MINIMUM VALUE PLAN (MVP)

The MVP plan benefits and rates you will pay for the plan are listed below. For complete details of the MVP plan contact your HR Department for the Summary of Benefits and Coverage.

There are no copays associated with the medical or prescription benefit. A select list of preventive services are covered at 100% and not subject to the deductible. For all other services, employees must meet a $6,500 deductible before benefits are eligible for plan payment.

Enrollment is dependent on the completion of an individual medical questionnaire (IHQ). You must return a completed IHQ to Fringe Benefit Group within **30 days** of your election or your enrollment will be **cancelled**. The IHQ can be returned through your secure American Worker member portal or through Docusign. You must include your email address on the enrollment form if you elect the MVP so that an IHQ can be emailed to you via DocuSign. **Any misrepresentations, misstatements or omissions of medical information may result in revision of your rates, denial of claims payment or loss of coverage.**

All IHQs are reviewed by medical underwriting to determine final rates.

Benefits	In-Network (PHCS)	Out-of-Network
Deductible - Individual - Family	 $6,500 $13,000	 $13,000 $26,000
Coinsurance	Plan Pays 100%	Plan Pays 50%
Out-of-Pocket Maximum** - Individual - Family	 $6,500 $13,000	 No Limit No Limit
Physician Services - Primary Care - Specialists - Diagnostic X-Ray & Lab - Surgery	Plan Pays 100% After Deductible	Plan Pays 50% After Deductible
Preventive Care	Plan Pays 100%	Plan Pays 50% After Deductible
Emergency Room	Plan Pays 100% After In-Network Deductible	
Additional Services (Facility Charges) - Surgery (Inpatient or Outpatiet) - Hospital (Inpatient or Outpatient)	Network Use Not Required Plan Pays 100% After Deductible	
Prescription Drugs	Plan Pays 100% After Deductible	
Monthly Rates*		
Employee Only Employee + Spouse Employee + Child(ren) Family	$571.60 $1,043.07 $948.76 $1,396.66	

Employee is responsible for single coverage premium costs, subject to income percentage guidelines set by ACA regulation, and 100% of dependent coverage premium costs.

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

PHCS Physician & Ancillary Network

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 hstconnect.com
- Customer service is available at (800) 440-7427

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.

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 at in-network pharmacies. Prescriptions are not covered at out-of-network pharmacies.

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

Ameritas

Dental

Keep a bright, healthy smile while supporting your overall well-being with affordable dental coverage.

Calendar Year Maximum	Up to $1,000 per Covered Member	
Deductible	$20 per Visit	
Covered Services	**Waiting Period**	**Coinsurance**
Preventive and Diagnostic Routine Exams, Cleanings, X-rays, etc.	None	Covered at 100% (MAC)*
Basic Treatment Restorative Amalgams and Composites Endodontics, Periodontics, Extractions, etc.	3 Months	Covered at 60% (MAC)*
Major Treatment Onlays, Crowns, Prosthodontics, etc.	12 Months	Covered at 50% (MAC)*

***Maximum Allowable Charge (MAC): Lower rates are achieved in part by limiting what is paid per procedure on non-network claims to the same amount that network dentists have agreed to charge.**

Weekly Rates	
Employee	$6.36
Employee + Spouse	$15.87
Employee + Child(ren)	$10.96
Family	$16.64

LOCATE NETWORK PROVIDERS

Call (800) 659-2223

- Select **option 3**

Visit www.Ameritas.com

- Select **"FIND A HEALTH PROVIDER"**
- Select **"DENTAL"**
- Select **"NETWORK PROVIDER"**
- Enter Your Location
- Select **"CLASSIC PPO" Network.**

EMPLOYEE HEALTH QUESTIONNAIRE

ONLY FILL OUT THIS FORM IF YOU ARE ENROLLING IN THE MINIMUM VALUE PLAN (MVP).

Please print or type in dark ink. See enrollment guide for benefit details and explanation of your cost. Retain a copy of this application for your records.

Employer Name:_____
Address:_____

Employee Name: _____ Gender: M or F Birth Date:_____
Address: _____ City:_____
County:_____ State:_____ Zip:_____
Home or Cell Phone:_____ Work Phone:_____ E-mail Address:_____

Are you a US Citizen? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated
If "No", what is your status?:_____

Date of Full-time Employment:_____ Average Hours worked per week:_____
Job Duties:_____
Owner, Partner or Corporate Officer? ☐ Yes ☐ No
Employment Status: ☐ Active ☐ COBRA/Continuation ☐ Retired ☐ Disability ☐ Other Leave

Coverage Type: ☐ Self only ☐ Self and Spouse ☐ Self and Child(ren) ☐ Self, Spouse and Child(ren)
OR
I am Waiving coverage for: ☐ Myself ☐ Spouse ☐ Child(ren)
And the Reason for waiving is: ☐ Covered by another group/individual health plan or
☐ Other_____

Spouse and/or Dependents to be covered (please include another page to list more dependents)						
Applicant Name(S)	**Relationship to Employee**	**M or F**	**Date of Birth**	**Social Security #**	**Height/ Weight**	**Tobacco Use?**
	Employee					
	Spouse					
	Child					
	Child					

Health Questions: Please answer the following, providing details to "YES" answers for all Applicants in the space indicated. If you need more space, please use a second form.

In the past (3) years, has any Applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or been advised to have treatment or surgery for any of the following:

a.	Heart attack, brain tumor, stroke, heart disease or heart problems? Or Other not listed?	☐ Yes ☐ No	g.	Diabetes, endocrine or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+? Or Other not listed?	☐ Yes ☐ No
b.	Cancer, tumor, lymphoma, or transplant? Or Other not listed?	☐ Yes ☐ No	h.	Alcoholism, drug, or any substance abuse? Or Other not listed?	☐ Yes ☐ No
c.	Emphysema, lung disorder, or COPD? Or Other not listed?	☐ Yes ☐ No	i.	Back or joint problems, rheumatoid arthritis, fibromyalgia, paralysis or any musculoskeletal condition? Or Other not listed?	☐ Yes ☐ No

d.	Brain disorder, bipolar, psychotic disorder, seizures, epilepsy, or any other mental or emotional condition? Or Other not listed?	☐ Yes ☐ No	j.	Currently pregnant, an expectant parent, premature delivery or multiple birth ? due date? ________________	☐ Yes ☐ No
e.	Kidney failure, dialysis, or disorder of the liver including hepatitis and cirrhosis, stomach, pancreas, colon or bladder? Or Other not listed?	☐ Yes ☐ No	k.	Any surgery, tests, drugs, doctor visit or hospitalization current, advised, planned or recommended?	☐ Yes ☐ No
f.	Hemophilia, blood disorder, anemia, circulatory disorder, or any blood or circulatory condition? Or Other not listed?	☐ Yes ☐ No	l.	Any Burns, or other medical condition(s) not listed in previous questions?, any disability?, or taking any prescription drugs?	☐ Yes ☐ No

Please provide FULL DETAILS to "YES" answers, including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed, please attach a separate page with details, including the Applicant's name.

Question Letter:	Applicant Name:	Condition/Diagnosis/Treatment/ Physician Name/Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/Treatment/ Physician Name/Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/Treatment/ Physician Name/Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/Treatment/ Physician Name/Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?

Authorization and Signature

My signature declares that the answers and medical information presented on this application are complete and accurate for all Applicants. I understand this information will be used as the basis for group underwriting. Any misrepresentations, misstatements or omissions of medical information that I make may result in revision of rates, or denial of my claims or my coverage. I understand that the following parties may need to review this information: Business Associates, reinsurers, and all persons authorized to represent these organizations for these purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my Dependent Applicants to provide all such information as requested by the aforementioned.

I understand that this Authorization may be needed for the purpose of gathering information to determine underwriting and group rating and I have included all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to the plan administrator.

Employee/Primary Applicant Signature:____ Date: __________________

SECURE EMAIL MESSAGE CENTER

SEND EMAILS SAFE AND SECURE TO THE AMERICAN WORKER

Security is much easier when it just works automatically; and that's exactly what the Secure Email Message Center offers. By automatically encrypting and decrypting messages and attachments, secure email is as easy as regular email for both senders and recipients.

THINGS TO KNOW

Emails and attachments are scanned automatically, removing extra work and eliminating stress about sensitive data going unprotected. If emails contain sensitive information, they are encrypted and delivered to the recipients, who must set up a password to open the message the first time. The next time the recipient receives an encrypted email, they will be asked to enter that same password.

- The Secure Email Message Center will deliver to any @theamericanworker (or other variations) email address.
- Sender may send attachments with a message size of up to 15 MB.
- The Secure Email Message Center will automatically recognize content that needs to be sent "secure". If the email is deemed secure, the recipient will receive a link to open the message center to retrieve and respond to an email. If the email does not contain sensitive information, the message will be delivered directly to their email program (Outlook, etc.).

YOU CAN ACCESS THE SECURE EMAIL MESSAGE CENTER DIRECTLY ON WWW.THEAMERICANWORKER.COM BY CLICKING ON THE "SECUREMAIL" LINK ON THE TOP.