2017 Benefit Summary

Century Healthcare

BENEFITS EFFECTIVE 01/01/2017

Important Contacts

Century Healthcare
Customer Service and Claims
(877) 685-2432
Monday through Friday
7:00 AM – 7:00 PM CST

Member Web Portal
(Access important plan documents, claim forms & temporary ID cards)
www.centuryhealthcare.com
Username: CHC5172
Password: heartland

PHCS Limited Benefit Network
www.multiplan.com/chc
(888) 371-7427

Pharmaceutical Benefits
www.century.data-rx.com
(800) 454-9399

24 Hr Nurse Line
(866) 796-1857 pin: 526

Please Note:
A separate claim form is needed for the AD&D, Accident Medical & Life benefits. The claims forms are accessible through the client web portal. Century Healthcare's Customer Service Department is also available.

All benefits except Accident Medical, Accidental Death & Dismemberment and Term Life are subject to Benefit Year Maximums as shown. Benefit Year means the 12 consecutive months from the group's original effective date.

Benefit Description	Value	Select
Preventive Services Covered at 100% All preventive services as specified by the Affordable Care Act such as annual physicals, mammograms, pap smears, preventive cancer screenings, routine lab and x-rays, and immunizations. Only Covered at 100% through in-network providers.	Included See MEC Summary	Included See MEC Summary Page
Doctor's Office Visit Benefits paid for a doctor's office visit for medically necessary treatment, care, or advice of a covered injury or sickness.	Plan pays $60 per day (6 days)	Plan pays $80 per day (6 days)
Outpatient Lab & X-Ray Benefits paid for outpatient lab tests and x-rays when ordered by a doctor and performed by an appropriately licensed technician.	Plan pays $60 per day (3 days)	Plan pays $80 per day (3 days)
Advanced Studies Limited to CT Scan, PET Scan, and MRI.	N/A	Plan pays $500 per day (1 day)
Emergency Room Benefits paid for emergency room visits for a medical emergency caused by sickness.	Plan pays $250 per day (1 day)	Plan pays $250 per day (1 day)
Inpatient/Outpatient Surgery Benefits Benefits paid if a covered person undergoes medically necessary surgery at the direction of a doctor for a coverer injury or sickness.	Inpatient: Plan pays $500 Outpatient: Plan pays $250 (1 IP or 1 OP surgery)	Inpatient: Plan pays $1,000 Outpatient: Plan pays $400 (1 IP or 1 OP surgery)
Inpatient/Outpatient Anesthesia Benefits Benefits paid at 25% of the surgery benefit for anesthesia services for pre-operative screening and during a surgical procedure.	Inpatient: Plan pays $125.00 Outpatient: Plan pays $62.50	Inpatient: Plan pays $250.00 Outpatient: Plan pays $100.00
Outpatient Minor Surgical Benefits Benefits paid if a covered person undergoes a covered outpatient minor surgery as defined in the policy.	Plan pays $60 per day (1 day)	Plan pays $80 per day (1 day)
Ambulance Benefits paid if a covered person requires transportation in an ambulance to the nearest hospital for treatment of an injury or sickness.	Plan pays $150 per day (3 days)	Plan pays $150 per day (3 days)
First Hospital Confinement Benefits Paid when a covered person is confined in a hospital for the first time in the Benefit Year. Pays in addition to the Hospital Confinement benefit.	N/A	Day 1: Plan pays $500
Hospital Confinement Benefits paid if a covered person is confined as an inpatient in a hospital due to a covered injury or sickness.	Plan pays $100 per day (30 days)	Plan pays $400 per day (30 days)
Maternity Benefits paid under the applicable provision for Doctor's Office Visits, Outpatient Lab & X-ray, Surgery, and Hospital Confinement for pregnancy related expenses.	Included	Included
ICU Confinement Pays in lieu of the Hospital Confinement Benefit.	Plan pays $200 per day (30 days)	Plan pays $800 per day (30 days)
Substance Abuse Confinement Benefits paid for confinement in a rehabilitation facility for substance abuse.	Plan pays $50 per day (30 days)	Plan pays $200 per day (30 days)
Mental Illness Disorder Confinement Benefits paid for confinement in a rehabilitation facility for mental or nervous disorders.	Plan pays $50 per day (30 days)	Plan pays $200 per day (30 days)
Skilled Nursing Facility Confinement Benefits Paid for confinement in a skilled nursing facility. Confinement must begin within 3 days of hospital confinement.	Plan pays $50 per day (30 days)	Plan Pays $200 per day (30 days)

BENEFITS EFFECTIVE 01/01/2017

Benefit Description	Value	Select
Accident Medical ($100 deductible per occurrence)	Up to $5,000 per occurrence	Up to $5,000 per occurrence
Accidental Death & Dismemberment		
Employee	$15,000	$15,000
Spouse	$7,500	$7,500
Children	$3,000	$3,000
Term Life Employee	$10,000	$10,000
Pharmaceutical Benefits	Copay Rx	Copay Rx

Copay Rx Plan(s)

Copay Rx - Plan 1: Tier 1 (Most Generics): $10 Co-Pay. Tier 2 (Some Generics & Preferred/Formulary Brand Name): $50 or 50%; whichever is greater. Tier 3 (Non-Preferred / Non-Formulary Brand Name): Employees pay 100% of the cost after pharmacy discounts. Monthly Maximum of $100 Employee / $200 Family. No Deductible. Restricted Formulary.

PHCS PPO Limited Benefit Network

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.

24 Hour Nurseline

All plan designs provide covered individuals with 24-hour telephone access to nurses for medical decision support and patient advocacy (available in multiple languages with an audio health information library).

MEC SUMMARY

Preventive Services are covered at 100% through participating providers. The following is a brief description of the preventive benefits available to members and it is subject to change under the Affordable Care Act. To learn more visit www.healthcare.gov.

- Routine physical exam
- Well women exam (annual)
- Annual mammogram
- Annual pap smear and other routine lab
- Breast thermography
- Bone density test
- Well baby / well child care exam
- Routine immunizations
- Flu and pneumonia vaccines
- Routine lab, x-rays, diagnostic testing and other medical screenings including:
  - ✓ Blood pressure
  - ✓ Diabetes
  - ✓ Cholesterol tests
- Many cancer screenings including:
  - ✓ Cervical cancer
  - ✓ Breast cancer
  - ✓ Colorectal cancer
- Contraception (FDA):
  - ✓ Approved contraceptive methods
  - ✓ Sterilization procedures
  - ✓ Patient education and counseling

  (Covered contraceptives do not include abortifacient drugs)
- Counseling on topics such as:
  - ✓ Obesity & eating healthy
  - ✓ Treating Depression
  - ✓ Alcohol & drug abuse
  - ✓ Smoking cessation
  - ✓ Domestic & interpersonal violence
  - ✓ Sexually transmitted diseases

IMPORTANT DETAILS

Network providers: Health plans are required to provide these preventive services only through an in-network provider.
Office visit fees: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

Coverage: Coverage is provided for preventive services only. Once a diagnosis has been made, the services are not covered under the MEC.

Talk to your health care provider: To know which covered preventive services are right for you — based on your age, gender, and health status — ask your health care provider.
For information on preventive practices, check out healthcare.gov.

Questions: If you have questions regarding your coverage, please call Customer Service at (877) 685-2432.

CHC Century Healthcare

IMPORTANT NOTICES

This document is a program highlight and it is not intended to be a complete or legal description of the program of benefits. The complete information will be in the group policy provided to the employer and the certificates of insurance that will be made available to all participating employees for the various programs selected.

1. The Limited Fixed Indemnity Insurance Plan is underwritten by Companion Life Insurance Company (A+ A.M Best rating).
2. Fairmont Specialty, a division of Crum & Forster Insurance Company, is the carrier for the Accident Medical and AD&D benefits.
3. The Term Life Insurance Plan is underwritten by The Standard Life Insurance.
4. The Prescription Drug Insurance Plan is underwritten by Gerber Life Insurance Company.

Premium rates for the insurance plan may be changed upon written notice 31 days in advance and may be subject to an initial rate guarantee period selected by the employer when applying for coverage.

Important Details for MEC coverage:

- Network providers: Health plans are required to provide these preventive services only through an in-network provider.
- Office Visit Fees: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit.
- Coverage: Coverage is provided for preventive services only. Once a diagnosis has been made, the services are not covered under the MEC. For more information regarding preventive services visit www.healthcare.gov.
- MEC Plan for Massachusetts Residents: This health plan does not meet the Minimum Creditable Coverage standards and therefore does not satisfy the Individual Mandate.

This program is not comprehensive major medical insurance; however, it is a cost-effective plan of limited medical benefits that provides an alternative to the high cost of healthcare.

Termination of Policy:

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance benefits under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

Eligibility:

These benefits are available to all employees in an eligible class designated by the employer and who are actively at work. Employees may enroll their spouse and children under 26 years of age.

EXCLUSIONS & LIMITATIONS

The Limited Fixed Indemnity Insurance Plan underwritten by Companion Life Insurance Company will not pay benefits for any loss or injury that is caused by, or results from:

1. Suicide or any attempt thereat, while sane or insane (In Missouri, the reference to insanity does not apply and suicide is no defense to payment under this Policy where the Covered Person is a Missouri citizen unless the Company can show that the Covered Person intended suicide when he or she applied for coverage, regardless of any language to the contrary in the Policy.)
2. any intentionally self-inflicted injury or sickness;
3. rest care or rehabilitative care and treatment unless a separate Benefit Rider is purchased;
4. cosmetic surgery or care or treatment solely for cosmetic purposes, or complications there from. This exclusion does not apply to cosmetic surgery resulting from a covered Accident if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
5. immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals unless a separate Benefit Rider is purchased;
6. routine newborn care, including routine nursery charges;
7. voluntary abortion, except with respect to the Insured or covered Dependent spouse:
    A. where such person's life would be endangered if the fetus were carried to term; or
    B. where medical complications have arisen from an abortion;
8. pregnancy of a Dependent child, unless required by law;
9. the treatment of:
    A. mental illness unless a separate Benefit Rider is purchased;
    B. functional or organic nervous disorder, regardless of cause unless a separate Benefit Rider is purchased;
    C. alcohol abuse unless a separate Benefit Rider is purchased;
    D. drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed, for more than 10 days in any Calendar Year, with respect to payment of the Daily In-Hospital Indemnity Benefit unless a separate Benefit Rider is purchased;
10. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
11. committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
12. air travel, except:
    A. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
    B. as a passenger for transportation only and not as a pilot or crew member;
13. any Accident occurring as a result of the Covered Person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place);
14. sex changes;
15. experimental treatments or surgery;
16. the reversal of tubal ligation and vasectomies;
17. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law;
18. treatment of exogenous obesity or weight control;
19. an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered;
20. accident or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;
21. air ambulance;
22. ground ambulance unless a separate Benefit Rider is purchased;
23. loss incurred, care or treatment received, or hospital confinement occurring outside of the United States or its possessions except in the event of a Medical Emergency.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Companion Life Insurance Company from providing insurance, including, but not limited to, the payment of claim

Submit the completed form to your employer

Enrollment Form for Group Insurance

Employer – Please complete this section

Requested Effective date: ____________ Date of Hire: ____________ Location: ____________

Current Employment Status: ❒ Full Time ❒ Part Time ______ (Number of Hours) ❒ Other ____________

Indicate one of the following: ❒ Initial Enrollment ❒ Open Enrollment ❒ New Hire ❒ Life Status Change ❒Waive Coverage

Employers Name: Heartland Automotive Services, Inc. CHC Group No. CHC 5172

Employee Information – Please print clearly and legible

Last Name	First Name	Middle Initial	Social Security No.
Mailing Address	City	State	Zip Code
E-mail Address	Primary Phone Number	Date of Birth	Location of Employment

Gender: ❒ Male ❒ Female	Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Legally Separated ❒ Widowed

Benefit Plan Selection Information for: ❒ New Coverage ❒ Change in Coverage

Value Plan (MEC Plus)	Biweekly Cost	Select Plan (MEC Plus)	Biweekly Cost
❒ Employee Only	$39.28	❒ Employee Only	$51.28
❒ Employee + 1	$71.26	❒ Employee + 1	$100.80
❒ Employee + Family	$121.48	❒ Employee + Family	$173.63

Dependent Information – To add more dependents than the ones below, please attach an additional page and label it with your name.
Please note that if you are enrolling dependents, the information below is required. If information is missing their enrollment could be delayed or declined.

Do you have an eligible Spouse? ❒ Yes ❒ No How many dependent children do you have? ____________

Spouse's Full Name:	SSN:	Date of Birth:	❒ M ❒ F
Child's Full Name:	SSN:	Date of Birth:	❒ M ❒ F
Child's Full Name:	SSN:	Date of Birth:	❒ M ❒ F
Child's Full Name:	SSN:	Date of Birth:	❒ M ❒ F

(Continued on Next Page)

Refusal of Coverage (check box below to waive coverage)

❐ I choose not to enroll in the Limited Benefit Medical Plan / Minimum Essential Coverage, plan(s) offered by my employer. I understand that if I decide to enroll at a later date I will not be able to do so unless it is during the next open enrollment period or a life status event. Please note that if there is a life status change you only have 30 days to enroll or make any changes to the policy.

I have read the Limited Fixed Indemnity Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Fixed Indemnity Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date

I authorize my employer to deduct the required premium for the plan I have elected from my pay.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

The MEC Plan for Massachusetts residents: This health plan does not meet the Minimum Creditable Coverage standards and therefore does not satisfy the individual mandate.

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.

______________________________ ______________________________

Employee's Signature Date Signed

Accidental Death & Dismemberment – Fairmont Specialty Services:

I understand that the benefits package being offered by my employer automatically includes a $15,000 Accidental Death & Dismemberment benefit through Fairmont Specialty Services.

Beneficiary Information – To add more beneficiaries than shown below, please attach an additional page and label it with your name.

Beneficiary 1		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

Beneficiary 2		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

Contingent Beneficiary – Benefits will be paid in case the primary beneficiaries did not survive the insured		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

If you do not name a beneficiary or if you are not survived by one, benefits will be paid in equal shares to the firs surviving class of the ones below:

1) Your Spouse 2) Your Child(ren) 3) Your Parents 4) Your Brother(s) and/or sister(s) 5) Your Estate

______________________________ ______________________________

Employee's Signature Date Signed

(Continued on Next Page)

Term Life and Dependent Life – The Standard:
I understand that the benefits package being offered by my employer automatically includes a $10,000 Term Life benefit as well as a $10,000 dependent life benefit for spouse and $2,000 for child(ren) through The Standard.

Beneficiary Information – To add more beneficiaries than shown below, please attach an additional page and label it with your name.

Beneficiary 1		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

Beneficiary 2		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

Contingent Beneficiary – Benefits will be paid in case the primary beneficiaries did not survive the insured		
Full Name:	Full Address:	
Social Security No.	% of Benefit	Relationship to Employee

If you do not name a beneficiary or if you are not survived by one, benefits will be paid in equal shares to the firs surviving class of the ones below:
1) Your Spouse 2) Your Child(ren) 3) Your Parents 4) Your Brother(s) and/or sister(s) 5) Your Estate

Employee's Signature

Date Signed