KELLY

EMPLOYEE ELECTION FORM

Please print clearly in CAPITAL letters

☐ New Subscriber ☐ ☐ WAIVER (*Signature Required*) ☐ ☐

Company Name:		KELLY Company ID:		Business Phone:	

1 EMPLOYEE

Last Name	First Name	MI	Suffix (Jr., Sr., etc.)

Street *Note: a PO Box is insufficient for any HSA, FSA, or HRA account*	Apt #

City	State	Zip Code	E-mail

Social Security #	Date of Birth (MM-DD-YY)	Gender M ☐ F ☐	Marital Status Single ☐ Married ☐ Partner* ☐	On your effective date, will you be actively at work on a full-time basis for this employer? ☐ Y ☐ N	Hrs/week

Home Phone	Full-time Hire Date (MM-DD-YY)	***Employer Use Only:***	Requested Effective Date (MM-DD-YY)	KELLY USE ONLY: H

** Domestic partner coverage availability is based on carrier and employer authorization.*

2 DEPENDENTS

Name (Last, First, MI)	Relationship	Social Security #	Birth Date	Sex	F/T Student (Y/N)**	Disabled (Y/N)	Tobacco (Y/N)	Dependent Elections	Primary Care Physician (POS or HMO plans only) Physician Name	PCP ID#	Existing Patient (Y/N)
	Subscriber							Health / Dental / Vision			
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*** If full time student, please submit proper form, or appropriate verification of student status according to carrier guidelines (statement from Registrar's office, etc.)*

Participating Dentist Name/Code/Office#: Existing Patient: ☐ Y ☐ N

If Eligible for Medicare: Effective Date (Part A): Effective Date (Part B): Effective Date (Part D):

3 PLANS

HEALTH	DENTAL	VISION
Group# ____	Group#: ____	Group# ____
Carrier ____	Carrier ____	Carrier ____
Plan ____	Plan ____	Plan ____
☐ Individual	☐ Individual	☐ Individual
☐ Individual & Child(ren)	☐ Individual & Child(ren)	☐ Individual & Child(ren)
☐ Individual & Adult	☐ Individual & Adult	☐ Individual & Adult
☐ Family	☐ Family	☐ Family
☐ Over 65 & Working FT	☐ Waive Coverage	☐ Waive Coverage
☐ Over 65 & Retired		
☐ Waive Coverage		

CDH Funding: ☐ HRA ☐ HSA **Contrib. Amount $**____

☐ FSA **Contrib. Amount $**____ ☐ DCAP **$**____

	Plan Name	Benefit Amt	Smoker?
☐ Life AD&D		$	☐ Y
☐ Vol. Life		$	☐ Y
☐ Vol. AD&D		$	☐ Y
☐ Vol. Sp. Life		$	☐ Y
☐ Vol. Dep. Life		$	☐ Y
☐ STD		$	/ week
☐ Vol. STD		$	/ week
☐ LTD		$	/ month
☐ Vol. LTD		$	/ month
☐ Supp. Life/AD&D		$	
☐ Critical Illness			
☐ Accident			
☐ Identity Theft			
☐ On-Line Medical			

4

Employee Occupation:	Employee Class:	Employee Salary:

Primary Beneficiary: Relationship:

Secondary Beneficiary: Relationship:

5 OTHER INSURANCE INFORMATION

Will you or your dependents continue health coverage with another insurer? ☐ Yes ☐ No

Other Health Insurer Name: ____

Who is covered? ☐ Self ☐ Spouse/Partner ☐ All Policy# ____

Effective Date: Term Date:

CERTIFICATION: I hereby apply, on behalf of myself and each dependent listed above, for the coverage(s) indicated. If accepted, coverage will be provided according to the terms and conditions of the benefit plan(s) between the appropriate carrier(s) and my employer. I agree to be bound by the benefit plan(s) of which this form will become part. I also agree to pay current and future charges for coverage(s) provided in excess of any employer contribution. The recorded answers on this form are to the best of my knowledge and belief full, complete and true as of this date. I further certify that the dependents listed above are eligible to enroll in the plan(s) selected. I have read and understand the second page of this form, including the sections titled The Role of Kelly and Waiver of Insurance, which are incorporated here by reference. **If you have any questions concerning the benefits and services provided by or excluded under this agreement, please contact a Service Representative before signing this Election Form. Coverage shall become effective solely upon final approval by the Carrier and not from the collection of premiums.** **THIS IS NOT AN APPLICATION FOR INSURANCE**

6 EMPLOYEE SIGNATURE: **DATE:**

EMPLOYER SIGNATURE / VERIFICATION: **DATE:**

8/5/15

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www.kellyway.com

BlueChoice HMO *Open Access* HRA/HSA Minimum Value

Integrated Deductible

Summary of Benefits

Services	In-Network You Pay[1]
	Visit www.carefirst.com/doctor to locate providers
FIRSTHELP—24/7 NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
BLUE REWARDS	
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $600 for taking an active role in getting healthy and staying healthy.
ANNUAL DEDUCTIBLE (Benefit period)[2]	
Individual	$4,000
Family	$8,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[3]	
Medical[4]	$6,550 Individual/$13,100 Family
Prescription Drug[4]	Combined with in-network medical out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT	
Lifetime Maximum	None
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	Deductible, then $30 PCP/$40 Specialist per visit
Imaging (MRA/MRS, MRI, PET & CAT scans)[5]	Deductible, then 20% of Allowed Benefit
Lab[5]	Deductible, then 20% of Allowed Benefit
X-ray[5]	Deductible, then 20% of Allowed Benefit
Allergy Testing	Deductible, then $30 PCP/$40 Specialist per visit
Allergy Shots	Deductible, then $30 PCP/$40 Specialist per visit
Physical, Speech and Occupational Therapy[6] (limited to 30 visits/condition/benefit period)	Deductible, then $40 per visit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then $40 per visit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES	
Urgent Care Center	Deductible,then $50 per visit
Emergency Room—Facility Services	Deductible, then $250 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible
Ambulance (if medically necessary)	No charge* after deductible

Services	In-Network You Pay[1]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)	
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES	
Home Health Care	Deductible, then 20% of Allowed Benefit
Hospice	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility	Deductible, then 20% of Allowed Benefit
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7]	Not covered
In Vitro Fertilization Procedures[7]	Not covered
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit
Office Visits	Deductible, then $30 per visit
Medication Management	Deductible, then $30 per visit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 50% of Allowed Benefit
Hearing Aids	Not covered
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider
Eyeglasses and Contact Lenses	Discounts from participating vision centers

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.
[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
[2] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.
[3] For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.
[4] Plan has an integrated medical and prescription drug out-of-pocket maximum.
[5] Members who reside in the CareFirst service area must use LabCorp as their Lab Test facility and freestanding facilities for Imaging and X-rays.
[6] There are no limits for children under age 21 when Physical, Speech and Occupational Therapy is included as part of Habilitative Services.
[7] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

Note: Upon enrollment in CareFirst BlueChoice, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: DC/CFBC/GC (R. 1/13); DC/CFBC/DOCS (R. 6/09); DC/CFBC/EOC (R. 6/09); DC/BC-OOP/SOB HDHP (R. 7/07); DC/CFBC/ATTC (R. 1/10); DC/CFBC/RX3 (R. 1/15); DC/CFBC/DOL APPEAL (R. 7/11) and any amendments.

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Pharmacy Program Summary of Benefits

Formulary 3 ■ 5-Tier ■ Minimum Value ■ Integrated Deductible ■ $15/35/60 ■ Specialty 50%/50%

Plan Feature	Amount You Pay	Description
Deductible	See medical summary of benefits for annual deductible amount	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$15	Generic drug are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$35	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Preferred Specialty Drugs (Tier 4) (up to a 34-day supply)	50% up to a $100 maximum	You pay 50% coinsurance up to a maximum of $100 for all preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Non-preferred Specialty Drugs (Tier 5) (up to a 34-day supply)	50% up to a $150 maximum	You pay 50% coinsurance up to a maximum of $150 for all non-preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Maintenance Drugs (up to a 90-day supply)	Generic: $30 Preferred Brand: $70 Non-preferred Brand: $120 Preferred Specialty: 50% up to a $200 maximum Non-preferred Specialty: 50% up to a $300 maximum	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Maintenance preferred and non-preferred specialty drugs up to a 90-day supply **must be filled through Exclusive Specialty Pharmacy Network** and you pay 50% coinsurance up to a maximum copay.
Mandatory Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance.	

Visit ***carefirst.com/rx*** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: DC/CFBC/RX3 (R. 1/18) • DC/CF/RX3 (R. 1/18)

Family of health care plans

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