SUMMARY PLAN DESCRIPTION

FOR

Employer Solutions Group LLC

GROUP LIMITED BENEFITS PLAN

Effective: July 28, 2022

TABLE OF CONTENTS

ADMINISTRATIVE INFORMATION

Name of Plan	Essential StaffCARE Group Limited Benefit Plan
Employer / Plan Sponsor	Employer Solutions Group LLC 7480 Flying Cloud Drive, Suite 200 Eden Prairie, MN 55344
Plan Sponsor's Employer Identification Number	20-2301006
Plan Number	510
Group Number	219300
Type of Plan	A welfare benefit plan providing group health benefits. A fixed indemnity medical plan and prescription drug 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)
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 Summary Plan Description 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terms of the Plan or the insurance contracts, the terms of the Plan and the insurance contracts will control, unless superseded by applicable law.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** or **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 Group Limited 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 the Planned Administrators Inc. (PAI) website at www.paisc.com.
- Calling 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.**

THIS CERTIFICATE PROVIDES LIMITED ACCIDENT AND SICKNESS COVERAGE

READ IT CAREFULLY

THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. IT IS NOT MEDICARE SUPPLEMENT INSURANCE. INSUREDS ELIGIBLE FOR MEDICARE SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

INTRODUCTION, LIMITED BENEFITS PLAN

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", "your", and "the Insured" throughout this document refer to you as the employee who may be entitled to benefits under the Plan.

The Plan provides the following benefits:

Fixed Indemnity Medical and Prescription Drug with the option to include the following benefits:

- Dental
- Term Life
- Accidental Death & Dismemberment; and
- Short-term Disability (for employees who work in all states EXCEPT CA, NJ, HI, RI, and NY)

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

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 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 PAI - experienced in processing and paying medical claims 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.paisc.com

MAKING CHANGES TO HEALTH INSURANCE BENEFITS

Post-Tax:

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

You may cancel coverage or change coverage tiers (such as moving from Family coverage to Employee only) at any time. However, once enrolled in the plan, you may only add coverage during subsequent open enrollment periods or due to a qualifying life event.

The following are considered qualifying life events for changes in coverage:

- Your current health care coverage will no longer be offered;
- You move to a new area that offers you different plans, or isn't covered by your current network;
- You get married, legally separated or divorced;
- You have or adopt a child;
- You lose other health coverage due to job loss, a decrease in work hours, end of COBRA coverage or other reasons;
- You become a U.S. citizen.
- Your income changes, or some other event changes your income or household status; or
- You are no longer covered on a family member's policy because you turned 26 or the policy holder has passed away.

In addition, you may request a special enrollment (for yourself and/or eligible dependents) within sixty (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 this medical benefit.

You can make changes by:

- Log on to www.esceportal.com and click on change benefit election.
- Select the QLE reason that applies to you.
- Enter the required information for the selected QLE.
- You will be required to upload supporting documents for the QLE.
- Once you hit submit it will be sent to your employer for their review and approval.
    - If the QLE is approved, you will receive an acceptance email and you have 31 days from the event to enroll or make changes.
    - If the QLE is rejected, you will receive an email stating the QLE was rejected and the ePortal system will not be open to enroll or make changes.

It may take two (2) to three (3) weeks for premiums to stop being deducted from your paycheck after the changes are received. These premiums will not be refunded to you, but coverage will continue for the periods for which these paycheck deductions are taken.

If you have questions about how to set up your coverage election contact Planned Administrators Inc.

Pre-Tax:

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

If you enrolled in pre-tax benefits when you completed an application for employment but did not have an assignment, you have up to thirty (30) days from the first date of your first assignment to make changes. If you enrolled in pre-tax benefits when you completed an application for employment and received an assignment, you have up to thirty (30) days from the date you were hired to make changes.

You may only add, cancel, increase, or drop coverage due to a qualifying life event or during subsequent open enrollment periods.

The following are considered qualifying life events for changes in coverage:

- Your current health care coverage will no longer be offered;
- You move to a new area that offers you different plans, or isn't covered by your current network;
- You get married, legally separated or divorced;
- You have or adopt a child;
- You lose other health coverage due to job loss, a decrease in work hours, end of COBRA coverage or other reasons;
- You become a U.S. citizen.
- Your income changes, or some other event changes your income or household status; or
- You are no longer covered on a family member's policy because you turned 26 or the policy holder has passed away.

In addition, you may request a special enrollment (for yourself and/or eligible dependents) within sixty (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 this medical benefit.

You can make changes by:

- Log on to www.esceportal.com and click on change benefit election.
- Select the QLE reason that applies to you.
- Enter the required information for the selected QLE.
- You will be required to upload supporting documents for the QLE.
- Once you hit submit it will be sent to your employer for their review and approval.
    - If the QLE is approved, you will receive an acceptance email and you have 31 days from the event to enroll or make changes.
    - If the QLE is rejected, you will receive an email stating the QLE was rejected and the ePortal system will not be open to enroll or make changes.

It may take two (2) to three (3) weeks for premiums to stop being deducted from your paycheck after the changes are received. These premiums will not be refunded to you, but coverage will continue for the periods for which these paycheck deductions are taken.

If you have questions about how to set up your coverage election contact Planned Administrators Inc.

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 Fixed Indemnity Medical, Prescription Drug, 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 Inc. 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 Inc.

Contributions to the Plan

If the employer provides an employer contribution, the employee will be responsible for the difference between the employer's contribution and the total premium amount based on the coverage tier selected. If the employer does not contribute, the employee is responsible for 100% of the total premium amount based on the coverage tier selected.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

Active eligible temporary hourly full-time or part-time employees who are 18 years or older with a valid Social Security Number (SSN) are eligible for the fixed indemnity medical, prescription drug, dental and term-life/accidental death & dismemberment insurance benefits. Also eligible to receive benefits are the employee's dependents who have a valid social security number and meet the following descriptions:

a) lawful spouse;

b) partner in a civil union;

c) domestic partner if: 1) the Insured has executed a domestic partner affidavit satisfactory to us; or 2) the Insured and his or her partner have registered as domestic partners with a government agency or office where registration is available and provide proof of registration, unless requiring proof is prohibited by law;

d) children who are less than age 26; and

e) child of any age if enrolled prior to age 26 who is totally incapable of self-sustaining employment due to a physical or mental handicap and chiefly dependent on the Insured for support and maintenance.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents and children for whom coverage has been court-ordered or required by an administrative order.

For a complete definition of "domestic partner", contact Planned Administrators Inc. (PAI).

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.

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 are 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 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 his or her coverage under 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 the necessary care and treatment of congenital malformation, birth abnormality and premature birth, 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 Coverage

A minor child who comes under the charge, care and control of the Insured while his or her coverage under the Policy is in force is covered for Injury and Sickness from the date of placement in the Insured's home. The child's coverage is the same as provided for other members of the Insured's family Coverage for the minor child continues, 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 we been aware of such child.

If you have questions concerning eligibility for benefits, please contact Planned Administrators Inc. at 1(866) 798-0803.

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 enrolled in a group major medical health benefit program sponsored by the Employer.

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 enrolled as a covered employee in 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 of coverage for which premium payment is made following termination of employment or you otherwise cease to be eligible for coverage;
- on the last day of coverage 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 of coverage for which required premium payments are made;
- that you cease to be in a class eligible for dependent coverage;
- that a covered dependent ceases to meet the definition of a dependent under eligibility;
- coverage for your dependents is discontinued under the Plan; or
- 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 Planned Administrators Inc. 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.

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.

If you have any questions about your Plan, you should contact the Plan Administrator. 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. 20220. 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 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 Planned Administrators Inc. 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.

FIXED INDEMNITY MEDICAL SCHEDULE OF BENEFITS, Essential StaffCARE

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact Planned Administrators Inc. at 1(866) 798-0803.

INPATIENT HOSPITAL BENEFIT (Payable benefits require a minimum 24 hour stay)	
Maximum Benefit Period	No annual maximum
Surgical Procedure – Per Day	$4,000
Administration of Anesthesia – Per Day	$800
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.)	$375
Hospital Confinement Daily Income – Per Day	$700
Intensive Care Unit Confinement Daily Income – Per Day (Paid in addition to Hospital Confinement Daily Benefit)	$800
Skilled Nursing – Per Day (Payable for stays in a skilled nursing facility after a hospital stay)	$100
OUTPATIENT BENEFITS (All outpatient benefits are subject to the outpatient maximum)	
Annual Maximum	$2,300
Physician Office Visits – Per Day	$120
Diagnostic Lab – Per Day	$200
Diagnostic X-Ray – Per Day	$300
Ambulance Services – Per Day	$300
Emergency Room for Sickness – Per Day	$200
Emergency Room for Accident – Per Day (For off-the-job accidents only)	$1,000
Surgical Procedure – Per Day	$1,000
Administration of Anesthesia – Per Day	$400
Physical Therapy - Per Day	$75
Speech Therapy - Per Day	$75
Occupational Therapy - Per Day	$75

Wellness (One benefit payment per calendar year for a routine examination or other preventive testing)	$125

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.

Cleft Lip and Cleft Palate
If dependents are covered, coverage shall be provided for Inpatient or Outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both up to age 18. Coverage will be the same as any Illness up to the maximum as shown on the Schedule of Benefits.

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.

First Hospital Admission Benefit
This is payable at the benefit amount shown on the Schedule of Benefits for the first day of a Covered Person's confinement in a Hospital as an Inpatient due to Injury or Sickness. This benefit is not payable for admissions only to a Hospital observation unit or emergency room.

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 per day up to a fixed amount.

Physician Office Visits
This benefit is payable per day 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.

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. 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.

FIXED INDEMNITY MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

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

a) declared or undeclared war or any act of war;

b) serving on full-time active duty in the armed forces of any country or international authority;

c) the Covered Person's commission of a felony;

d) 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; or

e) work-related Injury or Sickness.

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

a) eye examinations for glasses, any kind of eye glasses or prescriptions for them;

b) ear examinations or hearing aids;

c) 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 he or she is covered under the Policy and rendered within 6 months of the Accident;

d) reading or interpreting the results of any diagnostic laboratory or X-ray;

e) 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 he or she is covered under the Policy. Cosmetic surgery for an Injury must be performed within 90 days of the Accident causing the Injury and while his or her coverage is in force; or

f) services provided by the Covered Person, a member of the Covered Person's immediate family or the Employer.

PRESCRIPTION DRUG BENEFIT	
Per Covered Person	
Annual Maximum	$700
Per Day:	$40

Standard Prescription Drug Plan

For generic and brand prescriptions, the plan pays you $40 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 Claim Form at the back of this SPD to file your claim for reimbursement with Planned Administrators Inc.

CLAIM FILING PROCEDURES

Please follow the instructions below when you have claims for expenses:

- 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 in the Prescription Drug Benefit section of this Plan Document.

You can get these forms from the FORMS section at the end of this SPD, or you may print them from the PAI website at www.paisc.com.

When filing your own claims, here are some things you will need:

1. Limited Benefits Claim Form for each patient.
2. Itemized bills from the providers for each patient. 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, vision 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 Medical, Dental, and Prescription Drug claims to PAI.

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 Planned Administrators Inc. website at www.paisc.com 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

If you wish to file a formal appeal, you must write to:

Planned Administrators Inc.
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.

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. No such action can be brought more than three (3) years after we receive a claim.

DENTAL CARE BENEFITS

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact Planned Administrators Inc. (PAI) at 1(866) 798-0803.

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 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**	**80%**
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 Schedule of Covered Procedures section provides a list of the benefits provided under the Plan's dental coverage. Read this information carefully as there are several maximums and other limitations referenced. These limits are further explained following the section.

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.

SCHEDULE OF COVERED PROCEDURES:

COVERAGE CODE A - Insurance Percentage of Usual & Customary Charges is 80%

Diagnostic, Preventive, and Emergency Treatment of Dental Pain
Maximum of 1 exam, cleaning and film per 6 months
Maximum of 4 films for bitewings per 12 months
Maximum of 1 sealant-per tooth and space maintainer per 12 months which is limited to dependent children under 14

COVERAGE CODE B - Insurance Percentage of Usual & Customary Charges is 60%

Fillings

Crown and Bridge Repair

Denture Repair
Maximum of 1 repair, replacement or adding to dentures per 12 months
Maximum of 1 denture reline per 36 months

Oral Surgery (provides for extractions, surgical extractions, alveoloplasty, surgical incision)

COVERAGE CODE C - Insurance Percentage of Usual & Customary Charges is 50%

Endodontics
Maximum of 1 root canal and apicoectomy per 12 months

Periodontics
Maximum of 1 quadrant of gingivial flap procedure, osseous surgery and periodontal scaling & root planning per 6 months
Maximum of 1 quadrant of gingivectomy or gingivoplasty per 36 months
Maximum of 1 full mouth debridement per 36 months
Maximum of 1 periodontal maintenance procedure per 6 months

Crowns and Bridges
Maximum of 4 procedures per 12 months - This maximum does not apply to procedures such as temporary crown and crown repair

Dentures
Maximum of 4 procedures per 12 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.

a) service or supply not shown on the Schedule of Covered Procedures;

b) any procedure begun after the Covered Person ‘s insurance under this policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty days after the Covered Person’s insurance under this policy terminates;

c) any procedure begun or appliance installed before the Covered Person became insured under this policy;

d) any treatment that is elective or primarily cosmetic in nature and not generally recognized as an accepted dental practice by the American Dental Association;

e) the correction of congenital malformations (unless the procedure is performed on a Covered Dependent child and is necessary to correct a functional defect);

f) the replacement of lost or stolen appliances;

g) 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 insured under the policy, 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;

h) replacement of bridges unless the bridge cannot be made serviceable;

I) replacement of full or partial dentures unless the prosthetic appliance is more than five years old and cannot be made serviceable;

j) replacement of crowns, inlays or onlays unless the prior placement is more than seven years old and cannot be made serviceable;

k) appliances, services or procedures relating to: (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition or abrasion; (v) bite registration or (vi) bite analysis;

l) orthognathic surgery;

m) prescribed drugs, premedication, analgesia or general anesthesia;

n) any instruction for diet, plaque control and oral hygiene;

o) dental disease, defect or injury caused by a declared or undeclared war or any act of war;

p) 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;

q) 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;

r) for treatment of malignancies, cysts and neoplasms;

s) for orthodontic treatment unless otherwise listed as a Covered Procedure;

t) charges for failure to keep a scheduled visit or for the completion of any claim forms;

u) any procedure we determine which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;

v) service or supply rendered by someone who is related to a Covered Person by blood (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Covered Person's household;

w) any procedure, service or supply that is included as covered medical expenses under a group medical expense benefit plan;

x) expenses paid or payable for work-related injury or sickness or by any non-worker’s compensation coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);

y) expenses provided or paid for by any governmental program or law, except as to charges that the person is legally obligated to pay.

TERM LIFE INSURANCE BENEFIT PLAN

The following does not constitute all Plan benefits information. For the complete benefits provisions please contact Planned Administrators Inc. at 1(866) 798-0803.

All non-benefited, temporary hourly-paid employees not enrolled in any other insurance benefits from the Employer are eligible to participate in the Term Life Insurance Benefit Plan. You may also obtain life insurance for your spouse and/or eligible dependents.

Your term life insurance will become effective 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 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 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 rate quote, contact Planned Administrators Inc. (PAI) 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 once, twice, 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 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 five (5) years after we receive a claim.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFIT	
Employee	$20,000
Spouse	$20,000
Dependent (6 months to 26 years)	$5,000
Dependent (15 days to 6 months)	$2,500
Dependent (under 15 days)	$0

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 Planned Administrators Inc. (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 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

Benefits for Accidental Death and Dismemberment will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

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.
10. Injury or Sickness for which the Insured has received 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 Planned Administrators Inc. at 1(866) 798-0803.

Eligibility for Short-term Disability Benefit Plan

All non-benefited, temporary 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 Planned Administrators Inc. at 1(866) 798-0803.

Weekly Benefit	60% of your average weekly base pay received for work done for the Employer (excluding 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. 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.
3. declared or undeclared war or act of war.
4. the Insured's commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony.
5. the Insured's participation in a riot.
6. the Insured's engaging 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 to the Insured while a passenger on a licensed, commercial, nonmilitary aircraft.
9. Injury or Sickness for which the Insured has or had a right to payment under any workers' compensation or similar law.

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 Planned Administrators Inc. website at www.paisc.com 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:

Planned Administrators Inc., CLAIMS
P.O. Box 6702
Columbia, SC 29260

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

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to

cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Any adverse benefit determination will be in writing and include:

1) the specific reason or reasons for the decision;

2) specific references to the Policy provisions on which the decision is based;

3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

4) a description of the Insurance Company's review procedures and time limits applicable to such procedures;

5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal;

6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration;

7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist;

9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

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.

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure

to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision. However, any final adverse benefit determination on review will be in writing and include:

1) the specific reason or reasons for the decision;

2) specific references to the Policy provisions on which the decision is based;

3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim;

4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration;

6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and

9) any other notice(s), statement(s) or information required by applicable law.

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 above. No such action can be brought for denial of benefits more than five (5) 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 OptumRx Prescription Drug Discount, visit or call a participating network location.

OptumRx 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.paisc.com, log in with your group number (on your ID card), then click on the OptumRx link. You may also call Planned Administrators Inc. 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% - 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.

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 Planned Administrators Inc. toll free at 1(866) 798-0803.

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

Allergy Control Products Inc.

PAI members can take advantage of savings on products designed to reduce exposure to indoor allergens. The savings are at least 10 percent lower than the typical cost. This excludes Minimum Advertised Pricing (MAP) products. There is also a 20 percent discount on all encasings (mattress and pillow). Free shipping is available on orders of $150.00 or more.

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 50% off all access enrollment fee, plus 5% off all Jenny Craig food. For your discount go to www.jennycraig.com/affinity.

QualSight LASIK

With QualSight LASIK, members receive savings of 40 to 50 percent off the national average price of Traditional LASIK and significant savings on procedures such as Custom Bladeless (all laser) LASIK. With multiple locations in the state of South Carolina and many more throughout the country, QualSight LASIK offers members the choice of multiple providers.

TruHearing Digital Hearing Aids

TruHearing offers members and their families access to the TruHearing MemberPlus hearing aid program. MemberPlus offers exclusive savings on hearing aids and associated services. Members have free access to TruHearing's low, nationally fixed prices and services. Savings average $890 per hearing aid. For a full list of prices or more information, members can call toll-free 1-855-586-5507 or visit TruHearing's website (truhearing.com).

Telemedicine

Telemedicine is a service offered to insureds covered under the fixed indemnity medical plan. To access this service contact 1-888-930-8264. Note upon the discontinuation of coverage under the fixed indemnity medical plan, provider's selected through the telemedicine network will only be accessible via a membership.

PRIVACY NOTICE

This notice describes BCS Insurance Company's privacy practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations that implement HIPAA.

Our Legal Duty
HIPAA requires us to maintain the privacy of information we use and maintain about you (your medical information). We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We also must inform you of a breach involving your unsecured medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **July 1, 2013**, and 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. Any new terms will be effective for all medical information that we maintain, including medical information we create or receive before we make the changes. Before we make a significant change in our privacy practices, we will change this notice and post our new notice on our website. We will provide information about changes to the notice and how to obtain the notice in our next annual mailing 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.

Uses and Disclosures of Medical Information
We use and disclose medical information about you for the following purposes:

Treatment: We may use and disclose your medical information for treatment. For example, we may disclose your medical information to a physician or other health care provider who is providing treatment to you.

Payment: We may use and disclose your medical information to pay for benefits or to obtain premiums. For example, we pay claims to physicians, hospitals and other providers for services delivered to you that are covered by your health plan. We also use and disclose your medical information to establish your eligibility for benefits, to determine medical necessity, and to issue explanations of benefits. We may disclose your medical information to a health care provider or entity subject to HIPAA so they can engage in these type of payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our everyday work activities (health care operations). These operations include, for example, customer service, resolution of grievances, quality assessment and improvement activities, and fraud and abuse detection and compliance. They also include underwriting, enrollment, and other activities related to creating, renewing, or replacing a benefits plan. We may not, however, use or disclose genetic information for underwriting purposes. In limited circumstances, we may disclose your medical information to another entity subject to HIPAA so they can engage in their own health care operations.

Required or Permitted by Law: We may use or disclose your medical information when required by law, such as in response to a court order or for government health oversight activities (*i.e.*, inquiries from a State Department of Insurance). In limited circumstances, we may also give out medical information as permitted by law, such as for public health purposes (*i.e.*, reporting disease outbreaks), law enforcement purposes, research studies, to avoid a serious and imminent threat to health or safety, to create de-identified information, and for emergencies.

To You or Others Involved In Your Care: We may use or disclose your medical information to provide information to you or to a family member, friend or other person to help with your health care or with payment for your health care. Before we disclose your medical information to a family member, friend or other person, we will provide you with an opportunity to object to the use or disclosure. 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 is in your best interest.

Plan Sponsors: If you are a participant in a group health plan, we may disclose summary information about the enrollees in your plan to the employer (or other organization that sponsors your plan) to use to obtain premium bids for the health insurance coverage offered through your plan or to decide whether to modify, amend or terminate your plan. Summary information is partially de-identified information about claims history,

claims expenses, or types of claims experienced by plan enrollees. If the employer (or other plan sponsor) takes appropriate steps to comply with HIPAA, we may disclose medical information of individuals enrolled in your plan to the plan sponsor to permit the plan sponsor to perform plan administration functions. If this is the case, your group health plan will publish its own notice describing how it uses and disclosures your medical information.

Situations Other Than Those Above: Except as described in this notice, we may not use or disclose your medical information without your written authorization. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your medical information to send you communications about products and services. We do not need your written authorization, however, to send you communications about health related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights
In most cases, you have the right to look at or get a copy of the medical information that we use to make decisions about you. If you request copies, we may charge you a reasonable, cost-based fee for the copies. You also have the right to receive a list of instances in which we have disclosed health information about you for reasons other than treatment, payment, health care operations, and certain other purposes. If you believe the records we maintain about you are incorrect or are missing important information, you have the right to request that we correct our records.

If you believe that you would be in danger if we send your medical information to the address we have for you in our records, you have the right to request that we communicate with you using alternative means or an alternative location. We will accommodate your request if the request (a) states that our communications could put you in danger, (b) is reasonable, (c) specifies the alternative means or location for communicating with you, and (d) permits us to continue collecting premiums and paying claims under your health plan.

Finally, you may request that we place additional restrictions on how we use or disclose your medical information. We will consider your request but are not legally required to agree to it.

All requests to exercise these rights must be made in writing by you and directed to the contact person named below.

Your California Privacy Rights
If you are a California resident, California law may provide you with additional rights regarding our use of your personal information. To learn more about your California privacy rights, email privacyofficer@bcsigroup.com.

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, you may complain to us using the contact information listed at the end of this notice. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request. 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. Privacy Officer at BCS Insurance Company 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181 By phone: 833-227-4512, fax: 630-472-7822 or email: privacyofficer@bcsigroup.com.

If you have a question, a general complaint or concern unrelated to your privacy (for example, to request information about your plan or to request an ID card) please contact the Planned Administrators Inc. Customer Service Team toll-free at (866) 798-0803, by mail to Planned Administrators Inc. P.O. Box 6927 Columbia, SC 29260, or by e-mail at paicomplianceteam@paisc.com.

COBRA NOTICE

IMPORTANT INFORMATION- PLEASE READ AND KEEP FOR YOUR RECORDS.

COBRA NOTICE **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

This notice describes how/when your coverage can be continued after a coverage loss and also provides additional information about other coverage options available to you. Please read it carefully.

There may be more affordable options available to you through the Health Insurance Marketplace, Medicaid or other group health plan coverage (such as a spouse's employer-sponsored plan). Be sure to compare all your options to COBRA continuation & select what's best for you/your family.

Visit/call the Health Insurance Marketplace at: www.HealthCare.gov **/ 1-800-318-2596.**

COBRA Continuation Introduction

You are receiving this notice because you recently become covered under a Limited Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, a temporary extension of coverage under the Plan. The right to COBRA continuation coverage is created by federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage becomes available to you & members of your family covered under the Plan when you otherwise lose health coverage.

This notice summarizes COBRA continuation coverage, when it may become available to you, your family, & what to do to protect the rights.

For more information about your rights, obligations under the Plan & under federal law, you should contact Planned Administrators Inc. (PAI) at:

Planned Administrators Inc.
P.O. Box 6839 Columbia, SC 29260
or call Toll-Free: (866) 798-0803, 8:30 a.m. - 8:00 p.m. EST.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage when coverage otherwise ends because of a life event known as a "qualifying event" (specific qualifying events are listed below). COBRA continuation coverage is offered to each "qualified beneficiary", someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, & dependent children of employees may be a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay the premium for it. If you are an employee, you become a qualified beneficiary if you lose coverage under the Plan due to one of the following qualifying events:

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

A spouse of an employee is a qualified beneficiary if they lose coverage under the Plan because of any the following qualifying events:

1) The employee-spouse dies;
2) The spouse's hours of employment are reduced;
3) The 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 become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

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 is a qualifying event. If a proceeding in bankruptcy is filed, with respect to your employer and 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, & dependent children are also qualified beneficiaries in this case.

The Plan offers COBRA continuation to qualified beneficiaries only after PAI is notified of the occurrence of a qualifying event. 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 PAI 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 other qualifying events including divorce, legal separation of employee & spouse or dependent child's loss of eligibility as a dependent, *you* must notify PAI within 60 days after the qualifying event occurs. You must send this notice to:

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

Upon notice a qualifying event, 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 your family member 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 & you notify PAI in a timely fashion, you & 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 PAI is notified of the determination before the end of the 18-month period of COBRA continuation coverage.

This notice should be sent to:

Planned Administrators Inc., Attn: 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 & 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 & dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), gets divorced or legally separated.

The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent**. In all of these cases, you must make sure that PAI 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: 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 PAI's 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 informed of any family member address changes. You should also keep a copy of any notices you send to the Plan.

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.

Medical Claim Form

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

HOW TO FILE A MEDICAL CLAIM

Claim payment may be delayed if information is incomplete or missing.

Please note that HCFA and UB claim forms are available upon request from your provider.

_____Part One – Attach itemized bills.

Itemized bills are not balance due statements or Explanation of Benefits.

Checklist to make sure all information required has been enclosed:

- **_____ Doctor's name and address**
- **_____ Doctor's tax ID number**
- **_____ Patient's name**
- **_____ Diagnosis Code(s) ICD-9**
- **_____ Date of service**
- **_____ Charges/Cost of each treatment**
- **_____ Procedure Code(s) CPT-4**
- **_____ Place of service code**

_____Part Two (Page 2) – to be complete signed and dated.

To be completed by the Employee. Please note that employee signature, social security number, and authorization are required.

_____Part Three – Keep a copy for your records.

Mail your Medical claim form and itemized bills to:

PAI, P.O. Box 6702 Columbia, South Carolina 29260

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20201026

Medical Claim Form

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

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

Section 1: Employee Information

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

Address: _____
Street City State ZIP

Telephone: _____ Employer Name: _____ Group No. (from ID card): _____

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 25, is he or she dependent upon you for support? ☐ Yes ☐ No

Section 3: Claim Information

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

When did the accident or illness occur? _____ First date consulted for the diagnosis? _____

Please explain what you were treated for, and if it was an accident, provide details on how, when, and where it happened. (Attach a separate sheet of paper to to this form if necessary.) _____

Section 4: 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 healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

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

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20201026

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20201026

Dental Claim Form

Mail Claims to: PAI, PO Box 6702, Columbia, SC 29260

Please complete entire form.

Employer/Plan Name: _____

Dental Provider: _____ Covered Person: _____

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

Part 1: To be completed by Employee

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.

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.

Employee Signature: _____ _____ _____
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.)

_____ _____
Legal Guardian Name Address

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.621.20201026

ESC
Essential StaffCARE

Part 2: Dentist completes this form or attaches completed ADA dental form.

Name: _____ License Number: _____
Last First Middle

Social Security or Tax ID 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: _____

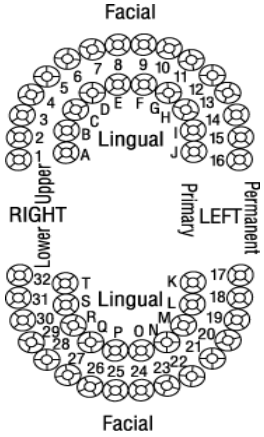
• Radiographs or models enclosed? ☐ Yes How many? _____ ☐ No

• 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 number 1 through number 32. Use charting system shown.

Identify missing teeth with "x"



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: _____

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

BCS

Underwritten by BCS Insurance Company
Oakbrook Terrace, Illinois

pai

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.621.20201026

ESC
Essential StaffCARE

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

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

Term Life Claim Form

Mail claims to PAI, P.O. Box 6702, Columbia, SC 29260-6702

Section 1. Employer's Statement

Employee's Name: _____
Last First Middle

Employee's Date of Birth: _____ Employee's Social Security Number: _____

Address: _____
Street City State ZIP

Deceased's Name: _____
Last First Middle

Date of Death: _____ Deceased's Relationship to Employee: _____

4 Ever Life Insurance Company Group Policy No.: _____ Certificate Number: _____
Attach Group Certificate (unless dependent claim)

4 Ever Life Insurance Company 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

Amount of Insurance: BASIC $ _____ SUPP: $ _____

Amount of Salary: $ _____ Per ☐ hour ☐ week ☐ month ☐ year

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, 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.
- A certified copy of the death certificate must be attached to the completed form.

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

Address: _____
Street City State ZIP

Birth Date: _____ Daytime Telephone: _____ Relationship to Deceased: _____

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.623.20211007

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

Important Tax Notice

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

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 healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

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.

Employee Signature	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

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.623.20211007

ESC
Essential StaffCARE

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

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

Accidental Death Claim Form

Mail claims to PAI, P.O. Box 6702, Columbia, SC 29260-6702

Section 1. Employer's Statement

Employee's Name: _____
Last First Middle

Employee's Date of Birth: _____ Employee's Social Security Number: _____

Address: _____
Street City State ZIP

Deceased's Name: _____
Last First Middle

Date of Death: _____ Deceased's Relationship to Employee: _____

4 Ever Life Insurance Company Group Policy No.: _____ Certificate Number: _____
Attach Group Certificate (unless dependent claim)

4 Ever Life Insurance Company 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

Amount of Insurance: AD&D: $ _____

Amount of Salary: $ _____ Per ☐ hour ☐ week ☐ month ☐ year

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, 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.
- A certified copy of the death certificate must be attached to the completed form.
- If claim is also made for Accidental Death 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 Deceased: _____

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

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

Important Tax Notice

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

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 healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

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.

_____ _____ _____

Employee Signature | 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

Section 4. Beneficiary's Statement for Insured's Accidental Death

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 Death: _____ Date of Employment at this Place: _____

Date and Time of Accident Causing Death: _____ _____ ☐ A.M. ☐ P.M.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

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

Date and Time of Death: _____ _____ ☐ 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 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 yes, please attach a copy of the report. If copy NOT attached, please complete below:

Autopsy performed by: _____ Date of 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*	*Accidental Death Benefits?*
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Beneficiary's Signature: _____ Date: _____

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

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

Accidental Dismemberment Claim Form

By furnishing this form and investigating the claim, the Company does not admit liability and does not waive its rights or defenses.

Section 1. TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

4 Ever Life Insurance Company Group Policy Number:	Certificate Number:	Social Security Number:

Claim is for: ☐ Employee ☐ Member ☐ Dependent	Name:	Relationship to Insured:

Insured's Name:	Job Title:	Last Date at Work:

Address:	Date of Birth Month Day Year

Insurance Classification	Effective date of last increase in benefits	Has insurance been terminated? ☐ Yes ☐ No	If "Yes," give date:

Full amount of Accidental Dismemberment Insurance	Amount of this Claim	
$	$	☐ 100% ☐ 50%

Is loss due to an occupational accident? ☐ Yes ☐ No	If "Yes," has Workers' Compensation claim been filed? ☐ Yes ☐ No

Name of Workers' Compensation carrier:	Address:

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 claimant 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 dismemberment, nor a waiver of any rights or defenses.

Employer/Plan Administrator _____ Address _____

Phone No. _____ Ext. _____

_____
City *State* *Zip Code*

Date _____ Email _____

By _____ _____
Title and Printed Name of Authorized Representative (required) *Signature of Authorized Representative (required)*

Section 2. TO BE COMPLETED BY EMPLOYEE, MEMBER OR DEPENDENT

Date of Accident:	Hour of Accident: ☐ A.M. ☐ P.M.	Place of Accident:

Describe what happened:	What injuries were sustained?

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

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

pai
Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

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

Was immediate First Aid sought? ☐ Yes ☐ No If "Yes," please list below: Name and Address of Doctor	Name and Address of Hospital	Name and Address of Other Medical Facility

Was accident reported to police or other official agency? ☐ Yes ☐ No	If "Yes," name and address of official agency:
Name and address of witnesses:	

Do you have other insurance providing dismemberment or loss of sight benefits? ☐ Yes ☐ No	If "Yes," name of other carrier:	Policy No.:
Name of auto insurance carrier, if loss is due to auto accident:		

Date	Signature of Employee, Member, or Dependent

Section 3. AUTHORIZATION – MUST BE SIGNED BY EMPLOYEE, MEMBER OR DEPENDENT

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

To healthcare providers:
You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

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.

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.

Date:	Signed:	Relationship to Insured if signed by other than Insured:

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.624.20211007

ESC
Essential StaffCARE

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

Attending Physician's Statement
Accidental Dismemberment Claim Form

By furnishing this form and investigating the claim, the Company does not admit liability and does not waive its rights or defenses.

Patient Name	Patient DOB	Patient SSN / Identifier

On what date were you first consulted for the condition described in the claimant's statement?

What history were you given on the initial visit as to the cause of the condition?

Of what symptoms did the patient complain?

Was there visible evidence of trauma? ☐ Yes ☐ No If "Yes," please describe:

Please describe any other findings revealed by your examination.

Was there any indication that disease might have caused or contributed to the loss? Yes ☐ No ☐ If "Yes," please explain:

COMPLETE ONLY THE APPROPRIATE SECTION

LOSS OF LIMB

A. State which member is affected
☐ Right hand ☐ Left hand ☐ Right foot ☐ Left foot ☐ Finger or Thumb

B. Point of amputation _____

Is this above the wrist or ankle (or the metacarpal-phalangeal joint for fingers)? ☐ Yes ☐ No

C. Date of amputation _____

D. In your opinion did amputation result solely from accidental bodily injury? ☐ Yes ☐ No

LOSS OF SIGHT

A. Visual acuity: with glasses OD_____ OS _____ Date _____
without glasses OD_____ OS _____ Date_____

B. Can vision be improved by treatment or lens? ☐ Yes ☐ No

C. In your opinion is loss of sight complete and irrecoverable? ☐ Yes ☐ No

D. In your opinion is loss of sight due solely to accidental bodily injury? ☐ Yes ☐ No

E. Is there a total loss of vision? When did such loss occur? _____

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.

Date	Signature of Physician	Address	Phone

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

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

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.626.20201026

HOW TO FILE A CLAIM

for

SHORT TERM DISABILITY

Claim payment may be delayed if information is incomplete or missing.

Part One (Page 1) – To be completed by the Employer. Please note that employer signature, date and employee's salary information are required.

Part Two (Page 2) – To be completed by Employee. Employee signature and date are required.

Part Three (Page 3) – To be completed by the Physician treating the employee for the illness/injury associated with the disability. Physician signature and date are required.

Checklist to make sure all information required has been enclosed:

_____ Part One of the claim form is complete, signed, and dated.

_____ Part Two of the claim form is complete, signed, and dated.

_____ Part Three of the claim form is complete, signed, and dated.

PLEASE NOTE
Medical premiums will not be deducted from your short-term disability payments. You must make arrangements to pay your medical premiums in order to maintain your medical coverage.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.628.20201026

Short-Term Disability/ Proof of Loss Form

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

Claims payment may be delayed if information is incomplete or missing.

Part One: *Employer Completes This Section*

Employer's Name: _____ Policy Number: _____

Address: _____
Street City State ZIP

Employer's Telephone No.: _____ Contact Person: _____ Email: _____

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

Address: _____
Street City State ZIP

Home Telephone: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Date Hired: _____ Effective Date of Coverage: _____

Base Earnings: Monthly $ _____ Weekly $ _____ 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 hereby 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

Part Two: *Employee Completes This Section*

Employee's Name: _____ Birth Date: _____
Last First Middle

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? 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 sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

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

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.628.20201026

photographic copy of this authorization shall be as valid as the original.

Employee Signature _____ 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 Three: *Attending Physician's Statement* (Medical records attached? ☐ Yes ☐ No)

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: _____

1) a. Diagnosis –ICD9 Code: _____ and concurrent condition description _____
If fracture or dislocation, describe nature and location. _____
b. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No If yes, explain: _____
c. Is condition pregnancy? ☐ Yes ☐ No If yes, what was the approximate date of commencement of pregnancy? _____
Type of delivery: _____
2) a. When did symptoms first appear or accident happen? Date: _____
b. When did patient first consult you for this condition? Date: _____
c. Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe. _____
3) a. Nature of surgical or obstetrical procedure, if any. _____
Date performed: _____ ☐ Inpatient ☐ Outpatient Describe fully and include current CPT-4 codes: _____
b. If performed in a hospital, give name of hospital and dates hospitalized. _____
4) Give dates of other medical (non-surgical) treatment, if any. _____
5) Is patient still under your care for this condition? ☐ Yes ☐ No If no, give date your services terminated: _____
6) a. How long was or will patient be continuously totally disabled? _____ , 20 _____ to _____ , 20 _____
If unknown, please estimate anticipated recovery date. _____
b. Is this an extension of a previous disability claim? ☐ Yes ☐ No Previous date: _____
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? ☐ Yes ☐ No If yes, identify: _____

Physician's Signature: _____ Date: _____
Physician's Name: _____ Degree: _____ Telephone: _____
(Print) Last First Middle

Address: _____
Street City State ZIP

Individual Practitioner's I.D. Number: _____

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.628.20201026

Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of insurance and civil damages.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware, Idaho, Indiana and Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or 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.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

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.

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: 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 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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

All Other States Not Listed Separately: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by 4 Ever Life Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.628.20201026

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 this 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 pay stubs)

Employee's Signature: _____

Return Form and Payment to: PAI
Attn: Missed Premiums
PO Box 6839
Columbia, SC 29260-6839

You must return this completed form with your payment.

Questions? Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Underwritten by BCS Insurance Company
Oakbrook Terrace, Illinois

Administered by Planned Administrators Inc.
Columbia, South Carolina
Form 1.629.20201026

BCS Insurance Company
Oakbrook Terrace, Illinois

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
INSOLVENCY UNDER THE 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."