Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

► _____ ► _____

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Department of Revenue Services
State of Connecticut

(Rev. 12/19)

Form CT-W4

Employee's Withholding Certificate

Complete this form in blue or black ink only.

Effective January 1, 2020

Employee Instructions

- Read the instructions on Page 2 before completing this form.
- Select the filing status you expect to report on your Connecticut income tax return. See instructions.
- Choose the statement that best describes your gross income.
- Enter the *Withholding Code* on Line 1 below.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the Military Spouses Residency Relief Act (MSRRA)* and no withholding is necessary.	**E**
My spouse **is** employed and our expected combined annual gross income is **greater** than $24,000 and less than or equal to $100,500. See *Certain Married Individuals*, Page 2.	**A**
My spouse **is not** employed and our expected combined annual gross income is **greater** than $24,000.	**C**
My spouse **is** employed and our expected combined annual gross income is **greater** than $100,500.	**D**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

Qualifying Widow(er)	Withholding Code
My expected annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $24,000.	**C**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

Married Filing Separately	Withholding Code
My expected annual gross income is **less** than or equal to $12,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $12,000.	**A**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

Single	Withholding Code
My expected annual gross income is **less** than or equal to $15,000 and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $15,000.	**F**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

Head of Household	Withholding Code
My expected annual gross income is **less** than or equal to $19,000 and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $19,000.	**B**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

* If you are claiming the Military Spouses Residency Relief Act (MSRRA) exemption, see instructions on Page 2.

Employees: See *Employee General Instructions* on Page 2. Sign and return Form CT-W4 to your employer. Keep a copy for your records.

1. Withholding Code: Enter *Withholding Code* letter chosen from above. ..... 1. _____

2. Additional withholding amount per pay period: If any, see instructions. ..... 2. $_____

3. Reduced withholding amount per pay period: If any, see instructions. ..... 3. $_____

❒ Check if you are claiming the MSRRA exemption and enter state of legal residence/domicile: _____

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			
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.

Employee's signature	Date

Employers: See *Employer Instructions,* on Page 2.

Is this a new or rehired employee? ❒ No ❒ Yes Enter date hired: _____ mm/dd/yyyy

Employer's business name	Federal Employer Identification Number
Employer's business address	
City/town State ZIP code	
Contact person	Telephone number – –

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in 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 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.

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

ENROLLMENT FORM

MEC 4S PM v6.0

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. Note: The Federal Affordable Care Act (ACA) individual mandate no longer imposes a penalty; however, please check your state for any individual mandate requirements or penalties.

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.