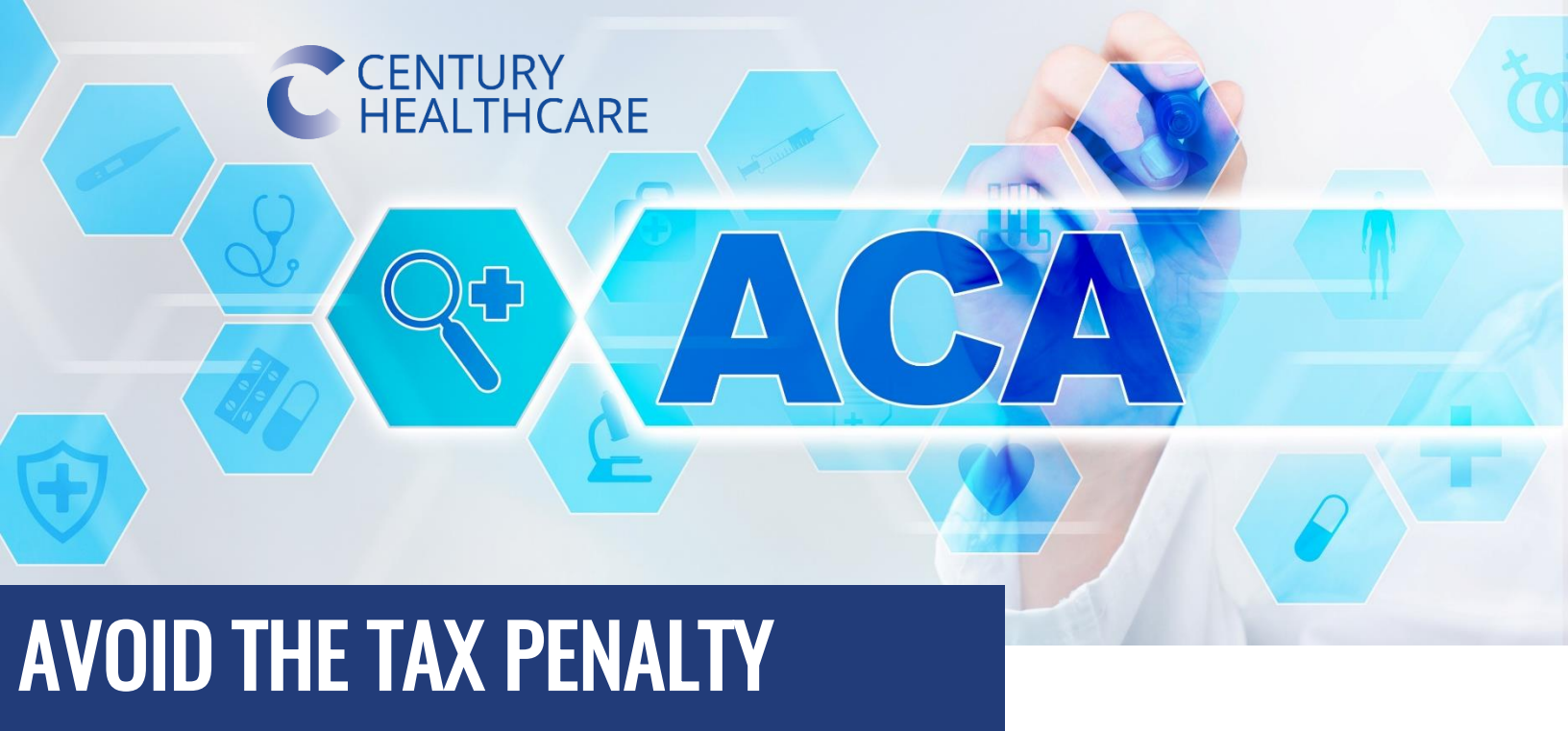




*American Trailer World*

# *2019 Benefit Summary*

A hand holding a hexagonal tile with a camera icon, surrounded by other hexagonal tiles containing medical icons like a stethoscope, syringe, microscope, pill, and human figure. The letters 'ACA' are prominently displayed in the center.

# ACA

## AVOID THE TAX PENALTY

### 2018 Individual Penalty Still In Play

The IRS will continue to enforce the tax penalties as dictated by the Affordable Care Act (ACA). Individuals must obtain qualified coverage through their employer or go to the exchange in order to fulfill the individual mandate.

### Reporting During Filing Season

The IRS has decided to require individuals to report medical coverage for the prior tax year when filing tax returns in order to accept and process the filing. The IRS will no longer accept “silent returns” without a response and individuals who do not provide their coverage information or proof of exemption, will be responsible to pay the penalty.

### Penalty Amounts

The penalty for 2017 and 2018 tax years will be 2.5% of your total household adjusted income, or \$695 per adult and \$347.50 per child (whichever is greater), up to a maximum of \$2,085.00.

### Enroll in ACA Compliant Coverage

The medical plans offered through your employer meet the ACA requirements and eliminate the individual tax penalty.

## Important Contacts

### Century Healthcare

Customer Service and Claims  
(877) 685-2432  
Monday through Friday  
7:00 AM – 7:00 PM CST

### Member Web Portal

(Access important plan documents, claim forms & temporary ID cards)  
[www.centuryhealthcare.com](http://www.centuryhealthcare.com)  
Username: CHC5600  
Password: Chc5600#



### PHCS Limited Benefit Network

[www.multiplan.com/chc](http://www.multiplan.com/chc)  
(888) 371-7427



### Pharmaceutical Benefits

[www.cerpasrx.com](http://www.cerpasrx.com)  
Pharmacy Customer Service: (844) 636-7506  
Mail Order Number: (844) 636-7506



### HealthiestYou

[www.healthiestyou.com](http://www.healthiestyou.com)  
(866) 703-1259

**Please Note:** A separate claim form is needed for the AD&D, Accident Medical & Life benefits. You may access the claims form through the client web portal or call the Century Healthcare's Customer Service Department.

## Benefit Description

### Preventive Services

All preventive services as specified by the Affordable Care Act such as annual physicals, mammograms, pap smears, preventive cancer screenings, routine lab and x-rays, and immunizations. See the MEC Summary.

### Doctor's Office Visit

Benefits paid for a doctor's office visit for medically necessary treatment, care, or advice of a covered injury or sickness.

### Outpatient Lab

Benefits paid for outpatient laboratory tests when ordered by a doctor and performed by an appropriately licensed technician.

### Outpatient X-Ray

Benefits paid for outpatient x-rays when ordered by a doctor and performed by an appropriately licensed technician.

### Advanced Studies

Limited to CT Scan, PET Scan, and MRI.

### Emergency Room

Benefits paid for emergency room visits for a medical emergency caused by sickness.

### Inpatient/Outpatient Surgery Benefits

Benefits paid if a covered person undergoes medically necessary surgery at the direction of a doctor for a covered injury or sickness.

### Inpatient/Outpatient Anesthesia Benefits

Benefits paid at 25% of the surgery benefit for anesthesia services for pre-operative screening and during a surgical procedure.

### First Hospital Confinement

Benefits Paid when a covered person is confined in a hospital for the first time in the Benefit Year. Pays in addition to the Hospital Confinement benefit.

### Hospital Confinement

Benefits paid if a covered person is confined as an inpatient in a hospital due to a covered injury or sickness.

### Maternity

Benefits paid under the applicable provision for Doctor's Office Visits, Outpatient Lab & X-ray, Surgery, and Hospital Confinement for pregnancy related expenses.

### Substance Abuse Confinement

Benefits paid for confinement in a rehabilitation facility for substance abuse.

### Mental Illness Disorder Confinement

Benefits paid for confinement in a rehabilitation facility for mental or nervous disorders.

### Skilled Nursing Facility Confinement

Benefits Paid for confinement in a skilled nursing facility. Confinement must begin within 3 days of hospital confinement.

## Value

100% Covered through in-network providers

Plan pays \$50 per day (6 days)

Plan pays \$10 per day (3 days)

Plan pays \$50 per day (2 days)

Plan pays \$200 per day (1 day)

Plan pays \$100 per day (1 day)

Inpatient: Plan pays \$500  
Outpatient: Plan pays \$250  
(1 IP or 1 OP surgery)

Inpatient: Plan pays \$125.00  
Outpatient: Plan pays \$62.50

Day 1: Plan pays \$500

Plan pays \$100 per day (30 days)

Included

Plan pays \$100 per day (30 days)

Plan pays \$100 per day (30 days)

Plan pays \$100 per day (30 days)

**Benefit Description****Value****Accident Medical**

(\$100 deductible per occurrence)

Up to \$5,000 per occurrence

**Accidental Death & Dismemberment**

Employee

\$15,000

Spouse

\$7,500

Children

\$3,000

**Term Life**

Employee

\$10,000

**Pharmaceutical Benefits**

Copay Rx Plan

Tier 1 (Most Generics): \$10 Co-Pay. Tier 2 (Some Generics & Preferred/Formulary Brand Name): \$50 or 50%; whichever is greater. Tier 3 (Non-Preferred / Non-Formulary Brand Name): Employees pay 100% of the cost after pharmacy discounts. Mail order option available for 90 day prescription supply at \$25 copay for tier 1 and \$125 or 50% for tier 2 medications. Monthly Maximum of \$250 Employee / \$500 Family. No Deductible. Restricted Formulary.

**PHCS PPO Limited Benefit Network**

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.

**Healthiest You (Unlimited Call at no cost to member)**

All plan designs provide covered individuals with 24/7 access to U.S. licensed physicians that can provide general advice and recommendations, diagnostic medical consultations, and write non-controlled prescriptions when appropriate. Healthiest You also provides members with access to an online wellness platform to help improve the member's overall health.

*All benefits except Accident Medical, AD&D, and Term Life are subject to Benefit Year Maximums as shown above.*

*Benefit Year means the 12 consecutive months from the group's original effective date. Please note that this is just a summary of the benefits and to know the full details of the policy the certificate of coverage needs to be reviewed once the policy is effective.*

*Benefits Effective 01/01/2019*

Preventive Services are covered at 100% through participating providers. The following is a brief description of the preventive benefits available to members and is subject to change under the Affordable Care Act. To learn more visit [www.healthcare.gov](http://www.healthcare.gov).

- Routine physical exam
- Well women exam (annual)
- Annual mammogram
- Annual pap smear and other routine lab work
- Breast thermography
- Bone density test
- Well baby / well child care exam
- Routine immunizations
- Flu and pneumonia vaccines
- Routine lab, x-rays, diagnostic testing and other medical screenings including:
  - Blood pressure
  - Diabetes
  - Cholesterol tests
- Contraception (FDA):
  - Approved contraceptive methods
  - Sterilization procedures
  - Patient education and counseling(Covered contraceptives do not include abortifacient drugs)
- Many cancer screenings including:
  - Cervical cancer
  - Breast cancer
  - Colorectal cancer

## IMPORTANT DETAILS

**Network providers:** Health plans are required to provide these preventive services only through an in-network provider.

**Office visit fees:** Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

**Coverage:** Coverage is provided for preventive services only. Once a diagnosis has been made, the services are not covered under the MEC.

**Talk to your health care provider:** To find out which covered preventive services are right for you — based on your age, gender, and health status — ask your health care provider. For information on preventive practices, visit [healthcare.gov](http://healthcare.gov).

**Questions:** If you have questions regarding your coverage, please call Customer Service at (877) 685-2432 or visit [www.centuryhealthcare.com](http://www.centuryhealthcare.com) to review your Summary Plan Description (SPD).

**Note:** This is a self-funded plan.



Submit the completed form to your employer

## Enrollment Form

Employer – Please complete this section

Requested Effective date: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Location: \_\_\_\_\_

Current Employment Status: ☐ Full Time ☐ Part Time \_\_\_\_\_ (Number of Hours) ☐ Other \_\_\_\_\_

Indicate one of the following: ☐ Initial Enrollment ☐ Open Enrollment ☐ New Hire ☐ Life Status Change ☐ Waive Coverage

Employers Name: American Trailer Works CHC Group No. CHC5600

Employee Information – Please print clearly and legible

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Last Name

First Name

Middle Initial

Social Security No.

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Mailing Address

City

State

Zip Code

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

E-mail Address

Primary Phone Number

Date of Birth

Location of Employment

|                                                                       |                                                                                                                                                                                                   |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Benefit Plan Selection Information for:

☐ New Coverage

☐ Change in Coverage

| Value Plan (MEC Plus)                          | Weekly Cost |
|------------------------------------------------|-------------|
| <input type="checkbox"/> Employee Only         | \$16.66     |
| <input type="checkbox"/> Employee + Spouse     | \$30.61     |
| <input type="checkbox"/> Employee + Child(ren) | \$24.81     |
| <input type="checkbox"/> Employee + Family     | \$41.66     |

Dependent Information – To add more dependents than the ones below, please attach an additional page and label it with your name.

Please note that if you are enrolling dependents, the information below is required. If information is missing their enrollment could be delayed or declined.

Do you have an eligible Spouse? ☐ Yes ☐ No

How many dependent children do you have? \_\_\_\_\_

|                                                                |                      |      |                |                                                       |
|----------------------------------------------------------------|----------------------|------|----------------|-------------------------------------------------------|
| <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Dependent Full Name: | SSN: | Date of Birth: | <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Dependent Full Name: | SSN: | Date of Birth: | <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Dependent Full Name: | SSN: | Date of Birth: | <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Dependent Full Name: | SSN: | Date of Birth: | <input type="checkbox"/> M <input type="checkbox"/> F |

(Continued on Next Page)

Refusal of Coverage (check box below to waive coverage)

☐ I choose not to enroll in the Limited Benefit Medical Plan / Minimum Essential Coverage / MVP Bronze, plan(s) offered by my employer. I understand that if I decide to enroll at a later date I will not be able to do so unless it is during the next open enrollment period or a life status event. Please note that if there is a life status change you only have 30 days to enroll or make any changes to the policy.

I have read the benefit summaries and enrollment material provided and accept the terms and conditions of the coverage outlined within them. I understand the Limited Benefit Medical, MEC Basic, MEC Plus, and MEC Enhanced plans do not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date.

I authorize my employer to deduct the required premium for the plan I have elected from my pay.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.

The MEC Plan for Massachusetts residents: This health plan does not meet the Minimum Creditable Coverage standards and therefore does not satisfy the individual mandate.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Employee's Signature

Date Signed

Accidental Death & Dismemberment – CRUM & Forster Specialty Services:

I understand that the benefits package being offered by my employer automatically includes a \$15,000 Accidental Death & Dismemberment benefit through CRUM & Forster Specialty Services.

Beneficiary Information – To add more beneficiaries than shown below, please attach an additional page and label it with your name.

|                     |               |                          |
|---------------------|---------------|--------------------------|
| Beneficiary 1       |               |                          |
| Full Name:          | Full Address: |                          |
| Social Security No. | % of Benefit  | Relationship to Employee |

|                     |               |                          |
|---------------------|---------------|--------------------------|
| Beneficiary 2       |               |                          |
| Full Name:          | Full Address: |                          |
| Social Security No. | % of Benefit  | Relationship to Employee |

|                                                                                                              |               |                          |
|--------------------------------------------------------------------------------------------------------------|---------------|--------------------------|
| Contingent Beneficiary – Benefits will be paid in case the primary beneficiaries did not survive the insured |               |                          |
| Full Name:                                                                                                   | Full Address: |                          |
| Social Security No.                                                                                          | % of Benefit  | Relationship to Employee |

If you do not name a beneficiary or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the ones below:

1) Your Spouse      2) Your Child(ren)      3) Your Parents      4) Your Brother(s) and/or sister(s)      5) Your Estate

Employee's Signature

Date Signed

**Term Life– The Standard:**

I understand that the benefits package being offered by my employer automatically includes a \$10,000 Term Life benefit through The Standard.

**Beneficiary Information – To add more beneficiaries than shown below, please attach an additional page and label it with your name.**

|                     |               |                          |
|---------------------|---------------|--------------------------|
| Beneficiary 1       |               |                          |
| Full Name:          | Full Address: |                          |
| Social Security No. | % of Benefit  | Relationship to Employee |

|                     |               |                          |
|---------------------|---------------|--------------------------|
| Beneficiary 2       |               |                          |
| Full Name:          | Full Address: |                          |
| Social Security No. | % of Benefit  | Relationship to Employee |

|                                                                                                              |               |                          |
|--------------------------------------------------------------------------------------------------------------|---------------|--------------------------|
| Contingent Beneficiary – Benefits will be paid in case the primary beneficiaries did not survive the insured |               |                          |
| Full Name:                                                                                                   | Full Address: |                          |
| Social Security No.                                                                                          | % of Benefit  | Relationship to Employee |

If you do not name a beneficiary or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the ones below:

1) Your Spouse      2) Your Child(ren)      3) Your Parents      4) Your Brother(s) and/or sister(s)      5) Your Estate

**Definition of a dependent child:**

- Unmarried child from live birth through age 20 or 24 if a registered full time student at an accredited institution
- Your unmarried child who meets either of the following requirements:
  - The child is insured under the group policy and, on and after the date on which insurance would otherwise end because of child's age, is continuously disabled.
  - The child was insured under the prior plan on the day before the effective date of your employer's coverage under the group policy and was disabled on that day, and is continuously disabled thereafter.
- Child includes any of the following, if they otherwise meet the definition of child:
  - Your adopted child or stepchild living in your home

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date Signed

## Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at [contact@hcrcompliance.com](mailto:contact@hcrcompliance.com) or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

---

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

---

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0183]。 (Chinese)

---

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

---

이 건보함에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

---

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

---

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

---

إذا كان لديكم ك لند شخص تساعاً هذسةلة بخصصو خطه لصحة، هذه فلدنا كالحق في الحصول على لمساو قدلمعلومات الضرورية بلغتكم ما نود نية تكلفه. للتحدث مع مترجا متصب ل 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resewwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

شما یا فرید که به او کمک می کنید سؤالاتی در باره این برنامه ی بهداشتی  
ردیاشید، کتیدا. بنریاد صعبد کرکه کمک مورجم، لطفاً به فریاد شما خبر د 1-844-398-6233 گانا تمان گر حاصل  
نمایید. (Persian-Farsi)

---