MSC
MEDICAL STAFFCARE

Reference Manual

Information for Branch Managers on **Fixed Indemnity Medical Plan**

Contact Information....3
Schedule of Benefits....4
Questions with Answers....6
Our Networks....7
Ordering Materials....8
New Hire Procedures....9
Fax Cover Sheet....10
Sample Enrollment Form....11
Change Forms....12
ID Card Information....14

ALTO HealthCare Staffing
Your position is our mission.

CIR
Insurance Applications Group, Inc.

Contact Information

Branch Services:

Primary Contact: 844-262-6022 – Essential StaffCARE Support Center

We have a single toll-free number and a single email address for you to use to submit your inquiries. Please contact the Medical StaffCARE Support Center at 1-844-262-6022 or via email at escsupport@paisc.com.

Representatives are available Monday – Friday from 8:30 a.m. – 5:00 p.m. ET.

Secondary Contact: 704-637-0022 – Medical StaffCARE Account Management

Use this contact in the event that the Primary Marketing Service Support Representative is unavailable and you are in need of immediate assistance. We ask that employees not call this number as it is reserved for management.

Member Services (Employee):

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

Members will call this number for questions regarding their plan coverage, ID Card, claim status, policy booklets, and to cancel or change their coverage

Customer Service Call Center hours are M-F 8:30am to 8:00pm EST
Spanish Speaking representatives are available

Fixed Indemnity Medical Benefits - Plan 3

Plan 3	
Medical Network	First Health
Network Provider Must Accept Plan	Yes
Prescription Network	Optum
Pre-Existing Condition Limitation	None
Wellness Care	
Wellness Care (one per year)	$100
Inpatient Benefits	
Standard Care	$700 per day
Intensive Care Unit Maximum [1]	$800 per day
Inpatient Surgery	$4,000 per day
Anesthesia	$800 per day
First Hospital Admission (1 per year)	$500
Skilled Nursing *(for stays in a skilled nursing facility after a hospital stay)*	$100 per day
Outpatient Benefits [2]	
Annual Outpatient Maximum	$2,250
Physician Office Visit (Virtual or In-Person)	$100 per day
Diagnostic (Lab)	$75 per day
Diagnostic (X-Ray)	$200 per day
Ambulance Services	$300 per day
Physical Therapy, Speech Therapy, Occupational Therapy	$50 per day
Emergency Room Benefit - Sickness	$200 per day
Emergency Room Benefit - Accident [3]	$1,000 per day
Outpatient Surgery	$1,000 per day
Anesthesia	$400 per day
Prescription Drugs [4]	
Annual Maximum	$600
Per Day	$30

[1] Pays in addition to standard care benefit [2]All outpatient benefits are subject to the outpatient maximum [3] Covers treatment for off the job accidents only [4] Not subject to outpatient maximum

Weekly Premiums	Medical
Employee Only	$34.41
Employee + Child(ren)	$57.12
Employee + Spouse	$65.38
Employee + Family	$87.06

Dental, Vision, Term Life, Short Term Disability, & Accidental Loss Benefits

Accidental Loss of Life, Limb & Sight			
Employee Amount	$20,000	Child Amount (6 mos to 26 yrs old)	$5,000
Spouse Amount	$20,000	Infant Amount (15 days to 6 mos)	$2,500
Accidental Loss of Life, Limb & Sight is part of the Medical Benefits			

Dental Benefits						
	Waiting Period	Coinsurance	Annual Maximum Benefit	$750	Deductible	$50
Coverage A	None	80%	Exams, Cleanings, Intraoral Films, and Bitewings			
Coverage B	3 Months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures			
Coverage C	12 Months	50%	Periodontics, Crowns, Endodontics, Bridges and Dentures			

Vision Benefits	In-Network		Out-of-Network	
	You Pay	*Plan Pays*	*You Pay*[3]	*Plan Pays*
Eye Exam[1] (including dilation)	$10 Copay	100%	100%	$35
Standard Contact Lens Fit Exam (includes follow-up)	Up to $55	$0	100%	$0
Premium Contact Lens Fit Exam (includes follow-up)	100%, after 10% discount	$0	100%	$0
Frames (once every 24 months)	80%, after $110 allowance	20% plus $110 allowance	100%	$55
Standard Plastic Lenses (single, bifocal, trifocal)[1,2]	$25 Copay	100%	100%	$25–$55
Contact Lenses *(Conventional) (materials only)*	85%, after $110 allowance	15% plus $110 allowance	100%	$88
Contact Lenses *(Disposable) (materials only)*	100%, after $110 allowance	$110 allowance	100%	$88
Contact Lenses *(Medically Necessary) (materials only)*	$0 Copay	100%	100%	$200

[1]Once every 12 months [2]15 higher in AK, CA, HI, OR, WA [3]After plan payment

Term Life Benefits			
Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at 70)	Child Amount (6 mos to 26 yrs old)	$5,000
Spouse Amount	$5,000 (terminates at age 70)	Infant Amount (15 days to 6 mos)	$1,000

Short-Term Disability			
Benefit	60% of base pay up to $150 per week	Waiting Period/Maximum Benefit Period	7 days/26 weeks

Weekly Premiums	Dental	Vision	Term Life	STD
Employee Only	$5.40	$2.42	$0.60	$4.20
Employee + Child(ren)	$14.58	$6.54	$0.90	n/a
Employee + Spouse	$10.80	$4.84	$0.90	n/a
Employee + Family	$20.52	$9.20	$1.80	n/a

Questions & Answers

Q: Do all employees have to complete an enrollment form?

A: Yes. By obtaining acknowledgement of either an acceptance or declination from each employee completes new-hire paperwork, you are limiting the liability you and your employer face. We never want an employee or family member of your agency to come back to you and say they were discriminated against and never offered insurance. It is in your company's best interest to make sure that all employees fill out the enrollment form and either elect or decline coverage.

Q: When can an employee enroll for benefits?

A: Employees may sign up for coverage during their first thirty (30) days of employment or during the company-wide open enrollment period. Employees who choose not to elect coverage during their own 30-day open enrollment period, or a company-wide open enrollment, will be asked to wait until the next company-wide open enrollment period before being allowed to elect coverage. Leaving one job assignment and immediately starting another does not constitute a "new" 30-day open enrollment period. If an employee has been terminated or laid off from an assignment and returns on a new assignment, after 6 or more weeks, he/she may re-enroll as a new hire. MSC/PAI considers an employee's first day on a job assignment, regardless of length, the start of their personal 30-day open enrollment period. This is why we encourage you to make sure ALL employees filling out new-hire paperwork complete an Medical StaffCARE enrollment form.

Q: Will an employee's insurance be canceled if a premium payment is missed?

A: No. Coverage may not be cancelled until the employee has missed six consecutive premium deductions. In the event that an employee misses a deduction(s), the employee may make direct payments to PAI, as long as there has been at least one payroll deduction made through their employer. It is the employee's responsibility to contact PAI to make arrangements for direct payments. PAI will NOT contact your employee if a premium payment is missed. Employees may not initiate coverage through a direct payment. If an employee chooses not to make payments for the week(s) they have a break, no benefit will be paid for claims incurred and submitted during the break in coverage. Payments must be received within 45 days of the date of the paycheck from which a premium deduction would have been made. If an employee comes back to work between one (1) and six (6) weeks, payroll deductions will automatically begin again and be applied on a going forward basis (the Monday following the next deduction). Deductions will only be taken weekly and will NOT be "caught up" by the employer or posted to back weeks.

Q: When will an employee and his/her eligible dependents be eligible for COBRA?

A: Employees become eligible to receive a COBRA offer if they have had at least one payroll deduction through their employer and have missed six consecutive premium payroll deductions. Once there is a six week break with no payroll premium reported, a COBRA letter is automatically generated and sent by PAI to the member's home address. If the employee or dependent is eligible, he or she may elect COBRA within sixty days from the date of their letter and the applicable premium must be remitted in full to the address provided in their letter. COBRA participants or "qualified beneficiaries", are not billed for their COBRA payment and must take responsibility to keep premium current. COBRA participants may generally stay on COBRA for up to 18 months from the date of a qualifying event that causes loss of coverage. A second qualifying event may allow extended COBRA coverage for up to 36 months. Qualifying events for COBRA are termination of employment, loss of coverage due to a reduction of hours, death of the employee, divorce or legal separation, change in status of a dependent, Medicare entitlement, retired employees, and for employer bankruptcy.

Q: Who is considered an "eligible dependent"?

A: Your eligible dependents are your spouse and your children under age 26 (this may vary by state).

Q: When can an enrollee add coverage for himself/herself or dependents?

A: An enrollee may add coverage for himself/herself during an annual open enrollment period or during a life changing event, such as birth, marriage, death, divorce, adoption, Medicare entitlement or loss of prior coverage. Proof of the event must be provided and enrollment or change must occur within thirty days of such event.

Our Networks

Please utilize the web site addresses or phone numbers below to locate a physician, dentist, or vision provider. **DO NOT** call with questions about your health plan. The networks do not have any knowledge of your medical plan.

Medical Network

First Health Network
www.myfirsthealth.com
1-800-226-5116

Prescription Network

For your pharmacy benefit information, visit:
www.paisc.com
1-866-798-0803

Dental Network

Dentemax
www.dentemax.com
1-800-752-1547

Vision Network

EyeMed Vision Care
www.eyemedvisioncare.com
1-866-559-5252

Ordering Materials

Contact Medical StaffCARE to:

Adjust quantity of materials on restock, Stop Restock, and Order More Materials

Phone Number: 864-527-7929
Email: supplies@iagbenefits.com
Website: www.medicalstaffcare.com/supplies

Restock

Upon request, your branch can receive an automatic recurring shipment (restock):

- Of English Enrollment Forms and/or Spanish Enrollment Forms
- Of Return Envelopes (for mailing employee applications to our third party administrator, PAI, for processing)
- All quantities can be adjusted for each branch's level of volume
- Restock is only adjustable in *quantities*, not frequency

If you choose to receive an automatic restock of forms, your forms will arrive every other month starting with your renewal month:

- If your plan renews in an odd month (Jan., March, May, July, Sept., Nov.), you will always receive restock in an odd month
- If your plan renews in an even month (Feb., April, June, Aug., Oct., Dec.), you will always receive restock in an even month
- **Example of how automatic restock works:** If your company renews your Indemnity plan in January, you will receive a *renewal* shipment in January with materials to hold Open Enrollment. You will then receive a *restock* of Enrollment Forms and Envelopes in March, May, July, Sept. and Nov.

Order As Needed

If your branch does not wish to receive an automatic restock, you may order forms as your branch needs them:

- No more than six orders per year
- Materials can be ordered at any time, but please try to order enough forms to last 2-3 months
- All orders will be shipped ground with UPS and cannot be expedited
- You will be responsible for printing your own forms if you do not allow enough time for shipping
- All shipments are mailed from Greenville, SC (29615)
- Visit *www.ups.com/maps* to see an estimated shipment time
- Please allow 1-2 days for printing

How to Submit Enrollment Forms

- Electronic Submission via Secure Site (2 business days)
  - *Most reliable way to submit for quick processing*
  - *Please contact service@iagbenefits.com to verify your FTP site*
- Faxing (4 business days)
  - *Please use Fax Cover Sheet on page 10*
- By Mail (up to 10 business days)
- **Please submit enrollment forms on a weekly basis. This will ensure benefit activation in a timely manner, as well as increase Compliance.**

New Hire Procedures

1. All new hires who complete an I-9 and W-4 will need to complete the MSC enrollment form. Please incorporate the Medical StaffCARE (MSC) enrollment form into your New Hire paperwork.
2. Ask your employees to complete the form to the best of their knowledge.
3. Every new hire must check **'Yes' or 'No'** on the enrollment application.
4. Don't let employees take the application portion of the form home.
5. Check the form for completeness. We must have all personal information on the top portion of the application including:
    - Social Security Number
    - Date of Birth
    - First and Last Name
    - Phone Number
    - Address
    - Dependent information if dependent coverage is elected.
    - Signature and Date
    - Election of 'Yes' or 'No'
6. Any information left off of the top portion of the enrollment form may delay coverage for the employee.
7. Fax the completed forms to PAI's secure fax at 1-803-264-0772. Please include a fax cover sheet alerting PAI how many applications are included in the fax transmission. You will find, enclosed, a fax cover template which includes important information to accompany your fax. Please feel free to use this version, or create your own.
8. If you prefer to mail your enrollment forms to PAI at least once a week, we will supply you with postage paid return envelopes.

Ask your employees to fill out the Medical StaffCARE enrollment form to the best of their knowledge and hand the benefit election portion back to you. Do not allow this portion to leave your office. Your new hire employee may take the remainder of the form home with them. The take home portion contains valuable information about their plan and also how they can make changes until they receive their ID card and Summary Plan Description from Planned Administrators.

Please do not let the benefit election portion of the enrollment form leave your office--- the chances of getting the form back within the eligibility period is slim and also leaves your company open for a liability. If an employee is unsure of the type of coverage they need, have them complete the top portion of the enrollment form with all personal information and check the box titled "No to all benefits" They can take the remaining portion home with them to discuss with family members. If the employee would like to change their initial election, the take home portion of the application will alert them on how this may be done. They may call the Medical StaffCARE Customer Service line directly, and a customer service representative will assist them in making changes.

Planned Administrators will do all the tracking of your employee's eligibility through their systems. We are receiving weekly payroll files from your corporate office, therefore we are able to monitor when deductions and benefits will begin. That is why we must insist that the Medical StaffCARE enrollment form be completed at the time the new hire paperwork is done and faxed to PAI at 1-803-264-0772 no less than once a week. Enrollment forms are date stamped upon receipt at PAI and keyed into the system within 4 business days. Once an employee has received an assignment, PAI will communicate back to your corporate office as to when premium deductions will begin.

MSC
MEDICAL STAFFCARE

ENROLLMENT FORMS
FAX COVER SHEET

GROUP #280800-CIR

NUMBER OF PAGES _____
BEING FAXED (INCLUDING COVER PAGE)

YOUR NAME _____

YOUR PHONE NUMBER _____

Please Fax to **ONE** of the following. Indicate which fax line you are using by checking the box below.

PAI's FAX NUMBERS:
- ☐ 1-803-264-0772
- ☐ 1-803-264-8571
- ☐ 1-803-264-8739
- ☐ 1-803-870-8060

B1 | OFFICE USE ONLY LOCATION _____ New Hire ☐ Rehire ☐ Date __ __ /__ __ /__ __ __ __

ENROLLMENT FORM

MSC 4ESC P3D v24.0

A. REQUIRED EMPLOYEE INFORMATION	PRINT USING BLACK or BLUE INK (Must Be Filled Out)		
Name	Social Security #	Phone	Gender M F
Address			Apt. #
City	State	Zip	Date of Birth / /

B. DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE MEDICARE BENEFITS?	☐ Yes ☐ No. If Yes, please continue.
Medicare Health Insurance Claim Number (HICN)	Medicare Effective Date
Name of Covered Person (s): 1.	2. 3.

C. LIMITED BENEFITS PLAN SELECTION

Payroll Deducted Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical Insurance Plan** before adding any additional benefits in Section C. Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection. These plans are underwritten by BCS Insurance Company and 4 Ever Life Insurance Company.

	FIXED INDEMNITY MEDICAL [1]	DENTAL [1]	VISION [1]	TERM LIFE [1]	SHORT-TERM DISABILITY [1, 2]
Employee Only	☐ $34.41	$5.40	$2.42	$0.60	$4.20
Employee + Child(ren)	☐ $57.12	$14.58	$6.54	$0.90	
Employee + Spouse	☐ $65.38	$10.80	$4.84	$0.90	
Employee + Family	☐ $87.06	$20.52	$9.20	$1.80	
	☐ **NO** to ALL Benefits	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, NJ, NY,** or **RI.**

For Term Life / Accidental Loss of Life, Limb & Sight, please write in your beneficiary information. Accidental Loss of Life, Limb & Sight is part of the Fixed Indemnity Medical Benefit.

Name Relationship

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

E. REQUIRED SIGNATURE

YOU MUST SIGN AND DATE, EVEN IF YOU DECLINE COVERAGE

By signing below, I confirm I have read the Benefits Summary and the Limitations and Exclusions for the recommended benefit plans. I understand that open enrollment is only available for a limited time; that making no benefit selection is a declination of benefit coverage and benefit coverage is only available to employees who are over the age of 18 with a valid SSN.

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

Medical StaffCARE

PLAN 3 - CHANGE FORM

280800-CIR

Mail / Fax to: Planned Administrators, Inc.
PO Box 6702
Columbia, SC 29260

Telephone (866) 798-0803
Fax (803) 264-0772

Underwritten by
BCS Insurance Company
Oakbrook Terrace, IL

Fill out this form ONLY if you are making changes in your coverage or terminating coverage.

A. REASON FOR THE CHANGE

☐ Address Change ☐ Name Change ☐ Add Dependent(s) ☐ Coverage Change ☐ Terminate Coverage

B. REQUIRED EMPLOYEE INFORMATION

MUST BE FILLED OUT — **Address/Name Change**

Name	Social Security #	Phone		Gender M F
Address	City	State	Zip	Apt. #
Employer		Hire Date / /		Date of Birth / /

Add/Change Dependent Information

Name	Social Security #	Date of Birth / /	Gender M F	Relationship
			M F	
			M F	

C. INDEMNITY PLAN CHANGES - Select the change you wish to make for each benefit

Weekly Rates

You **MUST** enroll in the **Fixed Indemnity Medical** Insurance Plan before adding any additional benefits in Section C.
Your coverage level for the additional benefits in Section C will be identical to your fixed indemnity medical plan selection.

	FIXED INDEMNITY MEDICAL [1]	DENTAL [1]	VISION [1]	TERM LIFE [1]	SHORT-TERM DISABILITY [1, 2]
Employee Only	☐ **$34.41**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Employee + Child(ren)	☐ **$57.12**	**$14.58**	**$6.54**	**$0.90**	
Employee + Spouse	☐ **$65.38**	**$10.80**	**$4.84**	**$0.90**	
Employee + Family	☐ **$87.06**	**$20.52**	**$9.20**	**$1.80**	
	☐ **Terminate** Plan	☐ Enroll	☐ Enroll	☐ Enroll	☐ Enroll
	☐ No Change	☐ Cancel	☐ Cancel	☐ Cancel	☐ Cancel
		☐ No Change	☐ No Change	☐ No Change	☐ No Change

[1] This coverage is not available to residents of **NH, HI,** or **PR.** [2] STD is not available to persons who reside in **CA, HI, NH, NJ, NY,** or **RI.**

Add/Change Life/Accidental Loss of Life, Limb and Sight Beneficiary

Primary	Relationship
Secondary	Relationship

D. REQUIRED SIGNATURE

I hereby authorize my employer to deduct the required premium contributions from my payroll earnings. I understand that deductions may continue under my old elections until this form is received and processed by PAI. Deductions will not be refunded. **I understand that making no selection in Section C for a benefit means I do not wish to make a change to that benefit.**

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

Form: MSC 4S P3D v24.0

Medical StaffCARE

PLAN 3 - FORMULARIO DE CAMBIOS

280800-CIR

Enviar por correo/fax a: Planned Administrators, Inc. PO Box 6702 Columbia, SC 29260

Teléfono (866) 798-0803
Fax (803) 264-0772

Con el aval de
BCS Insurance Company
Oakbrook Terrace, IL

Llene este formulario SÓLO si va a hacer cambios a la cobertura o a cancelarla.

A. RAZÓN DEL CAMBIO

☐ Cambio de dirección ☐ Cambio de nombre ☐ Agregar dependiente(s) ☐ Cambio de cobertura ☐ Cancelar la cobertura

B. INFORMACIÓN REQUERIDA DEL EMPLEADO

CONTESTAR TODO — **Cambio de dirección/nombre**

Nombre	# de Seguro Social	Teléfono		Género H M
Dirección	Ciudad	Estado	Código Zip	Apt. #
Empleador		Fecha de contratación / /		Fecha de nacimiento / /

Agregar/cambiar información de dependientes

Nombre	# de Seguro Social	Nacimiento / /	Género	Relación
			H M	
			H M	
			H M	

C. CAMBIOS AL PLAN DE COMPENSACIÓN FIJA - Elija el cambio que quiere en cada beneficio

Pagos semanales

DEBE registrarse en el **Plan de seguro médico de compensación fija** (Fixed Indemnity Medical) antes de agregar más beneficios en la Sección C. El nivel de cobertura de sus beneficios adicionales de la Sección C será idéntico a su selección del plan médico de compensación fija.

	PLAN MÉDICO DE COMPENSACIÓN FIJA [1]	PLAN DENTAL [1]	PLAN DE LA VISTA [1]	SEGURO DE VIDA [1]	DISCAPACIDAD A CORTO PLAZO [1, 2]
Solo empleado	☐ **$34.41**	**$5.40**	**$2.42**	**$0.60**	**$4.20**
Empleado + Hijo(s)	☐ **$57.12**	**$14.58**	**$6.54**	**$0.90**	
Empleado + Esposa/o	☐ **$65.38**	**$10.80**	**$4.84**	**$0.90**	
Empleado + Familia	☐ **$87.06**	**$20.52**	**$9.20**	**$1.80**	
	☐ Cancelar el plan	☐ Registrarse	☐ Registrarse	☐ Registrarse	☐ Registrarse
	☐ Sin cambio	☐ Cancelar	☐ Cancelar	☐ Cancelar	☐ Cancelar
		☐ Sin cambio	☐ Sin cambio	☐ Sin cambio	☐ Sin cambio

[1] Cobertura no disponible a residentes de **NH, HI** o **PR.** [2] STD no está disponible para personas que residen en CA, HI, NH, NJ, NY, or RI.

Agregar/cambiar al beneficiario del seguro de vida y del seguro por pérdida de la vida, de un miembro o de la vista por accidente

Primario	Relación
Secundario	Relación

D. REQUIRED SIGNATURE

Por medio del presente autorizo a mi empleador a deducir los aportes de las primas requeridas de mis ingresos por nómina. Entiendo que las deducciones pueden continuar bajo mis antiguas selecciones hasta cuando este formulario sea recibido y procesado por PAI. Las deducciones no serán devueltas. **Entiendo que el no hacer ninguna selección en la Seccion C de un beneficio, significa que no quiero hacer cambios a tal beneficio.**

FECHA __ __ /__ __ /__ __ __ __ ▶ **FIRMA**

ID Card Information

Q: How can employees get their ID cards?

A: Within two weeks of their first deduction, ID card(s) and a confirmation of coverage letter will be mailed to the employee's home address. If an employee needs to receive their ID card(s) sooner they can contact the MSC Support Center at 1-866-798-0803 and request copies to be emailed or faxed to them or their provider.

Q: After I sign up, when will my coverage go into effect?

A: Your coverage goes into effect the Monday following your first payroll deduction. Coverage can not be initiated with a pre-payment.

Q: How do I find an in-network physician or hospital?

A: While your medical plan does not impose an in-network restriction, you may realize additional savings by utilizing an in-network medical provider.

First Health Network - www.myfirsthealth.com - 1-800-226-5116

Q: Is there a phone number my doctor can call to get a list of my benefits?

A: Yes, your provider may call the Medical StaffCARE Customer Service number 1-866-798-0803 for scheduled benefits and benefit maximums.

Q: What if I need to have a prescription filled?

A: For generic and brand prescriptions dispensed by a pharmacist, the plan pays a per day amount up to the annual prescription drug maximum. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. The pharmacy provider will file a claim for the fixed dollar amount to be paid directly to you.

Q: Where can I get claim forms?

A: Medical and Dental claim forms may be obtained by calling our customer service line at 1-866-798-0803 or you may download claim forms from our website – www.paisc.com. Be sure to click on Medical StaffCARE on the welcome page.

Q: What if I want to cancel or make changes to my coverage?

A: Coverage may be canceled or reduced at any time, unless your employer takes premium deductions pre-tax. To make changes or cancel coverage by telephone call 1-866-798-0803.

Toll Free Customer Service Hotline: 1-866-798-0803
8:30 a.m. to 8:00 p.m. EST