouse ☐ Child

Employee's Name:________________________________Employee's SSN:_____ — _____ — _____
Last First Middle

Address: ____
Street City State ZIP

Is patient covered by another dental plan? ☐ Yes ☐ No

Dental Plan Name:____________________ Group Name and Number:____________________

Name and Address of Claims Administrator:________________________________

I accept the attending dentist's statement and authorize release of information relating hereto. I certify the truth of all personal information contained above. I agree to be responsible for payment of services provided during any ineligible period.

Signed (patient or parent if minor): ____________________________ **Date:** ____________

I hereby authorize payment directly to the below named dentist of the dental plan benefits otherwise payable to me.

Signed (employee):__________________________________ **Date:** ____________

Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured in unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross Blue Shield, self-insured and prepaid health plans):

> You are authorized to permit Planned Administrators, Inc. and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease of ________________________.
> Print Name of Insured

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent.

I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

________________________ ____________ ________________
Signed Date Relationship to insured if signed by other than insured

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

________________ ________________________________
Name Address

Part 2: Dentist

Name:____ License Number:________________
Last First Middle

Social Security or TIN Number:________________________________ Telephone: (______) ______—______

Mailing Address:____
Street City State ZIP

- Is treatment result of occupational illness or injury? ☐ Yes ☐ No (If yes, enter a brief description.)
____
- Is treatment result of auto accident? ☐ Yes ☐ No (If yes, enter a brief description.)
____
- Are any services covered by another plan? ☐ Yes ☐ No (If yes, enter a brief description.)
____
- If prostheses, is this initial placement? ☐ Yes ☐ No (If no, enter a reason for replacement and the date of prior placement.)

- First visit date current series:________________________ • Place of treatment: ☐ Office ☐ ECF ☐ Hospital ☐ Other
- Radiographs or models enclosed? ☐ Yes How many?________ ☐ No
- Pre-treatment estimate required if course of treatment is expected to exceed the limit specified in the benefit package and on the ID card:
(Check one.) ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

Examination and Treatment Plan: List in order from Tooth No 1 through No. 32. Use charting system shown.

Identify Missing teeth with "x"

Facial
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
A B C D E F G H I J
Lingual
Upper
RIGHT LEFT
Lower
Primary Permanent
T S R Q P O N M L K
Lingual
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
Facial

Tooth # or Letter	Surface	Description of Service (Including X-rays, prophylaxis materials used, etc.)	Date Service Performed Month/Day/Year	ADA Procedure Code	Fee
				Total:	

Remarks for unusual services: ____

I hereby certify that services listed above have been performed on the named patient on the dates indicated and that the fees shown are those currently charged to the majority of my patients.

Signed (dentist):____Date:________________

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.
Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma: 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.

WARNING:
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** any other person.) Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Essential StaffCARE

BCS

pai

Employer Group Life and Accidental Death & Dismemberment Claim Form

Mail claims to: Essential StaffCARE, P.O. Box 6702, Columbia, SC 29260-6702

Section 1. Employer's Statement

Employee's Name: ______________________________
Last First Middle

Employee's Birth Date: ____/____/______ Employee's SSN: _____—_____—_____

Address: ______________________________
Street City State ZIP

Deceased's Name: ______________________________
Last First Middle

Date of Death or Dismemberment: ____/____/____ Insured's Relationship to Employee ______________

4 Ever Life/BCS Insurance Group Policy No. ______________ Certificate No. ______________
(Attach Group Certificate (unless dependent claim)

4 Ever Life/BCS Insurance Group Policy Effective Date for Employee: ____/____/____ Date to which premium is paid: ____/____/____

Dependent: ____/____/____

Date Employed: ____/____/____ Employee's Occupation: ______________

Was employee at work on above coverage effective date? ☐ Yes ☐ No

If not at work on effective date, when did Employee return to work? ____/____/____ Number of hours worked per week: ______

Amount of Insurance: BASIC: $ __________ SUPP: $ __________ AD&D: $ __________

Amount of this claim ______ 100% ______ 50% ______ 25% What loss is claimed? ______________

Amount of Salary: $ __________ Per ☐ hour ☐ week ☐ month ☐ year Effective date of salary: ____/____/____

Date employee last reported for work: ____/____/____

Reason for employee stopping work: ☐ Deceased ☐ Illness ☐ Injury ☐ Other: __________
☐ Laid-off ☐ Terminated ☐ Vacation ☐ Retired Date: ____/____/____

I certify that the above information is correct based on our records. The information above and any accompanying documents and statements of all the physicians who attended or treated the deceased and all other papers required shall be part of the proofs of claim. The furnishing of this or any related form is not an admission that any insurance was in force on the date of death or dismemberment, nor a waiver of any rights or defenses.

Name of Employer/Company: ______________________________ Telephone: (____) _____—_____

Signed by: ______________________________ Date: __________

Section 2. Beneficiary's Statement

• If there is more than one beneficiary, each beneficiary must complete a copy of this section. • At least one beneficiary must complete the Authorization. • For Life Insurance claims, a certified copy of the death certificate must be attached to the completed form. • If claim is also made for Accidental Death & Dismemberment benefits, beneficiary must complete the reverse side.

Beneficiary's Full Name: ______________________________ SSN: _____—_____—_____
Last First Middle

Address: ______________________________
Street City State ZIP

Birth Date: ____/____/____ Daytime Telephone: (____) _____—_____ Relationship to Insured: __________

Important Tax Notice for Policyowner

Under Federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN) and to include it in any reports of taxable income it makes to the IRS. If you are an individual, your Social Security number is your Taxpayer Identification Number.

Certification: I certify that I am not subject to backup withholding (Section 3406(a)(1)(c) of the Internal Revenue Code), and I am a U.S. person (including a U.S. resident alien). I also certify that the Taxpayer Identification Number on this form is true, correct and complete.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Beneficiary's Signature: ______________________________ Date: __________

Section 3. Authorization

To physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies for organizations (including other insurance companies, BlueCross BlueShield, self-insured, and prepaid health plans) and specifically

______________________________ Hospital(s) and Dr.(s) ______________________________:

You are authorized to permit 4 Ever Life/BCS Insurance Company and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease of ______________________________.
Print Name of Insured

I understand the information obtained will only be used by 4 Ever Life/BCS Insurance Company to determine eligibility for insurance and benefits claimed under the Insured's policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or

organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in the form without my written consent.

I understand this authorization may be revoked by written notice to 4 Ever Life/BCS Insurance Company, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below.

I know I may request a copy of this authorization. I also agree a photocopy of this authorization shall be as valid as the original.

*Limitations, if any:______________________________

Signed ______________________ If other than insured, give relationship ______________________ Date ______________

Section 4. Beneficiary's Statement for Insured's Accidental Death or Dismemberment Please attach any newspaper articles, accident reports, autopsy report, and other documentation to support your claim. Also, please provide the following information:

Insured's Name: ______________________________
Last First Middle

Insured's Address: ______________________________
Street City State ZIP

Insured's Occupation at Time of Accident: ______________________ Date of Employment at this Place: ____/____/____

Date and Time of Accident: ____/____/____ ____:____ ☐ A.M. ☐ P.M.

Date and Time of Death or Dismemberment: ____/____/____ ____:____ ☐ A.M. ☐ P.M.

Place of Accident: ☐ At Work ☐ Recreation ☐ Highway ☐ Home ☐ Other: ______________________

Describe Accident in Detail: ______________________________

Give Names and Addresses of Witnesses (attach separate sheet if necessary)

Name	Address

If automobile accident, was insured: ☐ Driver of Vehicle ☐ Passenger ☐ Pedestrian

Did this accident occur in the course of the insured's usual occupation? ☐ Yes ☐ No

If yes, has workers' compensation claim been presented? ☐ Yes ☐ No

What injuries were sustained? ______________________________

Was immediate first aid sought? ☐ Yes ☐ No If yes, give name and address of:

Doctor: ______________________________

Hospital: ______________________________

Other: ______________________________

Was accident reported to police or other official agency? ☐ Yes ☐ No If yes, give name and address of department or agency:

____

Was an autopsy performed? ☐ Yes ☐ No If copy NOT attached, please complete below:

Autopsy performed by: ______________________ Date Performed: ____/____/____

Address: ______________________________
Street City State ZIP

Names and addresses of all physicians or practitioners who treated insured in last three years.

Name	Address (Street, City, State, ZIP)	Date Treated	Condition Treated

With what companies and in what amounts was life of deceased insured?

Name of Company	Policy Date	Amount	AD&D Benefits
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Beneficiary's Signature: ______________________________ Date: ______________

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

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Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: 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.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** any other person.) Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Disability Proof of Loss Form

Essential StaffCARE

Mail to: Essential StaffCARE, P.O. Box 6702, Columbia, SC 29260-6702

Please note: Failure to complete all sections of this form may result in delayed payment of claims.

Employer Completes This Section

Employer's Name:______________________ Policy Number:______________

Address:______________________ (Street, City, State, ZIP)

Employee's Name:______________________ (Last, First, Middle) SSN:____—____—____

Address:______________________ (Street, City, State, ZIP)

Home Telephone: (____) ____—______ Birth Date: ___/___/___ Sex: ☐ Male ☐ Female

Date Hired: ___/___/___ Effective Date of Coverage: ___/___/___

Base Earnings: Mo $________ Wkly $________ Occupation:______________

Employee laid off prior to this illness? ☐ Yes ☐ No If yes, date: ___/___/___

Date employee first unable to work: ___/___/___ Date employee returned to work: ___/___/___

Was illness or injury due to patient's occupation? ☐ Yes ☐ No (If yes, explain.)

____

I herby certify that the above named employee is a member of our group insurance program and the information stated above is correct to the best of my knowledge and belief.

Employer's Signature:______________________

Title:______________________ Date:______________

Employee Completes This Section

Employee's Name:______________________ (Last, First, Middle) Birth Date: ___/___/___

Date of First Treatment (Illness): ___/___/___ Date of Accident (Injury): ___/___/___

If accident, how did it occur?______________________

____

Did accident occur at work? ☐ Yes ☐ No Date first unable to work: ___/___/___

Did patient have same or similar condition in past? ☐ Yes ☐ No (If yes, when and list name and address of attending physician.)

____

Remarks:______________________

Authorization Instructions: The authorization should be completed and signed by the insured. If the insured is unable to work, the authorization should be completed and signed by the legal guardian or next-of-kin.

To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, the Social Security Administration, Blue Cross Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Planned Administrators, Inc. and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, taxes, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease of: ______________________.

Print Name of Insured

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

______________ ______________ ______________

Signed | Date | Relationship to insured if signed by other than insured

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

______________ ______________

Name | Address

IMPORTANT: Detach the portion below if employee's disability has not terminated. Forward it to the insurance company immediately upon employee's return to work.

Notice of Employee's Return to Work

IMPORTANT: It is the employee's responsibility to inform the insurance company of the date the employee returns to work.

Employee's Name:______________________ Employee's SSN:____—____—____

Returned to work on:______________ 20____ Employer:______________ (Company Name)

Signature:______________________ Date:______________ 20____

Attending Physician's Statement

Patient's Name ______________________________ Age __________
Last First Middle

Address: ______________________________
Street City State ZIP

Authorization to Release Information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.

Signed (Patient):______________________________ Date: ______________ 20______

1A. Diagnosis and concurrent conditions ______________________________
(If Fracture or Dislocation, describe nature and location.)

1B. Is condition due to injury or sickness arising out of patient's employment? (If "Yes" explain.) ☐ Yes ☐ No

____

1C. Is condition pregnancy? ☐ Yes ☐ No Date:______________ 20______
(If "Yes" what was the approximate date of commencement of pregnancy?)

2A. When did symptoms first appear or accident happen? Date:______________ 20______

2B. When did patient first consult you for this condition? Date:______________ 20______

2C. Has patient ever had same or similar condition? ☐ Yes ☐ No______________
(If "Yes" state when and describe.)

3A. Nature of Surgical or Obstetrical Procedure, if any. Date Performed: ______________ 20______ ☐ Inpatient ☐ Outpatient

(Describe fully and include current CPT-4 codes.)______________

3B. If performed in a hospital, give name of hospital and dates hospitalized.______________

From ______________ 20 ______ to ______________ 20 ______

4. Give dates of other medical (Non-Surgical) treatment, if any. Office ______________ 20______ Home ______________ 20 ______

Hospital______________ 20______

5. Is patient still under your care for this condition? ☐ Yes ☐ No Date:______________ 20______
(If "No" give date your services terminated.)

6A. How long was or will patient be continuously totally disabled? From ______________ 20______ to ______________ 20 ______

(Unable to work) If unknown, please estimate anticipated recovery date. Date:______________ 20______

6B. Is this an extension of a previous disability claim? ☐ Yes ☐ No From ______________ 20______ to ______________ 20______
(If yes, provide new dates through which patient will be totally disabled.)

7. To your knowledge does patient have other Health Insurance or Health Plan Coverage? (If "Yes" identify) ☐ Yes ☐ No

____

Signature: ______________________________ Date: ______/______/______

Physician's Name ______________________________ Degree:__________ Telephone: (____) ____—______
(Print) Last First Middle

Address: ______________________________
Street City State ZIP

Individual practitioner's SSN:______—______—______ All others employer I.D. Number: ______________

Fraud Statement

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

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New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

Underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois

Essential StaffCARE BCS pai

Missed Premium Direct Payment Form

Today's Date:____/____/____

Form Instructions

To ensure your coverage is continuous (without lapse) when a payroll premium deduction or deductions were missed:

1. Make a copy of this form.
2. Complete this form. If more than one pay period was missed, please include all beginning and ending dates.
3. Attach a personal check, money order, or cashier's check for the full premium payment due, make payable to Planned Administrators, Inc.
4. Return the form and your premium payment to the address below within 45 days of the missed paycheck date. Missed premium direct payments dated after 45 days of the missed premium cannot be accepted and will be returned.

Notes

- You may not make a direct payment to continue your coverage if you have never had a premium payment deducted from your paycheck or if you are no longer eligible.
- If you have been terminated you may not make up missed premiums. Instead, you will be notified of any rights that you have to continue coverage under COBRA.

Employee Information All blanks must be completed and form must be signed.

Company Name:____

Employee's Name:________________________________ SSN:_____—____—_____
(Please Print) Last First Middle

Maximum of six consecutive weeks of missed premium direct payments will be accepted. After that, coverage will be terminated.

Missed Paycheck Date	Pay Period Beginning Date	Pay Period Ending Date	Total Payment (must match your deduction on previous paystubs)
/ /	/ /	/ /	
/ /	/ /	/ /	
/ /	/ /	/ /	
/ /	/ /	/ /	
/ /	/ /	/ /	
/ /	/ /	/ /	

Employee's Signature:____

Return Form and Payment to: Planned Administrators, Inc.
Attn: Missed Premiums
PO Box 6839
Columbia, SC 29260-6839

Questions? Call the Essential StaffCARE Customer Service Line, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. Spanish-speaking representatives are available. The toll-free number is 1-866-798-0803.

You must return this completed form with your payment.

Underwritten by BCS Insurance Company and 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois

Form # 8.716 ESC Rvs. 05/07