2025

employer solutions staffing group LLC

MVP ELIGIBLE EMPLOYEES

The American Worker®

Provided by Fringe Benefit Group

MINIMUM VALUE PLAN (MVP)

The Minimum Value Plan provides comprehensive medical care to protect you from injury and illness as well as coverage for your annual preventive care visits.

Preventive services are covered at 100% and are not subject to a deductible. For all other services and prescriptions, you must meet a deductible before benefits are eligible for plan payment.

The Minimum Value Plan uses the PHCS Physician and Ancillary Network for professional and out-patient services. Save money on these services by going to an in-network provider. For out-of-network and facility charges, the Minimum Value Plan uses referenced based pricing. This means that after the deducible has been met, services are reimbursed based on Medicare rates. This allows members to use a facility of their choosing, and the plan will pay up to 150% of the Medicare rate for facility charges.

PRESCRIPTION BENEFITS
CerpassRx
Visit: **www.cerpassrx.com**
Call: **(844) 636-7506**

BENEFITS	PHCS PHYSICIAN AND ANCILLARY PPO NETWORK. CHARGES REIMBURSED BASED ON 150% OF MEDICARE FOR FACILITIES				
PLAN MAXIMUMS					
Deductible Individual / Family	$6,500 / $13,000				
Coinsurance	Plan pays 100%				
Out-of-Pocket Maximum* Individual / Family	$6,500 / $13,000				
BENEFITS					
Office Visit Out-patient Lab and X-Rays Complex Imaging Emergency Room Services In-patient / Out-patient Hospitalization Out-patient Prescription Drugs	Deductible & Coinsurance Apply Deductible & Coinsurance Apply Deductible & Coinsurance Apply Deductible & Coinsurance Apply Deductible & Coinsurance Apply Deductible & Coinsurance Apply				
Preventive care	Plan pays 100% (Deductible waived)				
Medical Price Shopping Tool	Estimate medical costs before scheduling				
Balance Billing Assistance	Access to Patient Advocacy Center (PAC)				
MONTHLY RATES					
HOURLY WAGE	$7.25 - $14.99	$15.00 - $19.99	$20.00 - $24.99	$25.00 - $29.99	$30.00 or more
Employee Only	$85.01	$175.89	$234.52	$293.15	$351.78
Employee + Spouse	$571.92	$662.80	$721.43	$780.06	$838.69
Employee + Child(ren)	$474.54	$565.42	$624.05	$682.68	$741.31
Family	$937.10	$1,027.98	$1,086.61	$1,145.24	$1,203.87

***Out-of-Pocket Maximum includes deductible and coinsurance.**

PHCS PHYSICIAN & ANCILLARY NETWORK: PHYSICIAN AND OUT-PATIENT SERVICES

Physician and many professional services are covered by the PHCS Physician and Ancillary network. You will pay less for care at PHCS Physician and Ancillary providers since the Plan will pay the in-network benefit. Use PHCS providers to get the most benefit from the Plan.

- To find a provider, visit **www.hstconnect.com**
- Customer service is available at **(800) 440-7427**

HST CONNECT MOBILE APP

Scan here to download or find it in the App Store or Google Play Store

- Find facility and other healthcare services, either in-network or with high VDHP acceptance rates
- Compare quality ratings and pricing for specific procedures
- View deductibles, copays and other plan information
- Direct dial healthcare providers and get driving directions
- Get prescription pricing estimates
- Look up information about procedures
- Communicate and receive notifications from HST's Patient Advocacy Center and submit balance bills directly through the app
- Access to HST's Provider Acceptance Rates helps minimize the risk of balance billing.

REFERENCE BASED PRICING: OUT-OF-NETWORK SERVICES & FACILITY CHARGES

The Plan pays Reasonable and Appropriate fees after any applicable copay, deductible and/or coinsurance for out-of-network physician and ancillary services as well as facility charges. If out-of-network providers or facilities charge more than Reasonable and Appropriate fees for services (not to exceed 150% of Medicare Allowable), you may be responsible and billed for charges in excess of the amount the Plan pays based on Reasonable and Appropriate fees for services.

PRECERTIFICATION

Certain services require precertification prior to services being rendered. If precertification is not received prior to services being rendered the amount the Plan pays will be reduced. Refer to your plan document for a list of services that require precertification.

BALANCE BILLING ASSISTANCE: FACILITY CHARGES

Your plan is based on fair and transparent pricing, if you receive a bill from a facility that is greater than what is listed as your responsibility on your Explanation of Benefits, call the Patient Advocacy Center. A patient advocate will be assigned to your case and will contact the facility directly to ensure that excessive hospital charges are not being passed down to you. Once the advocate has resolved the dispute with the facility, the advocate will notify you with the final resolution. To contact the Patient Advocacy Center call **(888) 837-2237** and make sure you have the information below on hand:

Patient's Full Name
Employer's Name
Service Dates
Copy of the bill
Copy of the Explanation of Benefits (Available in your AWP member portal)
Your contact Information

CERPASSRX: PRESCRIPTION DRUG COVERAGE

Effective and reliable coverage with access to over 63,000 network pharmacies nationwide. Prescriptions are covered at 100% after your copay and deductible at in-network pharmacies. Prescriptions are not covered at out-of-network pharmacies.

- To find a local pharmacy, visit www.Cerpassrx.com
- Customer service available anytime at **(844) 636-7506**

MEDICAL PRICE SHOPPING TOOL: HEALTHCARE BLUEBOOK

Do you need medical attention for a non-preventive service? You can still get a discount on those services by going to an in-network provider. Use this medical price shopping tool to shop for medical procedures at in-network providers in your area to find the best price and get an out-of-pocket cost estimate.

It's easy to find savings with a simple search before scheduling. Access the medical price shopping tool through your member portal at www.TheAmericanWorker.com or call **(855) 495-1190**.

The medical price shopping tool does not guarantee that cost estimates will be the price you are charged or pay for services.

WILL I RECEIVE AN ID CARD?

When you enroll in medical coverage for the first time, an ID card and policy information will be mailed to your home address we have on file. If you make a change to your medical coverage, a new ID card will be mailed to your address. You can request a new ID card by contacting Member Services or access a temporary ID card by logging into www.TheAmericanWorker.com.

For any non-medical coverage you elect, policy information will be mailed to your home address. You will not receive an ID card for non-medical coverage.

HOW DO I USE MY COVERAGE?

When seeking medical care, you should always ask your provider if they participate in the network associated with your plan. Present your medical ID card to your provider and ask them to call the customer service number to verify coverage. Be sure to locate an in-network provider prior to seeking care.

When making a Dental or Vision appointment, tell your provider your benefits are with Ameritas and they can verify coverage using your Social Security Number.

CONTACTS

BENEFIT	CONTACT	WEBSITE	PHONE NUMBER
Medical	The American Worker	**www.TheAmericanWorker.com**	(855)495-1190
Balance Billing Assistance	Patient Advocacy Center		(888) 837-2237

INTRODUCTION

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description, which will be mailed to you following your enrollment in the plan.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to one of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your spouse or domestic partner dies
- Your spouse's or domestic partner's hours of employment are reduced
- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct
- Your spouse or domestic partner's becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse or domestic partner

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any of the following qualifying events:

- The parent/employee dies
- The parent/employee's hours of employment are reduced
- The parent/employee's employment ends for any reason other than his or her gross misconduct.
- The parent/employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Record-keeper if any of the following qualifying events occur: the end of employment, a reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

DISCLAIMERS

Refer to official insurance policy and plan documents for more extensive information concerning your benefit plans. In the event of any conflict between this guide and the official plan documents, the plan documents, policy and certificate of coverage will govern.

Section 125 Disclaimer: By enrolling, you elect to participate in the American Worker plan for benefits available under the Internal Revenue Code Section 79, 105,106,125, and these sections as amended. You understand that the plan will automatically convert to pretax status and eligible payroll deductions which are provided through the Plan. You understand that by participating in this Plan your Social Security benefits may be reduced sine these premiums will be deducted before your salary is taxed. This election will remain in effective for the entire Plan Year. Your election CANNOT be changed during the Plan Year in accordance with the Internal Revenue Service Guidelines unless a qualifying event occurs. Qualifying events include: marriage, divorce, legal separation, death of spouse, birth or legal adoption of a child, death of a child, or spousal change of employment affecting insurance coverage. By enrolling you have accepted the terms detailed about.

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Benefits Enrollment Guide

THEAMERICANWORKER.COM / (866) 866-3424