Ace Staffing

Effective: March 1, 2021 to February 28, 2022

Print Name:_____ **Date:**_____

UHC	HMO BWPQ / 570
Deductible (Ind/Fam)	$5,000 / $10,000
In-Network Coinsurance	50% / 50%
Out-of-Pocket (Ind/Fam)	$6,600 / $13,200
Office Visit	$40
Specialist	$80
Routine/Preventative Lab	$0
Imaging:MRI, CT, Nuclear Study, etc	50% after Ded
Urgent Care	$50
Emergency Room	$350
Hospital - Inpatient	50% after Ded
Outpatient Surgery	50% after Ded
Prescription Drugs: RX Ded	
RX Deductible	$0
Tier 1	$10
Tier 2	$35
Tier 3	$70
Out-of-Network	
Non-Network Deductible (Ind/Fam)**	NA
Non-Network Coinsurance**	NA
Non-Network Out-of-Pocket (Ind/Fam)**	NA
Emergency Room**	$350
Employee Rates	
Select your Weekly Payroll Deduction	
Employee	$52.02
Employee + Spouse	$289.21
Employee + Children	$268.39
Employee + Family	$480.62

Sign:_____

Date:_____

WAIVER of Coverage:

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, wait until the next open enrollment period or as a late enrollee.

I am declining coverage due to existing other coverage:

____ Spouses Employer Plan ____COBRA from Prior ____ VA Eligibility

____ Individual Plan ____ Tricare ____ I do not have other coverage at this time

____ Covered by Medicare ____ Medicaid ____Other _____

Signature (waiving coverage): _____

I understand that my employer, Ace Staffing is providing me an opportunity to enroll in the employer sponsored benefit plan after I have completed my 60 day waiting period. Payroll deductions for the benefits I elected will be deducted from my paycheck on a weekly basis as part of a flexible plan under the internal revenue code, Section 125. I understand that this election shall remain in place until the annual open enrollment period which is February of each year. No changes to this election may take place unless I provide my employer with proof of a life qualifying event such as marriage, divorce, birth of a child, adoption or significant change in my spouse's employer sponsored plan or benefits. I further understand that I am responsible to verify my coverage election and applicable payroll deduction upon the first pay period for which deductions are made.

VISION

Vision Benefits	Standard Insurance
Plan / Frequency	12 / 12 / 24
Exam	$15
Materials	$30
PARTICIPATING PROVIDER BENEFITS	
Single Vision	$30
Bifocal	$30
Trifocal	$30
Lenticular	$30
Frames	$130
Contacts	$105 Allowance
NON-PAR PROVIDER BENEFITS	Reimbursement
Exam	Up to $40
Lenses	
Single Vision	Up to $40
Bifocal	Up to $60
Trifocal	Up to $80
Frames	Up to $45
Contacts	Up to $105
Weekly Deduction	Circle Deduction Amount Below
Employee	$0.00
Employee + Spouse	$1.12
Employee + Child(ren)	$1.52
Employee + Family	$2.65
Signature:	Date:

WAIVER of Coverage:

I am declining cover due to existence of other coverage:

____ Spouses Employer Plan ____COBRA from Prior Employer ____ VA Eligibility

____ Individual Plan ____ Tricare ____ I do not have other coverage at this time

____ Covered by Medicare ____ Medicaid ____Other _____

Signature (waiving coverage): DATE: