

Q: How do these limited benefit plans compare to major medical coverage?

A: Limited benefit plans are not “major medical” insurance plans. They are designed to help you pay for basic medical expenses, not catastrophic events. See your Summary Plan Description (SPD) for further details regarding your plan design and benefit exclusions and limitations.

Q: How does the deductible work?

A: All eligible (inpatient and outpatient) expenses are subject to the deductible and co-insurance except for office visits, which are described below.

Q: What doctors can I see?

A: Please call the number on the back of your ID card to find a network doctor in your area, or you may print a personal network directory for your area at www.beechstreet.com. If you live in Arkansas or Utah, you have access to the PHCS Network. You can print a personal network directory at www.phcs.com. Please select the PHCS Healthy Directions network on the web site. Residents of West Virginia have access to the Multiplan network. For participating Multiplan providers visit www.multipan.com.

Q: Do I have to go to an in-network provider?

A: It is not required that you go to an in-network provider. If you choose a provider who participates in the PPO network they receive two key advantages:

- They get the PPO discount for all services
- The provider will file the claim to the plan.

When an in-network provider is used, the provider will file the claim on your behalf and the plan will pay the provider. You are responsible for paying the difference between the network discount rate and the plan payment.

Q: What does the office co-pay cover?

A: Doctor’s office visits will be covered at 100% after a \$15 co-pay for all covered medical expenses performed in the doctor’s office, subject to the policy exclusions and limitations. The deductible is waived for doctor visits, although the deductible and 80% co-insurance will apply to any charges for services performed outside the doctor’s office (example: separate billing for lab and x-ray services).

Q: What medical expenses will be covered?

A: Examples include: hospital bills, doctor bills, prescription drugs, lab and x-ray, medical equipment and supplies, therapy, home health care, and hospice inpatient care. See your Summary Plan Description (SPD) for details.

Q: What rules apply?

A: In order to be covered, your medical expense must:

- be administered and ordered by a licensed physician;
- be medically necessary for the diagnosis and treatment of a sickness or injury; and
- not be excluded by the policy.

Q: Is there a pre-existing condition exclusion?

A: Yes. The group health coverage you are applying for may not provide benefits for pre-existing conditions for a period of 12 months for persons who enroll when first eligible or who enroll during a special enrollment period, or for a period of 18 months for persons who are late enrollees. This period may be reduced if you had previous Creditable Coverage and furnish Planned Administrators, Inc. (PAI) with a Certificate of Creditable Coverage. Until this certification is received and a determination is made whether or not you are entitled to a reduced exclusion period for a pre-existing condition, any claim submitted for a pre-existing condition, incurred during the 12-month (or for late enrollees, 18-month) period, will be denied. If a Certificate or other evidence of Creditable Coverage is subsequently received, the claim will be reconsidered.

Q: How are inpatient physician charges covered?

A: Inpatient physician charges (such as surgery, anesthesiology, and doctor visits while admitted to the hospital) are covered at 80% up to the annual plan maximum.

Q: What does the Inpatient Limit refer to?

A: This refers to hospital-billed charges, other than room and board, during an inpatient stay. Examples include: medications, supplies, etc.

Q: What if I go to the emergency room?

A: Emergency room charges will be covered as any other outpatient expense, subject to deductible and co-insurance, unless you are admitted to the hospital. If admitted to the hospital, emergency room charges will be covered as an inpatient expense.

Q: When should I expect an ID card?

A: An ID card and confirmation of coverage letter will be mailed to your home address within 10 business days of your effective date. If you do not receive these documents or you have a change of address please contact Essential StaffCARE customer service at 1-866-798-0803. Present your ID card to the provider at the time of service. ID cards are used by providers to verify the member's identification and eligibility status.

Q: Is Short-Term Disability offered in all states?

A: Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York and Rhode Island.

Q: How does the prescription plan work?

A: If you enroll in the medical plan, you are automatically covered by the prescription drug program through Caremark. Caremark has a national network with over 53,000 participating pharmacies. Present your ID card at a participating pharmacy to receive discounts for prescriptions. Save your receipt and file a claim for reimbursement. No benefits will be paid for over the counter products or medications or for drugs and medications dispensed while you are in a hospital.

Note: Some plans include an “Enhanced Rx” benefit where the pharmacy will take a copayment at the point of purchase. The prescription drug benefit may be subject to a monthly maximum or the overall annual outpatient maximum. Be sure you present your ID card when filling your prescriptions and refer to your specific plan for details.

Q: When can I enroll?

A: You may enroll during the annual group open enrollment, within 30 days of your 1st paycheck date, or if you have a qualifying life event. A qualifying life event (QLE) is defined as a change in your status due to one of the following: marriage, divorce, birth or adoption of a child (ren), termination, death of an immediate family member, Medicare entitlement, employer bankruptcy, loss of dependent status, or loss of prior coverage. In addition, you may request a special enrollment (for yourself, your spouse and/or eligible dependents) within 60 days of 1) 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. You must submit proof of the event along with your enrollment form.

Q: Who is considered an eligible dependent?

A: Eligible dependents include an employee’s spouse and children up to age 26.

Q: When will coverage start?

A: If the premium is deducted by payroll coverage typically begins the Monday following the check date for which the premium is deducted.

Q: Is there coverage for contraceptives on this plan?

A: Yes, oral contraceptives are covered under the prescription benefit. Non-oral contraceptives are not covered.

Q: Are maternity benefits covered?

A: Yes, maternity benefits are covered the same as any other condition under this plan.

Q: Are live representatives available to provide assistance?

A: Yes! If you have additional questions about your plan or claims, call the plan administrator at 1-866-798-0803 between the hours of 8:30 a.m. and 8 p.m. Eastern Standard Time. A language line is available with translation for most languages.