HABLAMOS **ESPANOL!**

## PEAK Technical

# It's Time to Choose Your 2016 Health Benefits

Choose Plan A, B or Both...

## A

### Plan A
**Wellness + Preventive**

Minimum Essential Coverage

**Starting at $15.84 / weekly**

## B

### Plan B
**Hospital Indemnity**

+ Sickness, Dr. Office Visits + Rx +
Accident, X-Ray + Teledoc
+Health Patient Advocacy + Hospitalization Benefits

**Starting at $30.08/ weekly**

optional purchase to add to coverage

## C

### Plan C:
**Optional Benefits**

+ Life +Dental
+ Short-Term Disability

***Enroll Today. Time is Limited.***

**IF YOU HAVE QUESTIONS ABOUT THE BENEFITS AVAILABLE TO YOU, PLEASE CALL**

## 866-629-5456

**MONDAY-FRIDAY 8AM - 7PM EST**

# Health Care for Everyone

The Affordable Care ACT (ACA) requires individuals to be enrolled in Minimum Essential Coverage (MEC) beginning on January 1, 2014, or pay a penalty (Individual Shared Responsibility). Employees and their family members can avoid the Individual Shared Responsibility penalty in 2016 if they are enrolled in Minimum Essential Coverage for all months in 2016 (may qualify for an exemption if your coverage gap is less than 3 months). Plan A provides Minimum Essential Coverage and enrolled members can satisfy the shared responsibility requirement for each month enrolled.

If you don't have coverage at all in 2016, you'll pay the higher of these two amounts:

- 2.5% of your yearly household income. (Only the amount of income above the tax filing threshold, about $10,150 for an individual, is used to calculate the penalty.) The maximum penalty is the national average premium for a Bronze plan.
- $695 per person for the year ($347.50 per child under 18). The maximum penalty per family using this method is $975.



## PLAN A PREVENTIVE SERVICES

Plan A covers 64 preventive services required per the government list of Preventive and Wellness Benefits. This list includes diabetes and cholesterol screenings, prenatal visits for pregnant women, and more. These benefits are covered at 100% when you visit a network provider. The benefits drop to 40% if you use an out-of-network provider. A full list of the covered services is provided. Plan A is Minimum Essential Coverage.



## PLAN B

Plan B offers coverage for things like doctor's office visits, laboratory services and X-rays. Plan B is a limited medical benefit plan. The amount of benefits that are paid for each covered service are shown on the Plan B page. These dollar amounts are what the insurance company pays for each covered service. Benefit payments are limited to what is shown in the table.



## NATIONAL PPO, NATIONAL DISCOUNTS

It is important that you use network doctors and medical facilities. If you use an out-of-network medical provider, the plan will pay fewer benefits. You can find in-network doctors and medical facilities at www.multiplan.com, or by calling First Staff Benefits at 866.629.5456.



## MEDICAL ID CARDS

As a member you will receive medical ID cards that need to be presented to your medical provider at the time of service

# Plan A | WELLNESS + PREVENTIVE ONLY

*Plan A is administered by Key Benefit Administrators, P.O. Box 129, Fort Mill, SC 29716*

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

| | |
|---|---|
| 1 | Abdominal Aortic Aneurysm one time screening for age 65-75 |
| 2 | Alcohol Misuse screening and counseling |
| 3 | Aspirin use for men ages 45 - 79 and women ages 55-79 to prevent CVD when prescribed by a physician |
| 4 | Blood Pressure screening |
| 5 | Cholesterol screening for adults |
| 6 | Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years |
| 7 | Depression screening |
| 8 | Type 2 Diabetes screening |
| 9 | Diet counseling |
| 10 | HIV screening |
| 11 | Immunization vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis) |
| 12 | Obesity screening and counseling |
| 13 | Sexually Transmitted Infection (STI) prevention counseling |
| 14 | Tobacco Use screening and cessation interventions |
| 15 | Syphilis screening |

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

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

## 26 COVERED PREVENTIVE SERVICES FOR CHILDREN

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

| WEEKLY | Employee | Employee + Spouse | Employee + Child(ren) | Family |
|---|---|---|---|---|
| PLAN A | $15.84 | $22.70 | $43.70 | $50.55 |

*This plan provides no coverage for sickness/hospitalization/surgical benefits. Refer to Plan B for those additional benefits including surgical/hospitalization/sickness.*

# Plan B

If you purchase Plan B you will receive limited medical benefits for sickness, accident, hospitalization and surgery.

## MEDICAL BENEFITS

| HOSPITAL INDEMNITY BENEFITS | | |
|---|---|---|
| | OPTION 1 | OPTION 2 |
| **In Hospital Benefits** | **(The amounts listed below are what the insurance company pays)** | |
| Daily In-Hospital Indemnity Benefit | $400 per day, 31 days max | $600 per day, 31 days max |
| Inpatient Surgical Indemnity Benefit Rider | $1,500 and 20% Anesthesia | $2,000 and 20% Anesthesia |
| Outpatient Surgical Indemnity Benefit Rider | $750 and 20% Anesthesia | $1,000 and 20% Anesthesia |
| Outpatient Physician Office Visit Indemnity Benefit | $80 per visit, 6 per year | $100 per day, 6 days max |
| Outpatient Diagnostic Lab Indemnity Benefit | $20, 2 days maximum | $30 per day, 4 days max |
| Outpatient Select Diagnostic Test Indemnity Benefit Rider | $100, 2 days maximum | $150 per day, 2 days max |
| Outpatient Advanced Studies Diagnostic Test Indemnity Rider | $400, 1 day maximum | $600 per day, 2 days max |
| Outpatient Prescription Drug Benefit | $30 generic, $60 brand 12 scripts max annually | $35 generic, $70 brand 12 scripts max annually |
| Wellness Benefit | $100 per occurrence, 1 max | $150 per occurrence, 1 max |
| Emergency Room Sickness Benefit | $200 per occurrence, 2 max | $200 per occurrence, 2 max |
| Inpatient Daily Intensive Care Benefit | $200 per day, 30 days max | $300 per day, 30 days max |
| Life & AD&D* | Employee: $10,000 Benefit Spouse: $5,000 Benefit Child(ren): $2,500 Benefit | Employee: $10,000 Benefit Spouse: $5,000 Benefit Child(ren): $2,500 Benefit |
| PPO | Multiplan | Multiplan |

| PLAN B WEEKLY PREMIUMS | | | | |
|---|---|---|---|---|
| | Employee | Employee + Spouse | Employee + Child(ren) | Family |
| OPTION 1 | $30.08 | $61.42 | $51.57 | $75.58 |
| OPTION 2 | $38.30 | $79.86 | $66.38 | $98.33 |

| COMBINED PLAN A + PLAN B WEEKLY PREMIUMS | | | | |
|---|---|---|---|---|
| | Employee | Employee + Spouse | Employee + Child(ren) | Family |
| OPTION 1 | $45.92 | $84.12 | $95.27 | $126.13 |
| OPTION 2 | $54.14 | $102.56 | $110.08 | $148.88 |

On all plan B benefits (with the exception of vision) missed premium is not required to be made up. If you miss **5 consecutive weeks** of payroll deductions your plan B benefits with terminate back to the last paid date. These rules do not apply to plan A.

*Please refer to your plan document for a detailed description of all exclusions.*

# Plan C

## ADDED COVERAGE: Purchase Optional Products

| SHORT-TERM DISABILITY INCOME INSURANCE - WEEKLY COST<br>*You must enroll in Plan B to purchase disability insurance.* | | |
|---|---|---|
| Elimination Period for Accident and Sickness | **14 days** | **Employee Only $4.95** |
| Maximum Disability Period | **6 months** | |
| Maximum Benefit Per Month | **$800** | |

| DENTAL INSURANCE<br>*You must enroll in Plan B to purchase dental insurance.* | |
|---|---|
| **Maximum Available Allowance** | $1,000 |
| **Coinsurance** | Diagnostic and Preventive Services: 80%<br>Basic Restorative Services: 50%<br>Major Restorative Services: 50% |
| **Deductible** | $50 Waived for Diagnostic and Preventive Services. No Family Maximum |
| **Waiting Period** | No waiting period for Diagnostic and Preventive and Basic Restorative Services; 12 months for Major Restorative Services. |

| DENTAL WEEKLY COST | |
|---|---|
| **Employee** | $4.51 |
| **Employee + Spouse** | $8.76 |
| **Employee + Child(ren)** | $9.52 |
| **Family** | $14.69 |

| $10,000 GROUP TERM LIFE WITH AD&D<br>*You must enroll in Plan B to purchase group term life insurance.* | |
|---|---|
| Employee Only, Weekly | **$1.06** |

# Plan C

## ADDED COVERAGE:
## Purchase Optional Products

| VISION INSURANCE | | |
|---|---|---|
| **Benefits** | **In-Network** | **Out of Network** |
| Contribution | Voluntary | |
| Product Type | Exam with Materials | |
| Network Type | Full Network | |
| **Benefits** | **Participating Provider** | **Non-Participating Provider*** |
| Examination (Once Every 12 months) | 100% | Up to $40 |
| Single/Bifocal/Trifocal Lens (Standard Plastic) (Once Every 12 months) | 100% | Up to $40/$60/$80 |
| Lenticular Lenses | 100% | Up to $80 |
| Retail Frame Allowance (Once Every 24 months) | Up to $130 | Up to $45 |
| Discount on Frame Overage at Participating Providers | 30% | N/A |
| Covered Selection Contacts | Up to 4 boxes | Up to $105 |
| Non-Selection Contacts | Up to $105 | Up to $105 |
| Necessary Contact Lenses | 100% | Up to $210 |
| Covered-in-full-Lens Options | Standard Scratch-Resistant Coating | N/A |
| Non-Covered Lens Options | Price Protection available for non-covered lens options ranging from 20-60% off retail pricing at participating providers. | |
| Laser Vision Discount | Advantica is proud to add value to your vision care program by offering access to discounted laser vision correction procedures through Laser Vision Network of America (LVNA). Members receive a discount of 15% off standard prices or 5% off promotional prices with any in-network surgeon | |

| Vision Weekly Cost | |
|---|---|
| Employee | $2.29 |
| Employee + Spouse | $3.75 |
| Employee + Child (ren) | $4.12 |
| Family | $5.62 |
| | **WEEKLY** |

Vision requires weekly premium payments in order to maintain coverage.

# ENROLLMENT FORM

**YOU MUST COMPLETE THIS ENROLLMENT FORM**

Group Name **PEAK Technical** ID# Location Effective Date

| | | | | |
|---|---|---|---|---|
| Member (Last, First, M.I.) | ☐Male ☐Female | Social Security No. | Date of Birth | |
| Spouse (Last, First, M.I.) | ☐Male ☐Female | Social Security No. | Date of Birth | Date of Marriage |
| Date of Hire / Avg hours worked per week | Annual Salary | Email Address | Employee ID | |
| Home address Street | Apt # | City | State | Zip Code |
| Home phone | Work phone/ext. | | | |

| Child name / Social Security Number | Date of birth | Gender | Full Time Student | Child name / Social Security Number | Date of birth | Gender | Full Time Student |
|---|---|---|---|---|---|---|---|
| | | ☐ M ☐F | ☐ Yes ☐No | | | ☐ M ☐F | ☐ Yes ☐No |
| Child name / Social Security Number | Date of birth | Gender | Full Time Student | Child name / Social Security Number | Date of birth | Gender | Full Time Student |
| | | ☐ M ☐F | ☐ Yes ☐No | | | ☐ M ☐F | ☐ Yes ☐No |

## MEDICAL

TransChoice Advance® Limited Benefit Medical Coverage

| **Weekly Premiums** | **Plan A** | **Plan B 1** | **Plan B 2** |
|---|---|---|---|
| Employee Only | ☐ $15.84 | ☐ $30.08 | ☐ $38.30 |
| Employee plus Spouse | ☐ $22.70 | ☐ $61.42 | ☐ $79.86 |
| Employee Plus Child(ren) | ☐ $43.70 | ☐ $51.57 | ☐ $66.38 |
| Employee & Family | ☐ $50.55 | ☐ $75.58 | ☐ $98.33 |

Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐Yes ☐No
If "Yes", List name(s)_____, who will be excluded from coverage.

Are you actively at work on a full time basis and able to perform the regular duties of your occupation? ☐Yes ☐No
If "No" , you and your dependents are not eligible for coverage.

If applying for spouse and/or child(ren) coverage, is/are any of the proposed insured currently disabled? ☐Yes ☐No
If "Yes", List name(s)_____, who will be excluded from coverage.

## DENTAL

**YOU MUST BE ENROLLED IN THE MEDICAL PLAN TO PURCHASE THIS COVERAGE.**

| **Weekly Premiums** | |
|---|---|
| Employee Only | ☐ $4.51 |
| Employee plus Spouse | ☐ $8.76 |
| Employee plus Child(ren) | ☐ $9.52 |
| Employee & Family | ☐ $14.69 |

## VISION

| **Weekly Premiums** | |
|---|---|
| Employee Only | ☐ $2.29 |
| Employee plus Spouse | ☐ $3.75 |
| Employee plus Child(ren) | ☐ $4.12 |
| Employee & Family | ☐ $5.62 |

## SHORT-TERM DISABILITY

**YOU MUST BE ENROLLED IN THE MEDICAL PLAN TO PURCHASE THIS COVERAGE.**

**Weekly Premium** Employee only ☐ $4.95

## LIFE BUY-UP

**YOU MUST BE ENROLLED IN THE MEDICAL PLAN TO PURCHASE THIS COVERAGE.**

**Weekly Premium** Employee only ☐ $1.06

**EMPLOYEE'S STATEMENTS AND AGREEMENTS:**

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties. I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administration office. Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for coverage.

Signed in (City/State) _____This _____ Day of (Month/Year) _____

Member's Signature_____ _____

Licensed Representative's Name _____ Licensed Representative's Signature _____
Agent #_____

If you choose not to enroll in coverage, please sign below. **I decline coverage at this time.**

Signed in (City/State) _____This_____Day of (Month/Year)_____

Employee's Signature_____

I agree that typing my full legal name and last four digits of my social security number shall be the electronic representation of my signature for all purposes, with the exception of the cancellation of any coverage, when I {or my Agent} use them on documents, including legally binding contracts, to include all Employee Benefits applications and Section 125 forms, just the same as a pen and paper signature.

Full Legal Name _____ Last Four Digits of Social _____

Customer Service Center
P.O. Box 11528
Knoxville, TN 37939

**IMPORTANT**
EMPLOYEE BENEFIT INFORMATION.
DO NOT DISCARD!

**PEAK TECHNICAL STAFFING**

# It's Time to Choose Your 2016 Benefits

**IF YOU HAVE QUESTIONS ABOUT THE BENEFITS AVAILABLE TO YOU, PLEASE CALL**

## 866-629-5456

**MONDAY-FRIDAY 8AM - 7PM EST**

Choose Plan A, B or Both

**A**



### Plan A
**Wellness + Preventive Only**

**Starting at $15.84/ weekly**

**B**



### Plan B
+ Sickness, Dr. Office Visits + Rx
+ Accident, X-Ray
+ Optional Hospitalization Benefits

**Starting at $30.08/weekly**

optional purchase to add to coverage

**C**



### Plan C
**Optional Benefits**
+ Life +Dental +Vision
+ Short-Term Disability