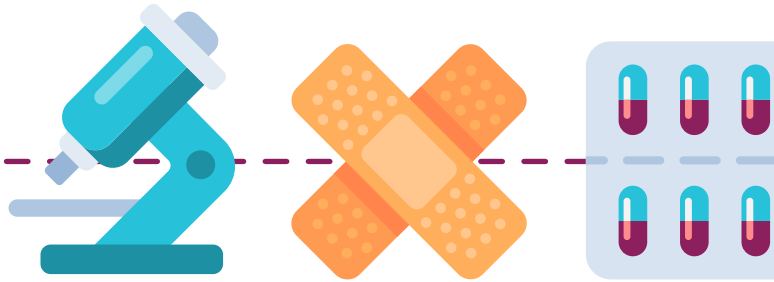
carepath BENEFITS

MINIMUM ESSENTIAL COVERAGE PLANS

Affordable coverage options designed to promote the health of your employees & their families.

- **MEC**
- **MEC+**
- **MEC** *CARE*
- **MEC** *PRIME*



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Carepath Benefits is pleased to offer four affordable Minimum Essential Coverage (MEC) plans that cover all the bases for preventive and wellness services but also go a step further, offering limited outpatient and inpatient medical benefits to give employers maximum flexibility in addressing costs and plan benefits while still prioritizing employee health. These value-based MEC plans offer an additional layer of tangible medical-related benefits for employees - in categories that they will appreciate!

Affordable, Flexible, and ACA-Compliant

MINIMUM ESSENTIAL COVERAGE & MORE!

Since provisions of the Affordable Care Act (ACA) were implemented in 2016, employers with 50 or more full-time (or equivalent) employees are required to provide at least a Minimum Essential Coverage group health benefit plan to avoid the $2,000 per employee penalty (indexed for inflation) for non-compliance. Carepath Benefits offers four MEC plan designs to meet the minimum essential coverage required services for employers in search of an affordable, ACA-compliant solution. Our MEC plans provide employers with an expanded set of options with regards to ACA-compliance.

If you offer our MEC plans alongside a major medical plan that meets the requirements for Minimum Value, you can also eliminate the possibility of the $3,000 penalty (indexed for inflation) in the event that an eligible employee purchases insurance through the Marketplace.

FEATURED PLAN DESIGNS

	MEC
64 Preventive & Wellness Services	✓
Telemedicine Services	✓
Primary Care Office Visit Copay	⊘
Specialist Office Visit Copay	⊘
Outpatient Services	⊘
Emergency Services	⊘
Inpatient Services	⊘
Rx Drug Benefits	⊘

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COVERED SERVICES

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Carepath's MEC Plans meet the criteria for preventive and wellness services as designated by the Centers for Medicare and Medicaid Services (CMS) by offering the following covered benefits:

15 COVERED PREVENTIVE SERVICES FOR ADULTS (AGES 18 AND OLDER)

1. Abdominal Aortic Aneurysm
2. Alcohol Misuse
3. Aspirin for CVD
4. Blood Pressure
5. Cholesterol
6. Colorectal Cancer
7. Depression Screening
8. Type 2 Diabetes Screening
9. Diet Counseling
10. HIV Screening
11. Immunizations
12. Obesity Screening
13. Sexually Transmitted Infection (STI) Prevention Counseling
14. Tobacco Use Screening
15. Syphilis Screening

23 COVERED PREVENTIVE SERVICES FOR WOMEN (INCLUDING PREGNANT WOMEN)

1. Anemia Screening
2. Bacteriuria urinary tract infection screening
3. BRCA Counseling
4. Breast Cancer Mammography
5. Breast Cancer Chemoprevention Counseling
6. Breastfeeding Support / Counseling
7. Cervical Cancer Screening
8. Chlamydia Infection Screening
9. Contraception (FDA Approved)
10. Domestic and interpersonal violence screening
11. Folic Acid Supplements
12. Gestational diabetes screening
13. Gonorrhea Screening
14. Hepatitis B Screening
15. Human Immunodeficiency Virus (HIV) Screening
16. Human Papillomavirus (HPV) DNA Test
17. Osteoporosis Screening
18. Routine prenatal visits
19. Rh Incompatibility Screening
20. Tobacco Use Screening
21. Sexually Transmitted Infections (STI) Counseling
22. Syphilis Screening
23. Well-woman visits

26 COVERED SERVICES FOR CHILDREN (UNDER 26 YEARS OLD ON PARENT'S PLAN)

1. Alcohol and Drug Use Assessments
2. Autism Screening
3. Behavioral Assessments
4. Blood Pressure Screening
5. Cervical Dysplasia Screening
6. Congenital Hypothyroidism Screening
7. Depression screening
8. Developmental Screening / Surveillance
9. Dyslipidemia Screening
10. Fluoride Chemoprevention Supplements
11. Gonorrhea Preventative Medication
12. Hearing Screening for Newborns
13. Height, Weight and Body Mass Index Measurements
14. Hematocrit or Hemoglobin Screening
15. Hemoglobinopathies or Sickle-Cell Screening
16. HIV Screening
17. Immunizations
18. Iron supplements
19. Lead Screening
20. Medical History throught Developmental Ages
21. Obesity screening and Counseling
22. Oral Health Risk Assessment
23. Phenylketonuria (PKU) Screening
24. Sexually Transmitted Infection (STI) prevention counseling
25. Tuberculin Testing
26. Vision Screening

IMPORTANT NOTES:

1) Plan participants must see a doctor within the PHCS PPO Network in order to be covered for the preventive services listed as part of the covered benefits summary.

2) All Mammography and Colonoscopy Screening require pre-certification.

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PLAN BENEFITS

In addition to the Preventive & Wellness covered services, our plans offer the following covered benefits:

BENEFITS	*MEC*
Preventive & Wellness Services	100% Coverage * **
Physician Office Visits	
• Primary Care Office Visit	Not Covered
• Specialist Office Visit	Not Covered
• Physician & Surgeon Professional Services	Not Covered
• Anesthesia Professional Services	Not Covered
Telemedicine Consultations	Included, $0 Copay
Outpatient Lab	Not Covered
Outpatient Radiology & Imaging	
• Physician Office/Freestanding Imaging Ctr.	Not Covered
• Hospital Outpatient	Not Covered
Outpatient Rehab & Therapy	Not Covered
Allergy Treatment	Not Covered
Emergency Services	
• Hospital ER (Facility Charge Only)	Not Covered
• Urgent Care / ER Professional Services	Not Covered
• Ambulance	Not Covered
• Air Ambulance	Not Covered
Outpatient Surgical Procedures	
• Physician Office / Freestanding Surgery Ctr.	Not Covered
• Outpatient Hospital	Not Covered
Inpatient Hospitalization	
• Medical Facility Services	Not Covered
Prescription Drug Benefits	Not Covered
COBRA Administration	Not Covered
PPO Network	PHCS *

* (Plan participants must see a doctor within the PHCS PPO Network in order to be covered for the benefits and services listed as part of the covered benefits summary
** (All Mammography and Colonoscopy Screening require pre-certification.)

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MEC PLAN PRICING

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Carepath's MEC Plans are affordable -- priced with maximum flexibility in mind.
The below provides you with a side-by-side comparison of our offering based on region:

Monthly Plan Pricing	Employee Contribution	Employer Contribution	Total Cost
Region A *(AK, CT, NJ, NY, PA)*			
Employee	$0.0	$73.03	$73.03
Employee+ Spouse	$57.42	$73.03	$130.45
Employee+ Child(ren)	$111.67	$73.03	$184.70
Employee+ Family	$165.90	$73.03	$238.93

Bi-weekly Plan Pricing	Employee Contribution	Employer Contribution	Total Cost
Region A *(AK, CT, NJ, NY, PA)*			
Employee	$0.0	$33.71	$33.71
Employee+ Spouse	$26.50	$33.71	$60.21
Employee+ Child(ren)	$51.54	$33.71	$85.25
Employee+ Family	$76.57	$33.71	$110.28

***** IMPORTANT NOTE: For AK, AR, CA, CO, CT, DE, FL, KY, MD, MN, NC, ND, NJ, NY, PA, TN, and UT*** - Specific minimum participation requirements apply. Groups in these states must be pre-approved to confirm compliance with state-specific requirements for aggregate attachment points. Region A rates are not final until written confirmation of state-specific compliance. Contact a Carepath Benefits Sales Representative for more details.

Carepath Benefits's products are designed with maximum flexibility in mind, utilizing a level-funded re-insurance platform that differs from traditional self-funded insurance. Our plans are 'level-funded' meaning that by design, any risk to the sponsoring employer has been removed through re-insurance coverage to protect the employer from liability for claims incurred.

The outlines represented herewithin are intended as a brief overview of the actual plan and represent in-network benefit levels. No benefits are payable for non-network services. Please refer to the Summary Plan Document (SPD) for the actual benefits, limitations, and exclusions. Certain procedures require pre-certification prior to scheduling in order to qualify for benefits. Failure to do so will result in penalties and/or non-coverage of services.

Plan rate schedule effective 1/1/21 through 12/31/21.

Individual Medical Questionnaire / Enrollment Form

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

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STATE SECURITY AGENCY

Section 1 – Employee Information

Full Name of Employee			Gender ◯ M ◯ F	Marital Status
Residence Address		City	State	Zip
Telephone Number *(include area code)*		Best Time to Contact *(if additional information is required by administrator)*	Email Address	
Date Began Full Time *(mm/dd/yy)*	DOB *(mm/dd/yy)*	Height	Weight	Social Security Number
Employed By **State Security Agency**	Employer's Phone *(include area code)* **718-268-8080**		Avg. No. of Hours Worked Weekly **Over 32 hours**	
Employer's Location – Street Address **70-21 Austin St. 3rd FL**		City **Forest Hills**	State **NY**	Zip **11375**
Occupation and Duties				

☐ I am an owner, partner or corporate officer ☐ I am **NOT** an owner, partner or corporate officer

I Am Enrolling For: ◉ Self Only ◯ Self & Spouse ◯ Self & Child(ren) ◯ Self, Spouse & Child(ren)

EMPLOYEE WAIVER

I am **NOT** enrolling because:

◯ COBRA from previous employer
◯ Coverage does not meet my needs
◯ Do not want to be Insured
◯ Medicare
◯ Enrolled in Medicaid
◯ Keeping own insurance
◯ Participating in Domestic Partner's Plan
◯ Other *(explain)* _____
◯ Participating in Parent's plan
◯ Participating in spouse's plan
◯ Covered under union labor health Plan
◯ VA Eligibility

DEPENDENT WAIVER

If you have dependents *(spouse and/or children)* and are not enrolling **ALL** of them, please complete the following:

I am **NOT** enrolling my *(check one or both)*: ☐ Spouse ☐ Child(ren) *(check one)*

Because: ☐ Covered by another group/individual health plan. ☐ Other *(explain)*

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been induced or pressured by anyone to decline such coverage. I understand that, if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted.

Individual Medical Questionnaire / Enrollment Form

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

Section 1 – Employee Information *(cont'd)*

PARTICIPANT INFORMATION – Complete for each person to be enrolled *(use additional sheet if necessary).*

Name of Participants	Relationship	Sex	Height	Weight	Date of Birth	SSN
1.						
2.						
3.						
4.						
5.						

PLAN SELECTION –

Section 2 – Other Coverage

Do you or your dependents have coverage under any health benefit plan? ☐ Yes ☐ No

COVERAGE TYPE

☐ Comprehensive Major Medical	☐ Other *(please provide copy of the benefit plan or schedule of benefits)*
Name of Health Plan	Health Plan Phone Number
Effective Date of Prior Coverage	Termination Date
Reason for Coverage Termination	

PLAN TYPE

☐ Employer Sponsored	Employer Name	Policy/Cert. Number
☐ Individual	Policy/Cert. Number	

Coverage was for ☐ Self ☐ Spouse ☐ Children

Individual Medical Questionnaire / Enrollment Form

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

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STATE SECURITY AGENCY

Section 3 – Medical History

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of, consultation, treatment or medication for:

	YES	NO
Brain or Nervous System	○	○
Endocrine or Adrenal Disorder	○	○
Liver, Pancreas or Kidney	○	○
Abnormal Blood Pressure	○	○
Heart or Circulatory System	○	○
Chest Pain or Stroke	○	○
Blood Disorder	○	○
Lymphatic Vessels or Glands	○	○
Cirrhosis or Hepatitis	○	○
Leukemia or Hodgkin's Disease	○	○
Cancer *(excluding Basal Cell Carcinoma)*	○	○
Alcohol or Drug Abuse	○	○
Congenital Disorders	○	○
Respiratory disorders other than Emphysema, TB and COPD	○	○

	YES	NO
Diabetes or Sugar in Urine	○	○
Digestive or Gastrointestinal Disorder	○	○
Breast or Reproductive Organs	○	○
Autoimmune Disorders	○	○
Disorders of Back or Spine	○	○
Rheumatoid Arthritis	○	○
Emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease	○	○
Multiple Sclerosis or Cystic Fibrosis	○	○
Skin or Collagen Disease	○	○
Disease of the Muscles	○	○
Arthritis other than rheumatoid	○	○
Joint Disorders	○	○
Mental/Emotional disorders	○	○

2. Within the last 5 years, has anyone enrolling for coverage been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection, any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition, significant weight loss, chronic fatigue, diarrhea, night sweats or enlarged glands?

○ Yes ○ No

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant or anticipating surgery or hospitalization, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self-care?

○ Yes ○ No 3a. If pregnant, please indicate due date _____

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized?

○ Yes ○ No

5. Are you or any dependent enrolling for coverage currently taking medication?

○ Yes ○ No

6. For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form?

○ Yes ○ No If "yes" answer, provide details below.

_____

_

_____

_____

Individual Medical Questionnaire / Enrollment Form

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

Section 3 – Medical History *(cont'd)*

Complete the table below to provide details to any "YES" answer from questions 1 through 6 (above)

Use a separate sheet if additional space is needed. Sign and attach additional pages
If taking medication for high blood pressure, please include your **last three** blood pressure readings

Person	Medical condition or specific reason for treatment	Dates of Treatment	Meds. & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition

Individual Medical Questionnaire / Enrollment Form

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

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Section 4 – Employee Statement and Signature

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed; A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; Underwriting Management Experts is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re- disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee _____ Date _____

Electronic copies of this enrollment card submitted via facsimile, email, or other electronic means shall be deemed an original.