InSync Consulting Services LLC

KEYSOLUTION℠

2022 ENROLLMENT GUIDE

Administration services by
Key Benefit Administration

Information for eligible employees of:

InSync Consulting Services

KEYSOLUTION℠

InSync Consulting Services LLC

MEC Minimum Essential Coverage

MEC provides first dollar coverage with great discount savings for MEC benefits.

There are preventive services covered at 100% for eligible expenses under the required government list of Preventive and Wellness Benefits. Services covered include immunizations, blood pressure screenings, diabetes and cholesterol screenings, prenatal visits for pregnant women and more. A full list of the covered services is included in this information.

The MEC comes with a medical ID Card that needs to be presented to your medical provider at your time of service.

Administration services provided by Key Benefit Administrators.

Minimum Essential Coverage (MEC) covers 100% of eligible expenses for the government listed Preventive and Wellness Benefits.

PREVENTIVE
CARE SERVICES
COVERED AT 100%

UNLIMITED
access to
RealTimeTelemed
and
RealTimeChoices

VALUABLE
BENEFITS FOR THE ENTIRE FAMILY

RealTimeTelemed℠
AN AMERICAN HEALTH DATA INSTITUTE PRODUCT

Access to board-certified doctors by phone or mobile application - at anytime from anywhere with a **$0 copay.** RealTimeTelemed was designed as an alternative to costly urgent care, ER visits or days of waiting for an appointment to see your primary care doctor for non-emergency medical issues.

RealTimeChoices℠
AN AMERICAN HEALTH DATA INSTITUTE PRODUCT

RealTimeChoices is a healthcare price transparency solution that gives you the tools you need to better manage your healthcare.

KEY BENEFIT ADMINISTRATORS

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Preventive Care

Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Unhealthy alcohol use screening and counseling
3. Aspirin use for adults ages 50-59 to prevent Cardiovascular Disease and Colorectal Cancer when prescribed by a physician
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults
6. Colorectal Cancer screening for adults starting at age 50 and continuing until age 75. This does not include Cologuard or FIT- DNA testing. Cologuard or FIT-DNA testing is not covered under the Plan.
7. Depression screening for adults
8. Type 2 Diabetes screening for adults
9. Diet counseling for adults
10. Fall Prevention to include physical therapy to prevent fall in community dwellings age 65 and older
11. Hepatitis B screening for adults
12. Hepatitis C screening for adults at high risk and one time for everyone between the ages of 18 and 79 years old.
13. HIV screening for all adults
14. Immunization vaccines for adults: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, and Varicella.
15. Lung Cancer Screening for adults age 55-80 who are at high risk because they smoke 30 packs a year (or have quit in the past 15 years)
16. Obesity screening and counseling for all adults
17. Sexually Transmitted Infection (STI) prevention counseling and screening for adults
18. Skin Cancer behavioral counseling for adults to age 24 with fair skin
19. Tobacco Use screening, counseling and cessation interventions for all adults
20. Syphilis screening for adults
21. Latent tuberculosis infection screening for adults.
22. Statin preventive medication for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors and a calculated 10 year cardiovascular disease event risk of 10% or greater.
23. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (PrEP) for person considered at high risk of HIV acquisition per USPSTF guidelines on identification of persons at high risk. The USPSTF recommends that the following persons be considered for PrEP: 1) Men who have sex with men, are sexually active, and have one of the following characteristics: (a) A serodiscordant sex partner (ie in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during receptive or insertive anal sex, or (c) A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months; 2) Heterosexually active women and men who have 1 of the following characteristics: (a) A serodiscordant sex partner (ie in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (eg a person who injects drugs or a man who has sex with men and women), or (c) An STI with syphilis or gonorrhea within the past 6 months; and 3) Persons who inject drugs and have 1 of the following characteristics: (a) Shared use of drug injection equipment or (b) risk of sexual acquisition of HIV (see above). It is important to note that men who have sex with men and heterosexually active persons are not considered to be at high risk if they are in a mutually monogamous relationship with a partner who has recently tested negative for HIV. In addition, all persons being considered for PrEP must have a recently documented negative HIV test result. Prior notification is required before PrEP is covered by the Plan; contact the Plan Supervisor at the number on the identification card.

Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Aspirin for pregnant women at high risk for preeclampsia.
3. Bacteriuria urinary tract or other infection screening for pregnant women
4. BRCA counseling and genetic testing for women at higher risk
5. Breast Cancer Mammography screenings every 1 to 2 years for women age 40 and over
6. Breast Cancer Chemoprevention counseling as well as breast cancer testing and medications for women with increased risk for breast cancer
7. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Non- network services will be payable as network services.
8. Cervical Cancer screening
9. Chlamydia Infection screening
10. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
11. Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.
12. Domestic and interpersonal violence screening and counseling for all women
13. Folic Acid supplements for women who may become pregnant when prescribed by a physician
14. Gestational diabetes screening
15. Gonorrhea screening for all women
16. Hepatitis B screening for pregnant women
17. Human Immunodeficiency Virus (HIV) screening and counseling
18. Human Papillomavirus (HPV) DNA Test: HPV DNA testing every three years for women with normal cytology results who are 30 or older
19. Osteoporosis screening over age 65 and older and post menopausal women at increased risk
20. Perinatal Depression counseling interventions for pregnant and postpartum persons at risk.
21. Preeclampsia screening in pregnant women with blood pressure measurements throughout pregnancy.
22. Routine prenatal visits for pregnant women
23. Rh Incompatibility screening for all pregnant women and follow-up testing
24. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
25. Sexually Transmitted Infections (STI) counseling
26. Syphilis screening
27. Urinary Incontinence screening
28. Well-woman visits to obtain recommended preventive services
29. Anxiety screening in adolescent women and adult women, including but not limited to, those who are pregnant or postpartum.

Covered Preventive Services for Children

1. Alcohol and Drug Use assessments
2. Anemia screening for children
3. Autism screening for children limited to two screenings up to 24 months
4. Behavioral assessments for children limited to 5 assessments up to age 17.
5. Bilirubin concentration screening for newborns.
6. Blood screening for newborns.
7. Blood Pressure screening
8. Cervical Dysplasia screening
9. Congenital Hypothyroidism screening for newborns
10. Depression screening for adolescents age 12 and older
11. Developmental screening for children under age 3, and surveillance throughout childhood
12. Dyslipidemia screening for children.
13. Fluoride Chemoprevention to include supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5.
14. Gonorrhea preventive medication for the eyes of all newborns
15. Hearing screening for all newborns and 3 additional screenings at periodic ages up to age 21.
16. Height, Weight and Body Mass Index measurements for children.
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents
19. HIV screening for adolescents
20. Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, and Varicella.
21. Iron supplements for children ages 6 to 12 months when prescribed by a physician
22. Lead screening for children
23. Maternal depression screening for mothers of infants at 1, 2, 4, and 6 month visits.
24. Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
25. Obesity screening and counseling
26. Oral Health risk assessment for young children up to age 10.
27. Phenylketonuria (PKU) screening in newborns
28. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
29. Skin Cancer behavioral counseling for children age 6 months and up who have fair skin
30. Tobacco Use screening, counseling and interventions to prevent initiation of tobacco use
31. Tuberculin testing for children
32. Vision screening for children.

For complete information on preventative services, visit the following US Health and Human Services website: www.healthcare.gov/coverage/preventive-care-benefits

KEY BENEFIT ADMINISTRATORS

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MEC Minimum Essential Coverage

	MEC
Covered Benefits	**In-Network**
Deductible (single/family)	$0/$0
Coinsurance (employee portion)	0%
Out-of-Pocket Maximum	$0/$0
PPO Network	
Emergency Room Services	N/A
Inpatient Hospital Services	N/A
Primary Care Visit to Treat an Injury or Illness	N/A
Specialist Visit	N/A
Mental/Behavioral Health and Substance Abuse Disorder Services	N/A
Advanced Imaging (CT, PET Scans, MRIs)	N/A
Rehabilitative Speech Therapy	N/A
Rehabilitative Occupational and Rehabilitative Physical Therapy	N/A
Preventive Care/ Screening/Immunization (MEC)	Covers 100% of the government's listed Preventive and Wellness Benefits
Laboratory Outpatient and Professional Services	N/A
X-rays and Diagnostic Imaging	N/A
Outpatient Facility Fee	N/A
Outpatient Surgery Physician/Surgical Services	N/A
Chronic Disease Management (CDM) Benefit	N/A
Life AD&D Benefit	N/A
RealTime Services	
RealTimeTelemed	Unlimited Calls
RealTimeChoices	Unlimited Access

MONTHLY RATES
EMPLOYEE
$79.20
EMPLOYEE + SPOUSE
$122.93
EMPLOYEE + CHILDREN
$191.39
FAMILY
$235.11

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MEC Plus

This plan includes the MEC Preventive benefits and the Fully Insured Indemnity benefits

	MEC Plus
Covered Benefits	**In-Network**
Inpatient Hospital Daily Indemnity Benefit	$100 daily benefit, 180 maximum days
Outpatient Physician Office Visit Daily Indemnity Benefit	$30 per day, 6 day maximum per benefit period
Outpatient Diagnostic X Ray and Lab Daily Indemnity Benefit	$50 per day with a 2 day maximum per benefit period
Daily Prescription Drug Benefit	$15 per day, 20 day maximum per benefit period
Initial Hospital Admission Daily Indemnity Benefit	$500 per day, 1 day maximum with 1 Admission per benefit period
Ambulance Service Daily Indemnity Benefit	$100 per day, 3 day maximum per benefit period
RealTime Services	
RealTimeTelemed	Unlimited Calls
RealTimeChoices	Unlimited Access

MONTHLY RATES
EMPLOYEE
$123.22
EMPLOYEE + SPOUSE
$212.75
EMPLOYEE + CHILDREN
$284.67
FAMILY
$377.25

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MVP Minimum Value Plan

The Minimum Value Plan (MVP) is a high deductible plan offering very limited coverage. This MVP excludes some categories of services that are typically covered by plans being offered on the Exchange and individual market. The MVP covers the following services after your $6,500 deductible is met. Emergency Room Services, Inpatient Hospital Services, Primary Care and Specialist visits, Imaging, Laboratory Services, X-rays and Diagnostic Imaging, and certain Generic and Preferred Brand drugs. Please pay close attention to the list of excluded benefit categories outlined below.

RealTimeHealth℠
AN AMERICAN HEALTH DATA INSTITUTE PRODUCT

RealTimeHealth is a diabetic management program that uses a state of the art cellular based glucometer to automatically, consistently and accurately take and record a member's glucose readings.

RealTimeChoices℠
AN AMERICAN HEALTH DATA INSTITUTE PRODUCT

RealTimeChoices is a healthcare price transparency solution that gives you the tools you need to better manage your healthcare.

The MVP offers a very limited benefit plan design excluding the following major service categories:

- Mental/Behavioral Health and Substance Abuse Disorder Services
- Rehabilitative Speech Therapy
- Rehabilitative Occupational and Rehabilitative Physical Therapy
- Skilled Nursing Facility
- Outpatient Facility Fees
- Outpatient Surgery Physician/Surgical Services
- Specialty Drugs (including compound drugs)
- Drugs related to mental health such as ADHD

The MVP offers a plan design with a $6,500 single deductible and a $13,200 family deductible. The Coinsurance responsibility is 40% paid by the enrolled member. The out-of-pocket maximum is $6,500 for single and $13,200 for a family.

As a MVP member, you will receive a medical ID Card that needs to be presented to your medical provider at your time of service.

Note: Because almost every benefit category is subject to the deductible it is important that you budget for the $6,500 deductible which comes out to be $541 a month in addition to your maximum premium contribution.

IMPORTANT

In order to enroll in the MVP program, there is an additional application that must be completed by the applicant. This application is mandatory and will require extensive information to complete. Below is a listing of items that are needed to complete the application.

- **Prior Medical Insurance information including:** Name of Carrier, Policy No., Effective Date, Termination Date (if applicable), Policy Holder's Name, Member ID, Employer Name, List of the Dependents covered on previous policy. This includes all Employer Sponsored Medical Plans, Medicaid, Medicare, Champus and Tricare.
- **Other Health Insurance Information including:** Name of Carrier, Policy No., Effective Date, Termination Date (if applicable), Policy Holder's Name, Member ID, Employer Name, List of the Dependents covered on previous policy. This includes all Employer Sponsored Medical Plans, Medicaid, Medicare, Champus, Tricare, etc.
- **Dependent information:** Full Name, Date of Birth, Social Security No., Date of Birth, Gender, Height, Weight. This includes minor dependents and spouses.
- **Medical History for the Past Five Years:** Physician Visit History, Chronic Condition History, Name, Address and Phone Number of diagnosing and treating physicians, begin and end date of treatment, treatment description and degree of recovery.

MVP

	MVP
Covered Benefits	**In-Network**
Deductible (single/family)	$6,500 / $13,200
Co-Insurance	60% (plan portion)
Out-of-Pocket Maximum (Single/Family)	$6,500 / $13,200
Emergency Room Services	$6,500 Deductible
Inpatient Hospital Services	$6,500 Deductible
Primary Care Visit to Treat an Injury or Illness	$50 Co-Pay and 60% Co-Insurance*
Specialist Visit	$70 Co-Pay and 60% Co-Insurance*
Mental/Behavioral Health and Substance Abuse Disorder Services	NOT COVERED
Advanced Imaging (CT, PET Scans, MRIs)	$6,500 Deductible
Rehabilitative Speech Therapy	NOT COVERED
Rehabilitative Occupational and Rehabilitative Physical Therapy	NOT COVERED
Preventive Care/ Screening/Immunization (MEC)	Covers 100% of the government's listed Preventive and Wellness Benefits
Laboratory Outpatient and Professional Services	$6,500 Deductible
X-rays and Diagnostic Imaging	$6,500 Deductible
Outpatient Facility Fee	NOT COVERED
Outpatient Surgery Physician/Surgical Services	NOT COVERED
Chronic Disease Management (CDM) Benefit	Covered Services at 100% (61) for 26 Predefined Chronic Diseases
Life AD&D Benefit	N/A
RealTimeChoices Transparency Program	UNLIMITED ACCESS
RealTimeHealth Diabetic Program	100% COVERED
Prescription Drugs	
Generic Drugs	$6,500 Deductible
Certain Preferred Brand Drugs	$6,500 Deductible
Certain Non-Preferred Brand Drugs	NOT COVERED
Specialty Drugs & Compounds	NOT COVERED

RATES
FOR ACTUAL RATES
See Next Page

*60% is plan portion for primary care visits to treat an injury or illness and specialist visits.

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MVP Benefit Counselor Line

PLEASE READ CAREFULLY

KEYSOLUTION MVP BENEFIT COUNSELOR LINE

The MVP Benefit Counselors are only available for questions specific to the MVP. If you have questions about any other parts of the KeySolution 5M program please contact your Human Resources representative and they will be happy to help answer any questions you might have.

WHAT DO I NEED PRIOR TO CALLING?

You must request, complete and return the MVP Health Questionnaire (MHQ) from your Human Resources Department. Prior to calling, please ensure that you have a copy of your most recent payroll stub readily available. Please allow five business days after submitting your MHQ before calling the counselor line. KBA must receive your MHQ prior to taking your call.

WHAT CAN I EXPECT FROM THIS CALL?

Our MVP Benefit Counselors are happy to help with any questions related to the KeySolution 5M MVP. The Benefit Counselor will walk through your contribution requirement for the MVP (9.61% of your gross annual income). They will also walk through the benefit categories that are and are not covered by the MVP.

PRE-CALL CHECKLIST

- ☐ Request Health Questionnaire from HR
- ☐ Complete Health Questionnaire
- ☐ Return Health Questionnaire to HR
- ☐ Obtain Copy of Recent Payroll Stub
- ☐ Wait Five (5) Business Days Before Calling

CONTACT

Key Benefit Administrators
KeySolution MVP Benefit Counselor Line

1.866.613.3450

Key Group Dental Insurance

THE GROUP DENTAL PLAN*

Key Group dental plans cover allowable charges for dental services at 100% coverage for preventive services, 80% coverage for basic services and 50% coverage for major services. The combined annual deductible is only $50 per person, which applies to all covered dental services.

PREVENTIVE SERVICES INCLUDE:

Routine exams and cleanings, emergency treatment for dental pain (minor), bitewing x-rays and fluoride, fluoride treatment for children under age 19.

BASIC SERVICES INCLUDE:

Simple restorative services, simple teeth removal, sealants for children ages 6-15 (one per 36 months), x-rays (full mouth or panorex, one per 36 months), x-rays of the roots of teeth.

MAJOR SERVICES INCLUDE:

Space maintainers, endodontics (includes root canals), periodontics, surgical teeth removal and other oral surgery, medically appropriate anesthesia related to covered surgery, major restorative services (crowns and inlays), dental implants (age 17 and up), denture relines (if over six months of installation), recementation and repair of crowns, inlays, bridges and dentures.

	Plan 3	Plan 4
PREVENTIVE		
Deductible	$50	$50
Waiting Period	N/A	N/A
Coinsurance	100%	100%
Exams	2 per Calendar Year	2 per Calendar Year
Bitewing and Fluoride	1 per Calendar Year	1 per Calendar Year
BASIC		
Deductible	$50	$50
Waiting Period	N/A	N/A
Coinsurance	80%	80%
MAJOR		
Deductible	$50	$50
Waiting Period	12 month	12 month
Coinsurance	50%	50%
ORTHO CHILD ONLY**		
Coinsurance	N/A	N/A
Deductible	N/A	N/A
Lifetime Max	N/A	N/A
Waiting Period	N/A	N/A
CALENDAR YEAR MAX	$1,000	$750

* Payment is based upon allowable charges in the area in which service is rendered. This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. Please see your certificate for details.

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KEY BENEFIT ADMINISTRATORS

Dental Plan

Monthly Rate	Plans	
	Plan 3	Plan 4
Employee Only	$36.96	$33.66
Employee + Spouse	$73.92	$67.31
Employee + Child(ren)	$79.71	$78.08
Family	$118.38	$110.14

Key Group Vision Insurance

VISION CARE SERVICES:	IN-NETWORK	OUT-OF-NETWORK
Exam with Dilation (as necessary)	$10 Copay	$35 Allowance
Contact Lens Fit and Follow-up: (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed)		
Standard**	$0 Copay	$40 Allowance
Premium***	$0 Copay, 10% off retail, then apply $55 allowance	$40 Allowance

FRAMES:	IN-NETWORK	OUT-OF-NETWORK
Any available frame at provider location	$100 Frame allowance, 20% off balance over allowance	$45 Allowance

STANDARD PLASTIC LENSES:	IN-NETWORK	OUT-OF-NETWORK
Single	$10 Copay	$25 Allowance
Bifocal	$10 Copay	$40 Allowance
Trifocal	$10 Copay	$55 Allowance

STANDARD PLASTIC LENSES:	IN-NETWORK	OUT-OF-NETWORK
UV Coating	$15 Copay	Discount available only at Network providers and retailers
Tint (Solid and Gradient)	$15 Copay	
Standard Scratch Resistant Coating	$15 Copay	
Standard Polycarbonate	$40 Copay	
Standard Anti-Reflective Coating	$45 Copay	
Standard Progressive (Add-On to Bifocal)	$75 Copay	
Other Add-Ons and Services	20% off retail	

CONTACT LENSES (MATERIAL ONLY):	IN-NETWORK Conventional and Disposable	OUT-OF-NETWORK
Not Medically Necessary	$0 Copay, $80 allowance, 15% off balance over allowance (conventional only).	$64 allowance
Medically Necessary	Paid in full	$200 allowance

FREQUENCY:	
Examination	12 months
Frames	24 months
Eyeglass Lenses	12 months†
Contact Lenses (in lieu of eyeglass lenses)	12 months††

**Standard Contact Lens Fitting: spherical clear contact lenses in conventional wear planned replacement (examples include, but not limited to, disposable, frequent replacement, etc.).

***Premium Contact Lens Fitting - all lenses design, materials and fittings other than Standard (examples include, but not limited to, toric, multifocal, etc.)

†Eyeglass lenses are paid in lieu of the contact lenses benefit. Once in a 12-month period defined by last date of service.

††The contact lens benefit is paid in lieu of eyeglass lenses. Once in a 12-month period defined by last date of service.

Disclaimer: This is a summary of benefits only. Please refer to the policy for comprehensive benefit details. Payment is based upon allowable charges in the area in which the service is rendered.

Key Group Vision Plan

Vision Exam Copay	$10
Frames	$100 Allowance
Eye Exam Frequency	12 months
Lenses Frequency	12 months
Frames Frequency	24 months
Contact Lenses Frequency	12 months

MONTHLY RATES

Employee Only	$9.53
Employee and Spouse	$23.79
Employee and Children	$28.15
Family	$37.45

ENROLLMENT / WAIVER
INSCRIPCIÓN / RENUNCIA A
MEC(Minimum Essential Coverage)+Supplements

CLIENT ID / NAME
NÚMERO DE IDENTIFICACIÓN / NOMBRE DEL CLIENTE
Insync Consulting

Section 1: **Employee Information** / Sección 1: **Datos del Empleado**

EMPLOYEE NAME
NOMBRE DEL EMPLEADO

EMAIL ADDRESS
CORREO ELECTRÓNICO

DATE OF BIRTH
FECHA DE NACIMIENTO

PHONE NUMBER
TELÉFONO

ADDRESS
DIRECCIÓN

CITY
CIUDAD

STATE
ESTADO

ZIP
CÓDIGO POSTAL

HIRE DATE
FECHA DE CONTRATACIÓN

MARITAL STATUS
ESTADO CIVIL
☐ SINGLE SOLTERO/A ○ MARRIED CASADO/A

GENDER
GÉNERO
○ MALE MASCULINO ☐ FEMALE FEMENINO

SOCIAL SECURITY
NÃŠMERO DEL SEGURO SOCIAL

Section 1a: **Dependent Information** / Sección 1a: **Información Dependiente**

DEPENDENT LEGAL NAME NOMBRE LEGAL DEL DEPENDIENTE	GENDER GÉNERO	RELATIONSHIP PARENTESCO	DATE OF BIRTH FECHA DE NACIMIENTO	SOCIAL SECURITY NÃŠMERO DEL SEGURO SOCIAL

Section 2: **Coverage Election** / Section 2: **Selección De Cobertura**

	MEC	MEC Plus	MVP		
EMPLOYEE (EE) ONLY EMPLEADO (EE) ÚNICAMENTE	☐ 79.20	☐ 123.22	☐ 757.27	☐	☐
EE + SPOUSE EE + CÓNYUGE	☐ 122.93	☐ 212.75	☐ 1,458.01	☐	☐
EE + CHILDREN EE + HIJO(S)	☐ 191.39	☐ 284.67	☐ 1,953.10	☐	☐
FAMILY FAMILIA	☐ 237.60	☐ 377.25	☐ 2,432.96	☐	☐

DECLINE COVERAGE
DECLINAR COBERTURA

☐ WAIVE MEDICAL COVERAGE
RENUNCIA DE COBERTURA MÉDICA
(SKIP TO SECTION 3)
(CONTINÚE EN LA SECCIÓN 3)

Section 2a: **Voluntary Benefit Options** / Sección 2a: **Beneficios Voluntarios**

Additional forms need to be submitted per elected voluntary coverage / Se deben presentar formularios adicionales según la cobertura voluntaria elegida

	DENTAL / DENTAL		VISION / VISIÓN	SHORT TERM DISABILITY DISCAPACIDAD A CORTO PLAZO	CRITICAL ILLNESS ENFERMEDAD CRÍTICA	COMPANION LIFE INSURANCE* COMPANION PÓLIZA DE SEGURO DE VIDA
	Plan 3	Plan 4				
EMPLOYEE (EE) ONLY EMPLEADO (EE) ÚNICAMENTE	☐ 36.96	○ 33.66	☐ 9.53	○ ○ ○ ○ ○	○ 5K ○ 10K ○ 15K ○ 20K	☐ 10k ○ 25K ○ ○ ○
EE + SPOUSE EE + CÓNYUGE	○ 73.92	○ 67.31	○ 23.79		○ 5K ○ 10K ○ 15K ○ 20K	○ 5K ○ ○ ○ ○ ○
EE + CHILDREN EE + HIJO(S)	○ 79.71	○ 78.08	○ 28.15		○ 5K ○ 10K ○ 15K ○ 20K	○ 2.5 ○ 5K ○ 7.5 ○ 10K
FAMILY FAMILIA	○ 118.38	○ 110.14	○ 37.45		○ 5K ○ 10K ○ 15K ○ 20K	

*Age banded; max spouse coverage limited to 50% of EE's elected coverage, up to $50k
La cobertura máxima del cónyuge está limitada al 50% de la cobertura elegida por el empleado

Notes / Notas

Acceptance of Coverage / Aceptación De Cobertura

Please read carefully before signing: I certify that the information on this enrollment form is true and complete. I acknowledge that I have been offered a Minimum Value Plan. I authorize my employer to deduct from my pay the amount listed above to pay the premiums for myself and/or my dependents. All dependents listed are my dependents as defined in the Plan Document. I understand that coverage will not be effective unless I complete all necessary forms for my above selected plans that I am electing. I understand all benefit options available. I cannot change or revoke any pre-tax election until the next open enrollment for the policy period unless I have a qualifying change in family status, such as: marriage, divorce, death of spouse or child, birth or adoption of a child, termination or commencement of employment status from full-time to part-time or part-time to full time, my spouse or I taking unpaid leave of absence, and such other events as a plan administrator determines will permit a change or revocation of an election. I also understand that if there are any changes to my family status or coverage status, I have 30 days to notify Human Resources or otherwise accept any penalty that may incur as a result in my failure to notify Human Resources. I authorize any health care provider to release all information pertaining to care provided to me or my dependents. A photocopy of this authorization shall be valid as the original. I understand that by participating in the Pre-Tax (Section 125) Plan, my Social Security benefits may be affected because the above elections will be deducted before my salary is taxed. Prior to each plan year, I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at this time, I will continue having my current election amounts plus any applicable increases deducted from my pay for the new plan year.

Por favor, lea atentamente antes de firmar: Certifico que la información en este formulario de inscripción es verdadera y completa. Reconozco que se me ha ofrecido un Plan de Valor Mínimo. Autorizo a mi empleador a que deduzca de mi pago las primas de mi plan y/o de mis dependientes, la suma a deducir corresponderá a la cantidad indicada anteriormente. Todos los dependientes que se describen en la lista son mis dependientes en conformidad a la definición del Documento del Plan. Entiendo que la cobertura de los planes que arriba seleccionados y que estoy eligiendo, no se hará efectiva a menos de que sean diligenciados todos los formularios necesarios. Comprendo todas las opciones de beneficios que se encuentran disponibles. No puedo cambiar o revocar ninguna opción de pre-impuestos hasta que el inicio del próximo periodo de inscripción de la póliza, a menos que se presente alguna modificación del estado familiar como: matrimonio, divorcio, fallecimiento de cónyuge o hijo, nacimiento o adopción de un hijo, terminación de contrato o cambio de un empleo de tiempo completo a tiempo parcial o viceversa, en ocasión en que mi cónyuge o yo tengamos una licencia no remunerada y cualquier otro evento que un administrador del plan determine que pueda permitir un cambio o revocación de un plan seleccionado. También entiendo que, si se presenta alguna novedad familiar o se presenten cambios en mi estado de cobertura, cuento con 30 días para notificar a la oficina de Recursos Humanos o de lo contrario se me podría impugnar alguna penalidad. Autorizo a cualquier proveedor de atención médica a propagar información acerca de atenciones médicas relacionadas conmigo o con mis dependientes. Una fotocopia de esta autorización se considerará de igual valor que la original. Entiendo que al participar en el Plan Pre-Impuestos (Sección 125), mis beneficios con el Seguro Social pueden verse afectados debido a que aquí selecciono será deducido de mi salario antes de mi declaración de impuestos. Cada año antes que el plan se renueve, se me ofrecerá la oportunidad de cambiar mis beneficios para el siguiente año del Plan. Si durante este periodo no diligencio y reenvío un nuevo formulario que liste mi nueva elección de beneficios, continuaré con los montos de mi selección actual más cualquier aumento que sea deducido de mi sueldo para el nuevo año del plan.

SIGNATURE
FIRMA

DATE
FECHA

Section 3: **Waiver of Coverage** / Sección 3: **Renuncia De Cobertura**

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself and/or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

Al firmar a continuación, certifico que se me ha dado la oportunidad de solicitar un plan de cobertura para mí y mis dependientes elegibles, si los hubiera. Estoy rechazando la inscripción como se indicó anteriormente. Entiendo que estoy rechazando la inscripción para mí y/o para mis dependientes elegibles (incluyendo a mi cónyuge) debido a otro seguro de salud o cobertura de un plan de salud de familiar. Puede que pueda afiliarme junto con mis dependientes elegibles a este plan en el caso en que yo, o mis dependientes perdamos la elegibilidad para la cobertura de otro seguro de salud (o si el empleador dejara de contribuir con mi plan de cobertura o las mis dependientes elegibles).

SIGNATURE
FIRMA

DATE
FECHA

OFFICIAL USE ONLY ☐ CARRIER ☐ HRP DATE OF HIRE EFFECTIVE DATE HR REP