Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Department of Revenue Services
State of Connecticut
(Rev. 11/18)

Form CT-W4P
Withholding Certificate for Pension or Annuity Payments

2019

Purpose: Form CT-W4P is for Connecticut resident recipients of pensions, annuities, and certain other deferred compensation, to tell payers the correct amount of Connecticut income tax to withhold. Your options depend on whether the payment is periodic or nonperiodic. Read instructions on Page 2 before completing this form.

Instructions for Periodic Payments, such as a monthly pension payment:

Step 1: (Required) Select the filing status and description of income from the chart below that best matches your situation. Enter the corresponding Withholding Code on Line 1.

Step 2: (Optional) To see the amount of tax that will be withheld monthly, go to **portal.ct.gov/DRS**, select *Forms*, below the section titled **Guidance** select *Calculators*, then select *Monthly Connecticut Withholding Calculator*.

Step 3: (Optional) To increase or decrease the amount that will be withheld, enter an additional amount on Line 2, or a reduction amount on Line 3.

Instructions for Nonperiodic Payments, such as an on demand distribution: Do **not** use the chart below. Either enter Withholding Code E on Line 1 which will result in $0 withholding; **or** enter Withholding Code E on Line 1 and a dollar amount on Line 2 for a specific amount to be withheld. If neither of these options are indicated, your payer will withhold at 6.99%.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is **less** than or equal to $24,000 **or** no withholding is necessary (i.e., withholding from other income source).	**E**
My spouse **has** income subject to withholding and our expected combined annual gross income is **greater** than $24,000 and less than or equal to $100,500.	**A**
My spouse **does not** have income subject to withholding and our expected combined annual gross income is **greater** than $24,000.	**C**
My spouse **has** income subject to withholding and our expected combined annual gross income is **greater** than $100,500.	**D**
I have significant other income and wish to avoid having too little tax withheld.	**D**

Married Filing Separately	Withholding Code
My expected annual gross income is **less** than or equal to $12,000 **or** no withholding is necessary (i.e., withholding from other income source).	**E**
My expected annual gross income is **greater** than $12,000.	**A**
I have significant other income and wish to avoid having too little tax withheld.	**D**

Single	Withholding Code
My expected annual gross income is **less** than or equal to $15,000 **or** no withholding is necessary (i.e., withholding from other income source).	**E**
My expected annual gross income is **greater** than $15,000.	**F**
I have significant other income and wish to avoid having too little tax withheld.	**D**

Qualifying Widow(er) With Dependent Child	Withholding Code
My expected annual gross income is **less** than or equal to $24,000 **or** no withholding is necessary (i.e., withholding from other income source).	**E**
My expected annual gross income is **greater** than $24,000.	**C**
I have significant other income and wish to avoid having too little tax withheld.	**D**

Head of Household	Withholding Code
My expected annual gross income is **less** than or equal to $19,000 **or** no withholding is necessary (i.e., withholding from other income source).	**E**
My expected annual gross income is **greater** than $19,000.	**B**
I have significant other income and wish to avoid having too little tax withheld.	**D**

Submit completed form to the payer of your pension or annuity, **not** DRS.

Department of Revenue Services
State of Connecticut

Withholding Certificate for Pension or Annuity Payments

2019 Form CT-W4P

Complete the following applicable lines.

1. Withholding Code: See instructions above. ..... **1.** _____

2. Additional withholding amount per payment, if any. ..... **2.** $ _____

3. Reduced withholding amount per payment, if any. ..... **3.** $ _____

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			Claim or identification number (if any) of your pension or annuity contract
City/town	State	ZIP code	

Declaration: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than $5,000, imprisonment for not more than five years, or both.

Payee's signature	Date

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

EXCEL PARTNERS

DIRECT DEPOSIT AGREEMENT FORM

Providing Professional Staffing Services Specializing in Administrative, Office, Accounting & Finance Support

Excel Partners realizes the importance of receiving your pay as quickly and conveniently as possible. In order to achieve this, we accept two forms of electronic payment which are described below. Please choose which method you prefer and return this form to us prior to starting your assignment. You may change your selection at any time.

Direct deposits occur every Thursday morning for time cards received prior to 10am the previous Monday, regardless of holidays.

Electronic Option 1 - Direct Deposit Account Information

Name of Financial Institution: _____

Routing Number (9 digits): _____

Account Number: _____

Account Type (Select one): ☐ Checking ☐ Savings

In order to verify the account and routing number, direct deposit forms will not be accepted without a voided/copy of a check or letter from your bank. You send a scan/photo separately to payroll@excel-partners.com or fax to (203) 978-6203.

Electronic Option 2 – WEX rapid! Paycard

MasterCard rapid! PayCard®

rapid! PayCard® MasterCard®

- Payment of wages by means of a PayCard is voluntary. Employee may instead choose to receive wages by direct deposit or negotiable check.
- Use rapid! Paycard at ATMs to get cash whenever you need it. Free withdrawals from Allpoint network ATMs. Convenient locations include CVS, Walgreens, Target, Costco and 7 Eleven. Go to www.allpointnetwork.com for a complete list.
- Use as a debit card and receive cash back with purchases.
- Take to any bank that displays the Mastercard logo and withdraw the entire balance to avoid check cashing fees.

Card ID Number: _____

For internal use only: Routing # 124085244 Account Number: _____ Date: _____

Authorization Agreement

I hereby authorize Excel Partners, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Excel Partners, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Excel Partners, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Excel Partners, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Name: _____ Date of Birth: _____ Social Security #: _____

Street Address (no PO Box): _____

City: _____ State: _____ Zip: _____ Phone: _____

_____ _____

Authorized Signature Date

EXCEL PARTNERS

Affordable Care Act Compliant, Self-Funded Minimum Essential Coverage (MEC) Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

1. You **MUST** complete the Enrollment Form as part of your New Hire Process.
2. Elect or decline all benefits on the Enrollment Form.
3. You **MUST** Sign and Date the bottom of the form, even if you decline coverage.
4. Return the Enrollment Form to your Branch Manager.
5. Keep the Benefits at a Glance page for your records.

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

The MEC Wellness/Preventive Plan is an employer-sponsored, self-funded plan that has been deemed to be in compliance with ACA rules and regulations. More information about Preventive Services may be found on the government website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/. For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

Voluntary Electronic Availability of Summary Health Information for MEC/Wellness Preventive Plan

Copies of the Summary of Benefits and Coverage ("SBC") and Summary Plan Description ("SPD") from Essential StaffCARE ("ESC") are available at the following link: www.essentialstaffcare.com/mec-sbc-spd

While you may have other health plans, this is the link for your specific MEC plan SPD with ESC. These important documents explain the terms and conditions of your *Health Plan, including eligi*bility, coverage amounts and exclusions along with your rights and responsibilities. At any time, you may request paper copies or revoke your consent to electronic delivery, free of charge, by calling 1-866-798-0803.

For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

ESC Essential StaffCARE

VSI **82907300-M-ECP** | OFFICE USE ONLY | LOCATION _____ | Rehire Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

MEC 4S PM v.5.0

A. REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Name	Social Security #	Home Phone	Gender M F
Address			Apt. #
City	State	ZIP	Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS HAVE MEDICARE?

☐ Yes ☐ No. If Yes, please fill out remainder of Section B.

Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date

Name of Covered Person(s): 1.	2.	3.

C. OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT SELECTION

Direct Payment Monthly Rates

Enrolling in the **Optional MEC Wellness/Preventive Benefit** may **DISQUALIFY** you from receiving a subsidy from the health insurance exchange. The MEC Wellness/Preventive Benefit is **NOT** underwritten by BCS Insurance Company. It is a benefit offered and provided by your employer. Rates for the MEC Wellness/Preventive Benefit are billed monthly.

MEC Wellness/Preventive

- ☐ **$58.19** Employee Only
- ☐ **$65.79** Employee + Child(ren)
- ☐ **$71.00** Employee + Spouse
- ☐ **$80.87** Employee + Family
- ☐ **NO** to MEC Wellness/Preventive

D. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner
Name	Social Security #	Date of Birth / /	Gender M F	Relationship ☐ Spouse ☐ Child ☐ Domestic Partner

E. REQUIRED SIGNATURE

You MUST sign and date this form, even if you decline coverage.

I have read the benefit packet and understand its limitations. I understand that I have been offered ACA compliant coverage (MEC Wellness/Preventive), and open enrollment is only available for a limited time. I understand that making no benefit selection is a declination of coverage.

DATE __ __ /__ __ /__ __ __ __ ▶ **SIGNATURE**

MEC WELLNESS/PREVENTIVE PLAN BENEFITS AT A GLANCE

ACA Required Wellness and Preventive Benefits

82907300-M-ECP

ADULTS	100% in network, 40% out of network
Abdominal Aortic Aneurysm	One time screening for men of specified ages who have ever smoked
Alcohol Misuse	Screening and counseling
Aspirin	Use for men and women of certain ages
Blood Pressure	Screening for all adults
Cholesterol	Screening for adults of certain ages or at higher risk
Colorectal Cancer	Screening for adults over 50
Depression	Screening for adults
Type 2 Diabetes	Screening for adults with high blood pressure
Diet	Counseling for adults at higher risk for chronic disease
HIV	Screening for all adults at higher risk
Immunization	Vaccines for adults' doses, recommended ages, and recommended populations vary: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella
Obesity	Screening and counseling for all adults
Sexually Transmitted Infection (STI)	Prevention counseling for adults at higher risk
Tobacco Use	Screening for all adults and cessation
Syphilis	Screening for all adults at higher risk
WOMEN	**100% in network, 40% out of network**
Anemia	Screening on a routine basis for pregnant women
Bacteriuria	Urinary tract or other infection screening for pregnant women
BRCA	Counseling about genetic testing for women at higher risk
Breast Cancer Mammography	Screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention	Counseling for women at higher risk
Breastfeeding	Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
Cervical Cancer	Screening for sexually active women
Chlamydia Infection	Screening for younger women and other women at higher risk
Contraception	Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
Domestic and Interpersonal Violence	Screening and counseling for all women
Folic Acid	Supplements for women who may become pregnant
Gestational Diabetes	Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea	Screening for all women at higher risk
Hepatitis B	Screening for pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV)	Screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test	High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Osteoporosis	Screening for women over age 60 depending on risk factors
Rh Incompatibility	Screening for all pregnant women and follow-up testing for women at a higher risk
Tobacco Use	Screening and interventions for all women, and expanded counseling for pregnant tobacco users
Sexually Transmitted Infections (STI)	Counseling for sexually active women
Syphilis	Screening for all pregnant women or other women at increased risk
Well-Woman Visits	To obtain recommended Preventive services for women under 65

continued on next page

MEC WELLNESS/PREVENTIVE PLAN BENEFITS AT A GLANCE
ACA Required Wellness and Preventive Benefits

CHILDREN	100% in network, 40% out of network
Alcohol and Drug Use	Assessments for adolescents
Autism	Screening for children at 18 and 24 months
Behavioral	Assessments for children of all ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
Blood Pressure	Screenings for children: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 yers; 15 to 17 years
Cervical Dysplasia	Screening for sexually active females
Congenital Hypothyroidism	Screening for newborns
Depression	Screening for adolescents
Developmental	Screening for children under age 3, and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk of lipid disorders. Ages: 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years
Fluoride Chemoprevention	Supplements for children without fluoride in their water source
Gonorrhea	Preventive medication for the eyes of all newborns
Hearing	Screening for all newborns
Height, Weight, and Body Mass Index	Measurements for children ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
Hematocrit or Hemoglobin	Screening for children
Hemoglobinopathies	Or Sickle Cell screening for newborns
HIV	Screening for adolescents at higher risk
Immunization	Vaccines for children from birth to age 18-- doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella
Iron	Supplements for children ages 6 to 12 months at risk for anemia
Lead	Screening for children at risk of exposure
Medical History	For all children throughout development: Ages: 0-11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; 15 to 17 years
Obesity	Screening and counseling
Oral Health	Risk assessment for young children: Ages: 0 to 11 months; 1 to 4 years; 5 to 10 years
Phenylketonuria (PKU)	Screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI)	Prevention counseling and screening for adolescents at higher risk
Tuberculin	Testing for children at higher risk of tuberculosis: Ages 0 to 11 months; 1 to 4 years; 5 to 10 years; 11 to 14 years; and 15 to 17 years
Vision	Screening for all children

MONTHLY MEC PREMIUM Policy Number **82907300-M-ECP**

Employee Only	**$58.19**	**Employee + Spouse**	**$71.00**
Employee + Child(ren)	**$65.79**	**Employee + Family**	**$80.87**

MEMBER SERVICES

For frequently ask questions regarding the MEC Wellness Preventive Benefit, please go to *www.esc-enrollment.com/FAQMEC.*

PLEASE NOTE: To make changes or cancel coverage by telephone call (800) 269-7783. Your Company has chosen to take your payroll deductions on a **Post-Tax** basis.

Essential StaffCARE Customer Service: 1-866-798-0803

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, and policy booklets and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.paisc.com and click on "Members" and enter your group number.