



**EMPLOYER SOLUTIONS STAFFING GROUP II, LLC  
MVP6500 PLAN**

**AMENDMENT NO. #1  
EFFECTIVE BEGINNING JANUARY 1, 2026**

The Employer Solutions Staffing Group II, LLC MVP6500 Plan (the “Plan”) is hereby amended with the following changes. All other sections of the Plan remain unchanged.

1. To amend the section, Introduction and Purpose; General Plan Information, subsection “Participating Employer(s)” by removing the section completely and inserting the following:

**PARTICIPATING EMPLOYER(S):** Employer Solutions Staffing Group II, LLC, 26-2726508  
Employer Solutions Staffing Group, LLC, 20-8084369

2. To amend the section, Introduction and Purpose; General Plan Information, by inserting the following:

**Employee Contributions and Coverage Periods**

For Employees who contribute to the Plan on a non-monthly basis, each deduction is applied to the coverage period for which the deduction is taken. This ensures that contributions are aligned with actual periods of coverage, consistent with ERISA’s plan asset rules.

3. To amend the section, Covered Medical Benefits, by inserting the following:

**Genetic Counseling or Testing.** In addition to coverage specified under Preventive Care, benefits are available for prenatal genetic testing for inherited susceptibility to a medical condition and counseling related to family history or test results to determine the physical characteristics of an unborn child. Refer to the Genetic Information Nondiscrimination Act of 2008 (GINA) subsection for information regarding the prohibition of discriminating on the basis of genetic information.

4. To amend the provision, Preventive Care, within the Covered Medical Benefits section by removing the section completely and inserting the following:

**Preventive Care.** Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act’s (ACA) requirement to offer coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).



See the following websites for more details:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>;  
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics>;  
[https://www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC\\_AAref\\_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html](https://www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html);  
<https://www.aap.org/periodicityschedule>;  
<https://www.hrsa.gov/womensguidelines/>.

***NOTE:** The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.*

5. To amend the section, Covered Medical Benefits, by inserting the following:

**Telehealth.** Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided via audio or video communications.  
*NOTE: This benefit is not the same as a Teladoc or HealthiestYou type of benefit.*

6. To amend the section, Medical Exclusions, by inserting the following:

**Cell Therapy.** Expenses related to cell therapy unless otherwise stated as covered.

7. To amend the section, Medical Exclusions, by inserting the following:

**Gender-Affirming Care.** Related to gender-affirming care.

8. To amend the section, Medical Exclusions, by inserting the following:

**Gene Therapy.** Expenses related to gene therapy unless otherwise stated as covered.

9. To amend the section, Medical Exclusions, by inserting the following:

**Marijuana.** For marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.

10. To amend the section, Medical Exclusions, by inserting the following:

**Medical Travel.**



11. To amend the section, Medical Exclusions, by inserting the following:

**Sexual Dysfunction.** For any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants and hormonal therapy, except of dysfunction due to organic disease or gender dysphoria, unless otherwise specified by the Plan.

12. To amend the provision, Covered Expenses, within the Prescription Drug Benefits section by inserting the following:

**Allergy Sera.** Charges for allergy sera.

13. To amend the provision, Exclusions, within the Prescription Drug Benefits section by inserting the following:

**Impotency.** A charge for impotency medication, including Viagra.

14. To amend the section, General Limitations and Exclusions by inserting the following:

**Long Term Care.** That are related to long term care.

15. To amend the provision, Continuation During USERRA, within the Continuation of Coverage section by removing the section completely and inserting the following:

**Continuation During USERRA**

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period (if applicable), and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

16. To amend the provision, Trade Reform Act and Further Consolidated Appropriations Act, 2020, within the Continuation of Coverage section by removing the following section completely:



**Trade Reform Act and Further Consolidated Appropriations Act, 2020**

The Further Consolidated Appropriations Act, 2020 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance.” These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual’s group health plan coverage ends.

A Participant’s eligibility for subsidies under the Further Consolidated Appropriations Act, 2020, affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact); for information about the Health Coverage Tax Credit (HCTC), please see: <https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC>.

17. To amend the provision, Requirements for First Level Appeal, within the Claim Procedures; Payment of Claims Section by removing the following section completely:

**Requirements for First Level Appeal**

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. All Pre-service claims must be sent to the Utilization Review Manager. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant’s appeal must be addressed as follows:

American Health Holdings  
7400 W. Campus Rd, F-510  
New Albany, OH 43054  
Phone: 1-800-664-6803  
Fax: 1-866-881-9643



For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Fringe Benefit Group, Inc.  
11910 Anderson Mill Road  
Austin, TX 78726  
Phone: 1-855-495-1190  
Website/Email: memberservices@fbg.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

18. To amend the section, Definitions by inserting the following:

**“Cell Therapy”**

“Cell Therapy” is a treatment in which intact, living cells are injected, grafted, or implanted into a patient to achieve a therapeutic effect. Includes adoptive cell therapy (ACT), stem cell therapy, and cellular immunotherapy such as CAR-T, unless specifically excluded.

19. To amend the provision, Deductible, within the Definitions Section by removing the section completely and inserting the following:

**“Deductible”**

“Deductible” shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments. However, certain covered benefits may be considered Preventive Care or telehealth and remote care services and paid first dollar. The Participant's ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

20. To amend the section, Definitions by inserting the following:

**“Gene Therapy”**

“Gene Therapy” is a medical treatment that introduces, removes, or alters genetic material within a patient's cells to treat or prevent disease, including treatments that utilize viral vectors or gene-editing technologies such as CRISPR.



21. To amend the section, Definitions by inserting the following:

**“Health Savings Account (HSA)”**

“Health Savings Account (HSA)” shall mean an account created in connection with a High Deductible Health Plan. The money placed in this account can be used to pay for covered health care costs or saved for future health care costs. The account accrues interest.

22. To amend the section, Definitions by inserting the following:

**“High Deductible Health Plan (HDHP)”**

“High Deductible Health Plan” shall mean a health plan which has to meet specific federal rules. Participants in a High Deductible Health Plan may be able to put money into a Health Savings Account or health reimbursement arrangement to help pay for health care. The plan Deductible applicable for such plans is generally higher than that of a standard health plan.

23. To amend the section, Definitions by inserting the following:

**“Network” or “In-Network”**

“Network” or “In-Network” shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network’s Providers have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant’s identification card.

Network Providers do not include Hospitals, Ambulatory Surgical Centers, dialysis facilities and other facilities for Inpatient and Outpatient services. Determinations for these Providers, and Covered Expenses, will be subject to the Maximum Allowable Charge subject to the Network Provider Deductibles, Copayments, Coinsurance percentage and maximum limits.

24. To amend the section, Definitions by inserting the following:

**“Out-of-Area”**

“Out-of-Area” shall mean services received by a Participant outside of the normal geographic area supported by the Plan’s Network, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

25. To amend the provision, Participant, within the Definitions Section by removing the section completely and inserting the following:

**“Participant”**

“Participant” shall mean any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation, who is eligible for benefits (and enrolled) under the Plan.



26. To amend the section, Plan Administration by inserting the following:

**Summary of Material Modification (SMM)**

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

**Summary of Material Reduction (SMR)**

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.



27. To amend the provision, Reproductive Health Information, within the HIPAA Privacy section by removing the section completely and inserting the following:

**Reproductive Health Information**

Pursuant to federal law (29 FR 32976), unless required by law, the Plan will **not** use or disclose PHI which is requested to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for either purpose.

If the Plan receives a request for PHI which is potentially related to reproductive health care for one of these impermissible purposes, the Plan will not use or disclose PHI without first obtaining a signed attestation from the requesting party that the request is not for an impermissible purpose.

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:

**Employer Solutions Staffing Group II, LLC**

By: Chris Levine

Printed: Chris Levine

Title: ceo/president

Date: 4/13/2026