The American Worker®

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# 2024 Benefits Enrollment Guide

## NOW IS YOUR CHANCE TO ENROLL

# YOUR ENROLLMENT OPPORTUNITY

We value your contributions and in appreciation of your service we are pleased to offer a variety of affordable benefit plans through The American Worker. We encourage you to review this guide so you understand your options and can make the right choices for you and your family.

## Eligibility

You are immediately eligible for all of The American Worker benefit plans. There is no waiting period.
Your spouse and dependent child(ren) up to age 26 are eligible for all plans except Short-term Disability.

## Enrollment

You can enroll during the new hire onboarding process or within 30 days of receiving your first paycheck.
Your coverage will become effective the Monday after premium is deducted from your paycheck.

## Enroll Now

You can enroll in coverage online, by phone, or on your mobile device.

**Online:** www.TheAmericanWorker.com
Available anytime

Under **Login and Enroll** choose **Register & Enroll**
**Returning Users**: Login with your username & password
**New Users:** Select **Employee ID** and enter
- Employee ID #: Your Social Security Number
- Group #: 98418
- Date of Birth: Your Date of Birth

**Phone:** (877) 220-1862
Monday - Friday
8:00 AM - 8:00 PM ET

**Mobile Device:**
Text STAFFBENEFITS
to (855) 932-4533
Available anytime

## Benefit Deductions and Changes During the Year

The cost of coverage is deducted from your paycheck before taxes are taken out, which saves you money. Since deductions are processed pretax, IRS regulations determine when you can enroll, change or terminate coverage during the year.

You must enroll when initially eligible or during Open Enrollment and the coverage you elect will remain in place for the entire year. If you don't, you must wait until the next Open Enrollment. However, if you experience a **Qualifying Life Event (QLE)** during the year, you may be eligible to enroll in, make changes or cancel coverage.

Qualifying Life Events include, but are not limited to: birth, adoption or legal guardianship; marriage, divorce, or legal separation; death of a spouse or child; spousal change of employment affecting insurance coverage.

You have 30 days from the date of the QLE to call The American Worker to make a change. If you do not, you will not be able to make a change until the next Open Enrollment period. Coverage changes must be consistent with the QLE and documentation may be required.

# Medical Plans: 5 Options

### MED ENHANCED
- Copays for Dr. Visits, Labs, X-rays and Generic Drugs
- 100% in-network coverage for ACA required Preventive Services
- Telemedicine with free consultations
- Medical price shopping tool to estimate out-of-pocket costs for care

### MED ENHANCED PLUS
- Includes all the Med Enhanced benefits ***PLUS***
- Coverage for Accidents, Hospital Stays, Surgeries and more

### MED ADVANTAGE
- 100% in-network coverage for ACA required Preventive Services
- Prescription drugs discounts
- Medical price shopping tool to estimate out-of-pocket costs for care

### MED ADVANTAGE PLUS
- Includes all the Med Advantage benefits ***PLUS***
- Coverage for Dr. Visits, Labs, X-rays, Hospital Stays, Surgeries and more
- Telemedicine with free consultations

### MED BASIC
- Coverage for Dr. Visits, Labs, X-rays, Hospital Stays, Surgeries and more
- Prescription drugs discounts
- Telemedicine with free consultations

# Specialty Benefit Plans

### DENTAL
- Pays up to $500 per year with a $20 copay per visit

### VISION
- $10 deductible for Exams & up to $120 for Frames

### CRITICAL ILLNESS & HOSPITAL
- Pays up to $5,000 for a covered Critical Illness
- Coverage for Hospital Stays

### SHORT-TERM DISABILITY
- Pays $200 per week for up to 26 weeks

### LIFE/AD&D INSURANCE
- $20,000 of Life & AD&D coverage for Talent

### ACCIDENT COVERAGE
- Pays up to $5,000 per occurrence

## Medical Coverage Options Overview

You can choose **ONE** of the five medical options below. The benefits vary by plan. Review the chart below to better understand and compare your options so you can make the right choice for you and your family.

| Coverage Overview | Basic | Advantage | Advantage Plus | Enhanced | Enhanced Plus |
|---|---|---|---|---|---|
| First Health Network | ✓ | ✓ | ✓ | ✓ | ✓ |
| Primary Care Office Visit<br>Specialist Office Visit | Pays $100/Day | | Pays $100/Day | You Pay $10*<br>You Pay $75* | You Pay $10*<br>You Pay $75* |
| Teladoc | ✓ | | ✓ | ✓ | ✓ |
| Outpatient Diagnostic Lab<br>Outpatient Diagnostic X-ray | Pays $75/Day<br>Pays $200/Day | | Pays $75/Day<br>Pays $200/Day | You Pay $20* | You Pay $20* |
| Outpatient Diagnostic Advanced Studies | Pays $300/Day | | Pays $300/Day | | Pays $300/Day |
| Minimum Essential Coverage (MEC) Preventive Services | | Plan Pays 100%* | Plan Pays 100%* | Plan Pays 100%* | Plan Pays 100%* |
| Accident (per occurrence) | Pays up to $300 | | Pays up to $300 | | Pays up to $1,000 |
| Emergency Room Sickness | | | | | Pays $150/Day |
| Inpatient Surgery | Pays $1,000/Day | | Pays $1,000/Day | | Pays $2,000/Day |
| Hospital Admission (lump sum benefit) | Pays $500/ Confinement | | Pays $500/ Confinement | | Pays $1,000/ Confinement |
| Inpatient Hospital Indemnity | Pays $100/Day | | Pays $100/Day | | Pays $600/Day |
| Inpatient Intensive Care Unit | Pays $200/Day | | Pays $200/Day | | Pays $1,200/Day |
| Prescription Drug | Generic & Brand Discounts | Generic & Brand Discounts | Generic & Brand Discounts | Generic Copays Brand Discounts | Generic Copays Brand Discounts |

***You MUST visit a First Health Network provider for services to be covered. Services from out-of-network providers are NOT covered.**

| Weekly Rates | Basic | Advantage | Advantage Plus | Enhanced | Enhanced Plus |
|---|---|---|---|---|---|
| Talent Only | $16.52 | $5.11 | $21.63 | $18.39 | $31.87 |
| Talent & Spouse | $27.85 | $7.55 | $35.40 | $46.63 | $78.51 |
| Talent & Child(ren) | $27.97 | $7.82 | $35.79 | $56.59 | $79.89 |
| Talent & Family | $42.25 | $8.71 | $50.96 | $76.50 | $111.92 |

**Note: Biweekly rates are twice the weekly rates. Monthly rates are slightly more than 4 times the weekly rates.**

### First Health Network*

Members have access to one of the nations largest Physician and Hospital networks

- Over 490,000 provider locations across the country
- To locate a provider, visit www.FirstHealthLBP.com

*Tip... When making an appointment, make sure to tell your provider your coverage includes the First Health network and confirm they participate in the network.*

### Teladoc: Talk to a Doctor Anytime for FREE**

Quality care in minutes from U.S. board-certified doctors 24 hours a day, 365 days a year by phone, online video or mobile app

- Convenient and effective care at no cost to you
- Doctors diagnose, treat and, if needed, prescribe medication
- Avoid expensive urgent care or ER visits for non-emergencies

*Registration required prior to use*

***Teladoc state requirements: AR and DE require initial consultations to be done via video. ID requires all consultations are done via video.*

# MED BASIC PLAN

The Med Basic Plan provides coverage for healthcare services due to an accident or illness. The plan pays a fixed amount per day for covered services. The plan pays in addition to other coverage, which can help offset out-of-pocket costs when receiving treatment.

You have access to the First Health Network, but can choose any provider for services. Visiting a First Health Network provider can reduce your costs, since a discount will be applied to your bill. The plan also includes Teladoc with no cost consultations and prescription drug discounts to help you save on medical expenses.

| Services | Med Basic Plan |
|---|---|
| Primary Care Office Visit<br>Specialist Office Visit | Plan pays $100 per day; 6 days per year |
| Outpatient Diagnostic Lab | Plan pays $75 per testing day; 3 days per year |
| Outpatient Diagnostic X-Ray | Plan pays $200 per testing day; 3 days per year |
| Outpatient Diagnostic Advanced Studies | Plan pays $300 per testing day; 3 days per year |
| Accidental Injury Care | Plan pays up to $300 per occurrence |
| Surgical Indemnity Benefit<br>-Daily Inpatient Surgical<br>-Daily Outpatient Surgical<br>-Daily Outpatient Minor<br>-Outpatient Benefit Maximum | <br>Plan pays $1,000 per day, 1 day per year<br>Plan pays $500 per day<br>Plan pays $100 per day<br>1 day per year |
| Anesthesia | Plan pays 30% of Surgical Benefit |
| Hospital Admission (lump sum) | Plan pays $500 per confinement |
| Daily In-Hospital Indemnity<br>Intensive Care Unit<br>Substance Abuse<br>Mental Illness<br>Skilled Nursing (Inpatient) | Plan pays $100 per day; 500 day lifetime max<br>Plan pays $200 per day; 30 days per year<br>Plan pays $50 per day; 30 days per year<br>Plan pays $50 per day; 30 days per year<br>Plan pays $50 per day; 60 days per stay |
| *Teladoc | No cost access to doctors by phone or online |
| *Prescription Drugs | AWP Value Rx Discount Program |
| *First Health Network | Physician & Hospital |
| **Weekly Rates** | **Med Basic Plan** |
| Talent Only<br>Talent & Spouse<br>Talent & Child(ren)<br>Talent & Family | $16.52<br>$27.85<br>$27.97<br>$42.25 |

**Services not underwritten by Nationwide Life Insurance Company.*

*The Med Basic Plan (a) is not a substitute for minimum essential health coverage under the Affordable Care Act (ACA), and (b) does not qualify as minimum essential coverage under the ACA.*

*The Med Basic Plan is not available to New Hampshire, New Mexico and Vermont residents. Benefits vary for Washington residents.*

# ADDITIONAL MED BASIC PLAN FEATURES

## First Health Network

Members have access to the First Health Network, which provides savings on Physician and Hospital services. By visiting a First Health provider you can reduce your out-of-pocket expenses.

- Over 490,000 provider locations across the country
- Network providers submit claims for you to simplify the claim process
- To locate a provider online, visit **www.FirstHealthLBP.com**

*Note: You can visit a First Health or out-of-network provider for service and the Med Basic Plan will pay the same benefit amount.*

## AWP Value Rx - Provided by CerpassRx

The AWP Value Rx program is designed to provide substantial prescription drug savings. This plan will help you identify affordable generic and brand name drugs.

- Select generic and brand name drugs available for $10, $20, $50 or less
- Non-Select Generic and Brand drugs are available at a discount
- Over 70,000 participating pharmacies nationwide
- To locate a pharmacy, visit **www.AWPValueRx.com**

*Note: The AWP Value Rx program is a non-insurance discount program*

## Teladoc

24/7 on-demand access to a national network of U.S. Board-certified doctors through the convenience of phone, video or mobile app visits. Teladoc doctors can diagnose, treat and prescribe medication for a variety of issues.

- No cost consultations
- Receive medical care from anywhere without taking time off work
- Fast treatment - Median call back in just 10 minutes
- Avoid expensive urgent care or ER visits for non-emergency issues
- Call **(800) 835-2362** or visit **www.Teladoc.com**

# MED ADVANTAGE AND MED ADVANTAGE PLUS PLANS

Both plans provide 100% in-network coverage for all ACA required Preventive Services and Prescription discounts.

The Med Advantage Plan only covers Preventive Services. It does not provide coverage for illness or accidents.

The Med Advantage Plus Plan adds coverage Doctor Visits, Labs, X-rays, Surgeries, Hospital Stays, and more. It also includes Teladoc with no cost consultations.

| | Med Advantage | Med Advantage Plus |
|---|---|---|
| **Preventive Services** | | |
| Minimum Essential Coverage (MEC) Preventive Services | Plan pays 100% for all ACA required Preventive Services *(See page 9 for details)* **You MUST visit a First Health Network provider for services to be covered** | |
| **Additional Services - All below services pay on a calendar year basis per person, unless stated otherwise.** | | |
| *First Health Network | Physician & Hospital | |
| *Prescription Drugs | AWP Value Rx Discount Program | |
| *Medical Price Shopping Tool | Estimate medical costs before scheduling | |
| Primary Care Office Visit<br>Specialist Office Visit | N/A | Plan pays $100 per day; 6 days per year |
| Outpatient Diagnostic Lab | N/A | Plan pays $75 per testing day; 3 days per year |
| Outpatient Diagnostic X-Ray | N/A | Plan pays $200 per testing day; 3 days per year |
| Outpatient Diagnostic Advanced Studies | N/A | Plan pays $300 per testing day; 3 days per year |
| Accidental Injury Care | N/A | Plan pays up to $300 per occurrence |
| Surgical Indemnity Benefit<br>-Daily Inpatient Surgical<br>-Daily Outpatient Surgical<br>-Daily Outpatient Minor<br>-Outpatient Benefit Maximum | N/A | Plan pays $1,000 per day, 1 day per year<br>Plan pays $500 per day<br>Plan pays $100 per day<br>1 day per year |
| Anesthesia | N/A | Plan pays 30% of Surgical Benefit |
| Hospital Admission (lump sum) | N/A | Plan pays $500 per confinement |
| Daily In-Hospital Indemnity<br>Intensive Care Unit<br>Substance Abuse<br>Mental Illness<br>Skilled Nursing (Inpatient) | N/A | Plan pays $100 per day; 500 day lifetime max<br>Plan pays $200 per day; 30 days per year<br>Plan pays $50 per day; 30 days per year<br>Plan pays $50 per day; 30 days per year<br>Plan pays $50 per day; 60 days per stay |
| *Teladoc | N/A | No cost access to doctors by phone or online |
| **Weekly Rates** | **Med Advantage** | **Med Advantage Plus** |
| Talent Only | $5.11 | $21.63 |
| Talent & Spouse | $7.55 | $35.40 |
| Talent & Child(ren) | $7.82 | $35.79 |
| Talent & Family | $8.71 | $50.96 |

**Services not underwritten by Nationwide Life Insurance Company.*

*The Med Advantage Plus Plan is not available to New Hampshire, New Mexico and Vermont residents. Benefits vary for Washington residents.*
*The Med Advantage and Med Advantage Plus Plans do not satisfy state coverage requirements in Massachusetts.*

# MED ENHANCED AND MED ENHANCED PLUS PLANS

Both plans include copays for Doctor Visits, Labs, X-ray, and Prescription Drugs at in-network providers. They also provide 100% in-network coverage for all ACA required Preventive Services and access to Telaoc.

The Med Enhanced Plus Plan adds coverage for Accidents, Surgeries, Hospital Stays, and more.

| | Med Enhanced Plan | Med Enhanced Plus Plan |
|---|---|---|
| **Self-Funded Services - First Health Network provider use required** | | |
| Minimum Essential Coverage (MEC) Preventive Services | Plan pays 100% for all ACA required Preventive Services *(See page 9 for details)* **You MUST visit a First Health Network provider for services to be covered** | |
| Primary Care Office Visit | You pay $10 per visit; 6 visits per year | |
| Specialist Office Visit | You pay $75 per visit; 1 visit per year | |
| Outpatient Diagnostic Lab & X-ray | You pay $20 per visit; 6 visits per year | |
| Prescription Drugs<br>-Generic<br>-Brand<br>-Monthly Maximum | CerpassRx<br>$10 copay<br>Discounts<br>Unlimited | |
| **Additional Services - All below services pay on a calendar year basis per person, unless stated otherwise.** | | |
| *First Health Network | Physician & Hospital | |
| *Teladoc | No cost access to doctors by phone or online | |
| *Medical Price Shopping Tool | Estimate medical costs before scheduling | |
| Outpatient Diagnostic Advanced Studies | N/A | Plan pays $300 per testing day, 3 days per year |
| Accidental Injury Care | N/A | Plan pays up to $1,000 per occurrence |
| Emergency Room Sickness | N/A | Plan pays $150 per day, 2 days per year |
| Surgical Indemnity Benefit<br>-Daily Inpatient Surgical<br>-Daily Outpatient Surgical<br>-Daily Outpatient Minor<br>-Outpatient Benefit Maximum | N/A | <br>Plan pays $2,000 per day, 1 day per year<br>Plan pays $1,000 per day<br>Plan pays $200 per day<br>1 day per year |
| Anesthesia | N/A | Plan pays 30% of Surgical Benefit |
| Hospital Admission (lump sum) | N/A | Plan pays $1,000 per confinement |
| Daily In-Hospital Indemnity<br>Intensive Care Unit<br>Substance Abuse<br>Mental Illness<br>Skilled Nursing (Inpatient) | N/A | Plan pays $600 per day; 500 day lifetime max<br>Plan pays $1,200 per day; 30 days per year<br>Plan pays $300 per day; 30 days per year<br>Plan pays $300 per day; 30 days per year<br>Plan pays $300 per day; 60 days per stay |
| **Weekly Rates** | **MEC Enhanced Plan** | **MEC Enhanced Plus Plan** |
| Talent Only | $18.39 | $31.87 |
| Talent & Spouse | $46.63 | $78.51 |
| Talent & Child(ren) | $56.59 | $79.89 |
| Talent & Family | $76.50 | $111.92 |

**Services not underwritten by Nationwide Life Insurance Company.*

*The Med Enhanced Plus Plan is not available to New Hampshire, New Mexico and Vermont residents. Benefits vary for Washington residents.*
*The Med Enhanced and Med Enhanced Plus Plans do not satisfy state coverage requirements in Massachusetts.*

# MINIMUM ESSENTIAL COVERAGE (MEC)

Regular checkups, immunizations and screenings help you stay healthy. These preventive services reduce the risk of severe illness by detecting the early signs of diabetes, heart disease, certain cancers or other chronic conditions.

The Medical plans that include Minimum Essential Coverage (MEC) provide 100% coverage for all Preventive Services required by the Affordable Care Act. These plans plan pays 100% for all covered services at First Health network providers.

First Health Network is one of the country's largest networks with over 490,000 locations nationwide. Preventive Services from out-of-network providers are not covered so it's important you visit a First Health provider.

## COVERED SERVICES OVERVIEW

**Flu shots & routine immunizations**

**Preventive prescription drugs**

**COVID-19 vaccine**

**Medical screenings**

- Blood pressure
- Cholesterol
- Diabetes
- Hepatitis C

**Annual well-woman exam**

**Contraception**

- FDA approved methods excluding abortifacient drugs
- Sterilization procedures

**Cancer screenings**

- Colorectal
- Breast

**Well baby & well child exams**

**Counseling on topics including:**

- Alcohol & drug abuse
- Contraception use
- Depression
- Diet & obesity
- Domestic violence
- Sexually transmitted diseases
- Tobacco cessation

## EXAMPLE

**You go to the doctor for an annual physical exam. This type of service often includes a charge for the office visit and a lab screening.**

**IN-NETWORK**

| $160 Office Visit Cost | + | $170 ACA Approved Lab Cost | = | $330 Exam Total Billed | Your Cost $0 |
|---|---|---|---|---|---|

**OUT-OF-NETWORK**

| $160 Office Visit Cost | + | $170 ACA Approved Lab Cost | = | $330 Exam Total Billed | Your Cost $330 |
|---|---|---|---|---|---|

## PRESCRIPTION BENEFITS

At the pharmacy you'll receive covered preventive prescriptions like contraceptives and statins for free! You'll also save on non-preventive prescriptions. Simply show your ID card.

## ADDITIONAL COVERED SERVICES

While the MEC plan covers many more services, the U.S. Preventive Services Task Force periodically updates the list of covered services. They also set the requirements such as age, gender or health conditions for services to be covered. For the most current listing, visit www.Healthcare.gov/preventive-care-benefits/.

*IMPORTANT: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that you may be required to pay some costs for 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.*

# ADDITIONAL PLAN FEATURES

## First Health Network

Members have access to the First Health Network, one of the nations largest networks. By visiting a First Health provider you can reduce your out-of-pocket costs.

- Over 490,000 provider locations across the country
- Network providers submit claims for you to simplify the claim process
- To locate a provider online, visit www.FirstHealthLBP.com

*Note: Network use required for MEC Preventive Services and all Self-funded benefits*

## Teladoc

**(INCLUDED IN MED ADVANTAGE PLUS, MED ENHANCED & MED ENHANCED PLUS PLANS)**

24/7 on-demand access to a national network of U.S. Board-certified doctors through the convenience of phone, video or mobile app visits. Teladoc doctors can diagnose, treat and prescribe medication for a variety of issues.

- No cost consultations
- Receive medical care from anywhere without taking time off work
- Fast treatment - Median call back in just 10 minutes
- Avoid expensive urgent care or ER visits for non-emergency issues
- Call **(800) 835-2362** or visit www.Teladoc.com

## AWP Value Rx - Provided by CerpassRx

**(INCLUDED IN MED ADVANTAGE & MED ADVANTAGE PLUS PLANS)**

The AWP Value Rx program is designed to provide substantial prescription drug savings. This plan will help you identify affordable generic and brand name drugs.

- Select generic and brand name drugs available for $10, $20, $50 or less
- Non-Select Generic and Brand drugs are available at a discount
- Over 70,000 participating pharmacies nationwide
- To locate a pharmacy, visit www.AWPValueRx.com

*Note: The AWP Value Rx program is a non-insurance discount program*

## CerpassRx

**(INCLUDED IN MED ENHANCED & MED ENHANCED PLUS PLANS)**

Effective and reliable prescription drug coverage with a broad network of over 70,000 participating pharmacies nationwide.

- **Formulary Generic Drugs:** $10 Copay
- **Non-formulary Generic & Brand Drugs:** Discounts
- **Monthly Maximum:** Unlimited
- To locate a pharmacy, visit www.CerpassRx.com or call **(844) 636-7506**

## Medical Price Shopping Tool: Healthcare Bluebook

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. Access the medical price shopping tool through your member portal at www.TheAmericanWorker.com or call **(855) 495-1190**.

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

Ameritas

## Dental

Keep a bright, healthy smile and support your overall well-being with affordable coverage. You can use any provider, but using an Ameritas network provided will save you money. This plan is underwritten by Ameritas.

| **Calendar Year Maximum** | Up to $500 per Covered Member | |
|---|---|---|
| **Deductible** | $20 per Visit | |
| **Covered Services** | **Waiting Period** | **Coinsurance** |
| **Preventive & Diagnostic**<br>Routine Exams, Cleanings, X-rays, etc. | None | Covered at 100% (MAC)* |
| **Basic Treatment**<br>Restorative Amalgams & Composites<br>Endodontics, Periodontics, Extractions, etc. | 3 Months | Covered at 60% (MAC)* |
| **Major Treatment**<br>Onlays, Crowns, Prosthodontics, etc. | 12 Months | Covered at 50% (MAC)* |
| **Weekly Rates** | | |
| Talent | $4.26 | |
| Talent & Spouse | $10.66 | |
| Talent & Child(ren) | $7.67 | |
| Talent & Family | $11.52 | |

**LOCATE NETWORK PROVIDERS**

**Call (800) 659-2223**

- Select **option 3**

**Visit** www.Ameritas.com

- Your network is **"CLASSIC PPO"**

**You will not receive an ID card. Your provider will be able to access your benefits using your Social Security Number.**

**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.*

## Vision

A regular eye exam won't just help you see better, it can also detect the first signs of serious health conditions. Visit a VSP Choice provider to get the most out of your vision plan. This plan is underwritten by Ameritas.

| **Deductibles** | $10 for Exams & $25 for Eye Glass Lenses or Frames[1] | |
|---|---|---|
| **Covered services** | **VSP Choice Network** | **Out-of-Network** |
| **Annual Eye Exam** | Covered in Full | Up to $45 |
| **Lenses** (per pair)<br>Single Vision / Bifocal<br>Trifocal / Lenticular | <br>Covered in Full<br>Covered in Full | <br>Up to $30 / Up to $50<br>Up to $65 / Up to $100 |
| **Contacts**<br>Fit & Follow Up Exams<br>Elective<br>Medically Necessary | <br>15% Discount<br>Up to $120<br>Covered in Full | <br>No Benefit<br>Up to $105<br>Up to $210 |
| **Frames** | Up to $120[2] | Up to $70 |
| **Frequency**<br>Exam / Lens / Frames | Based on Date of Service<br>12 Months / 12 Months / 24 Months | |
| **Weekly Rates** | | |
| Talent | $1.86 | |
| Talent & Spouse | $3.68 | |
| Talent & Child(ren) | $3.43 | |
| Talent & Family | $5.24 | |

**LOCATE NETWORK PROVIDERS**

**Call (800) 877-7195**

**Visit** www.Ameritas.com

- Your network is **"VISION: VSP"**

**You will not receive an ID card. Your provider will be able to access your benefits using your Social Security Number.**

*[1]Deductible applies to a complete pair of glasses or frames, whichever is selected.*
*[2]The Costco allowance will be the wholesale equivalent.*

# SHORT-TERM DISABILITY, LIFE/AD&D AND ACCIDENT

## Short-Term Disability*

Daily life depends on consistent income, but accidents and serious illnesses can keep you out of work. This plan can help you cover your expenses by paying you cash if you get sick or injured and can't work.

| | |
|---|---|
| **Weekly Maximum Benefit** | Plan pays $200 lump sum |
| **Maximum Benefit Period** | 26 weeks |
| **Waiting Period** | 7 days (Accidents & Sickness) |

Coverage includes disability due to pregnancy and childbirth.

| Weekly Rates | |
|---|---|
| Talent Only | $3.47 |

*CA, NJ, NY and RI residents may be entitled to additional state disability benefits.*

## Life/AD&D Insurance*

Life insurance can help your loved ones during a trying time. This benefit provides cash that can assist your family in the event of your passing. Enroll in this benefit to protect the future of the ones that depend on you the most.

| | |
|---|---|
| **Life/AD&D Insurance** | |
| Talent | Plan pays $20,000 |
| **Dependent Life Insurance** | |
| Spouse | Plan pays $2,500 |
| Child (6 months to 26 years) | Plan pays $1,250 |
| Infant (10 days to 6 months) | Plan pays $200 |

| Weekly Rates | |
|---|---|
| Talent Only | $0.54 |
| Talent & Spouse | $0.81 |
| Talent & Child(ren) | $0.81 |
| Talent & Family | $1.62 |

**Short-term Disability and Life and AD&D are underwritten by Nationwide Life Insurance Company.*
*Coverage is not available to New Hampshire, New Mexico and Vermont residents. Rates vary for Washington residents.*

CRUM & FORSTER
A FAIRFAX COMPANY

## Accident Coverage

Accidents happen and while treatment is key to recovery, it can be expensive. This benefit can help offset the costs of getting healthy and have you back to living well.

| | |
|---|---|
| **Accident Medical Coverage**** | Plan pays up to $5,000 per occurrence |
| **Eligible Expenses:** | |
| Physician's Visits (Inpatient/Outpatient) | Hospital/ICU Room & Board |
| Diagnostic Labs & X-Rays (Inpatient/Outpatient) | Emergency Room Treatment |
| Surgery (Inpatient/Outpatient) | Anesthesia |
| Physiotherapy (Inpatient/Outpatient) | Ambulance |
| **Accidental Death & Dismemberment** | |
| Talent | Plan pays $15,000 |
| Spouse | Plan pays $7,500 |
| Child(ren) | Plan pays $3,000 |
| **Weekly Rates** | |
| Talent Only | $2.65 |
| Talent & Spouse | $5.54 |
| Talent & Child(ren) | $5.54 |
| Talent & Family | $5.54 |

***Expenses must be incurred within 30 days of the accident to be covered.*

## Critical Illness and Hospital Indemnity Package*

Life's unexpected turns can be stressful and costly. The Critical Illness and Hospital Indemnity can help ease the burden by providing a benefit if you or a loved one are diagnosed with a covered critical illness or hospitalized.

| | |
|---|---|
| **Critical Illness Benefit (First Ever Occurrence)** | |
| Talent | Plan pays $5,000 |
| Spouse | Plan Pays $2,500 |
| Child(ren)** | Plan Pays $1,250 |
| **Hospital Indemnity Benefit** | |
| Hospital Admission (lump sum) | Plan pays $1,000 per confinement |
| Daily In-Hospital Indemnity | Plan pays $100 per day; 500 day lifetime max |
| Intensive Care Unit | Plan pays $200 per day; 30 days per year |
| Substance Abuse | Plan pays $50 per day; 30 days per year |
| Mental Health | Plan pays $50 per day; 30 days per year |
| Skilled Nursing Facility | Plan pays $50 per day; 60 days per stay |
| **Weekly Rates** | |
| Talent Only | $4.03 |
| Talent & Spouse | $9.41 |
| Talent & Child(ren) | $6.95 |
| Talent & Family | $11.92 |

***Child coverage is from 6 months to 26 years of age.*

### COVERED CONDITIONS

- Heath Attack
- Stroke
- Major Organ Transplant
- End-Stage Renal Failure
- Life Threatening Cancer

### CRITICAL ILLNESS BENEFIT DESCRIPTION

The plan pays a one-time, lump-sum benefit in the event an insured person is diagnosed with their first occurrence of a covered condition. The diagnosis must occur after the coverage is effective and while the policy is in force.

The plan pays 100% of the Critical Illness benefit if a covered person is diagnosed with any covered condition except cancer after their effective date.

- If the cancer diagnosis is less than 90 days after the effective date, 10% of the Critical Illness benefit will be paid.
- If the cancer diagnosis is more than 90 days after the effective date, 100% of the Critical Illness benefit will be paid.

**Critical Illness and Hospital Indemnity are underwritten by Nationwide Life Insurance Company.*
*Coverage is not available to New Hampshire, New Mexico and Vermont residents. Rates vary for Washington residents.*

# OTHER BENEFITS OFFERED BY EMPLOYBRIDGE

*NOT ADMINISTERED BY THE AMERICAN WORKER*

Employbridge also provides the following benefits to our Talent. If you have questions or want additional information on these programs use the contact information in the descriptions below.

***The American Worker does not administer these benefits. The American Worker does not have information on these programs and is unable to answer any questions about these benefits.***

## ANTHEM MEDICAL COVERAGE - ELIGIBLE FULL-TIME

Full-time Talent may enroll in comprehensive medical coverage through Anthem. Full-time Talent are those who worked 30 or more hours per week during a look-back period to gain full-time eligibility. If you are eligible, you will receive separate communication regarding Anthem enrollment and may enroll online at www.myemploybridgebenefits.com or by phone at **(877) 785-5125**.

## EMPLOYEE ASSISTANCE PLAN - PROVIDED BY ANTHEM

Free and confidential counseling is available through Anthem to Talent and their family by phone, in-person, and online. Just call **(800) 999-7222** or visit www.anthemEAP.com and enter "**employbridge**".

## RETIREMENT SAVINGS OPPORTUNITY - THROUGH AMERICAN FUNDS

You have opportunity to save for retirement through an American Funds IRA. To enroll or learn more about an American Funds IRA, please email benefits@employbridge.com.

# PAYING FOR BENEFITS AND MISSED PREMIUM PAYMENTS

## HOW DO I PAY FOR COVERAGE?
Your premium will be deducted from your paycheck.

## WHAT HAPPENS IF I DON'T HAVE A PAYROLL DEDUCTION?
Your benefits will be suspended. Your benefits will resume when you have a paycheck with a deduction.

## WHAT HAPPENS IF I HAVE A CLAIM WHEN MY BENEFITS ARE SUSPENDED?
Your claim will be denied and you will pay for 100% of the cost for the care you received.

## HOW DO I KEEP MY COVERAGE IF I MISS A DEDUCTION?
You can make a payment directly to The American Worker to avoid having coverage suspended.

## HOW DO I MAKE A PAYMENT IF I MISSED A DEDUCTION?
You can pay online or by phone. Payment options include credit or debit card, personal check, and money order. You can also set up an automatic payment from your credit card or bank account to pay for missed deductions.

**Online:** Visit www.TheAmericanWorker.com and login to your employee portal
**Phone:** Call The American Worker at **(877) 220-1862**

**NOTE:** If you setup automatic payments, you must contact The American Worker to cancel automatic payments when your employment ends. If you do not, your account will be charged and you will not receive a refund.

## HOW LONG DO I HAVE TO MAKE A PAYMENT FOR A MISSED DEDUCTION?
You have 30 days from the date of your paycheck without a deduction to make a premium payment. If you do not pay for the missed deduction within 30 days, you will not be able to pay for that coverage period at a later date.

## WILL MY COVERAGE BE TERMINATED IF I DON'T PAY MY PREMIUM?
If you do not pay your premium for six consecutive weeks, your coverage will be terminated for nonpayment. **Please review your paycheck to make sure your premium is deducted. If it is not, contact The American Worker immediately to make a payment and avoid having your coverage terminated.**

# FAQ'S AND CONTACTS

## 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 | (877) 220-1862 |
| PPO Network | First Health Network | www.FirstHealthLBP.com | (800) 226-5116 |
| Prescription Drug Coverage | CerpassRx | www.CerpassRx.com | (844) 636-7506 |
| Telemedicine | Teladoc | www.Teladoc.com | (800) 835-2362 |
| Dental | Ameritas | www.Ameritas.com | (800) 659-2223 |
| Vision | Ameritas | www.Ameritas.com | (800) 877-7195 |
| Short-term Disability<br>Life and AD&D<br>Critical Illness and Hospital | The American Worker | www.TheAmericanWorker.com | (877) 220-1862 |
| Accident Coverage | Crum & Forster | | (800) 952-4320 |

# COBRA

## 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

**This enrollment guide provides an overview of some of the benefit plans you are eligible for through employbridge. Refer to official plan documents, insurance policy and/or certificate of coverage for more extensive information concerning your benefit plans. In the event of a conflict between this guide and the official documents, the plan documents, policy and/or certificate of coverage will govern how your benefits are determined and administered. employbridge, in its sole discretion, reserves the right to amend or terminate at any time the benefit plans described in this enrollment guide.**

**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.

**State restrictions**
The benefit plans described in this enrollment guide are not available in all states. Restrictions include but are not limited to:
**New Hampshire, New Mexico and Vermont residents** are not eligible for the Med Basic, Med Advantage Plus, Med Enhanced Plus, Short-term Disability, Life/AD&D or Critical Illness and Hospital package.
**Hawaii residents** are not eligible any of the benefit plans described in this enrollment guides.
**Massachusetts residents** are eligible for all medical plans, but none of these plans meet the individual health insurance requirements and do not satisfy the individual mandate in Massachusetts.

**Med Advantage, Med Advantage Plus, Med Enhanced and Med Enhanced Plus Plans** (include Minimum Essential Coverage)
These plans provide Plan Participants with minimum essential coverage under the federal income tax rules. Individuals that do not enroll in these plans may be eligible for a federal tax credit that lowers their monthly premium or a reduction in certain cost-sharing if they enroll in a health insurance plan through the federal or state exchange. Individuals that enroll in these plans may not be eligible for a federal tax credit though a federal or state exchange while enrolled in these plans. **These plans do not provide comprehensive health insurance. Limitations and exclusions apply.**

You can access a Summary of Benefits and Coverage (SBC) for these plans online at www.TheAmericanWorker.com. If you are unable to access the SBC online or want a copy mailed to your home call **(877) 220-1862**.

**Med Basic Plan** (Fixed Indemnity benefits only)
This plan is not comprehensive health insurance and is not intended or recommended to replace comprehensive health insurance in which you currently participate. The plan provides fixed indemnity insurance benefits. This enrollment guide is for summary purposes only. The insurance benefits of the Med Basic Plan are underwritten by Nationwide Life Insurance Company. A detailed Certificate of Coverage is available upon enrollment. **Limitations and exclusions apply.**

The Med Basic Plan (a) is not a substitute for minimum essential health coverage under the Affordable Care Act (ACA), and (b) does not qualify as minimum essential coverage under ACA.

**Accident Medical Coverage:** This is a brief summary of the Accident coverage available under this plan. The issued Policy contains the compete limitations, exclusions, definitions and plan provisions. Plan features and availability may vary by state. Full details of the coverage are contained in the Policy on file with the Policyholder. If any conflict should arise between the contents of this summary and the respective Policy, the terms of the Policy will govern in all cases.

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**Nationwide and Nationwide N and Eagle are service marks of Nationwide Mutual Insurance Company.**
The coverage is underwritten by Nationwide Life Insurance Company, Columbus, Ohio (CA COA #7032). The Fixed Indemnity Plan applicable to policy form SRCP 2000 or state equivalent. Nationwide and the Nationwide N and Eagle are service marks of Nationwide Mutual Insurance Company. NSM-0301AO (06/23).

The American Worker®
Provided by Fringe Benefit Group

**Benefits Enrollment Guide**

THEAMERICANWORKER.COM / (855) 860-4121

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.theamericanworker.com or call 1-855-495-1190. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-495-1190 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | **Yes** | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | **Yes.** See www.firsthealthlbp.com or call 1-855-495-1190 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | **No** | You can see the specialist you choose without a referral.<br>NOTE: only preventive services by a specialist are covered. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | Not Covered | Excluded Service |
| | Specialist visit | Not Covered | Not Covered | Excluded Service |
| | Preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | All tests other than preventive care/screening are considered an Excluded Service. |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available by calling 855-495-1190 | Generic drugs | Not Covered | Not Covered | ACA preventive medications are covered at No Charge. All other medications are offered a discount only. |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | Excluded Service |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not Covered | Excluded Service |
| | Emergency medical transportation | Not Covered | Not Covered | Excluded Service |
| | Urgent care | Not Covered | Not Covered | Excluded Service |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered | Excluded Service |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| **If you need mental** | Outpatient services | Not Covered | Not Covered | Excluded Service |

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **health, behavioral health, or substance abuse services** | Inpatient services | Not Covered | Not Covered | Excluded Service |
| **If you are pregnant** | Office visits | Not Covered | Not Covered | Cost sharing does not apply for preventive services. All other services are considered an Excluded Service. |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | Excluded Service |
| | Rehabilitation services | Not Covered | Not Covered | Excluded Service |
| | Habilitation services | Not Covered | Not Covered | Excluded Service |
| | Skilled nursing care | Not Covered | Not Covered | Excluded Service |
| | Durable medical equipment | Not Covered | Not Covered | Excluded Service |
| | Hospice services | Not Covered | Not Covered | Excluded Service |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Excluded Service |
| | Children's glasses | Not Covered | Not Covered | Excluded Service |
| | Children's dental check-up | Not Covered | Not Covered | Excluded Service |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Diagnostic tests (non-preventive)
- Eye care (Child)
- Home health
- Imaging
- Maternity
- Prescription drugs
- Rehabilitation
- Skilled nursing care
- Weight loss programs
- Bariatric surgery
- Dental care (Adult)
- Durable medical equipment
- Habilitation services
- Hospice
- Infertility treatment
- Mental Health services
- Primary care visit (non-preventive)
- Routine eye care (Adult)
- Specialist visit (non-preventive)
- Chiropractic care
- Dental care (Child)
- Emergency services
- Hearing aids
- Hospital stays
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Surgery

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • | • | • |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-495-1190.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.com.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **100%**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,600 |
| **The total Peg would pay is** | **$12,600** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well- controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **100%**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $5,400 |
| **The total Joe would pay is** | **$5,400** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **100%**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,800 |
| **The total Mia would pay is** | **$2,800** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.fbg.com or call 1-855-495-1190. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-495-1190 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | **Yes** | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | **Yes.** See www.firsthealthlbp.com or call 1-855-495-1190 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | **No** | You can see the specialist you choose without a referral.<br>NOTE: only preventive services by a specialist are covered. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $10/visit | Not Covered | Limited to a combined 6 visits per person per calendar year (combined with maternity and mental health/substance abuse visits) |
| | Specialist visit | $75/visit | Not Covered | Limited to 1 visit per person per calendar year |
| | Preventive care/screening/ immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $20/testing day | Not Covered | Limited to 6 testing days per person per calendar year. Ultrasounds are limited to 3 per pregnancy. |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available by visiting www.CerpassRx.com or calling 844-636-7506 | Generic drugs | $10/prescription | Not Covered | Generic contraceptives are covered at No Charge. File a paper claim to receive reimbursement. |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | Excluded Service |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not Covered | Excluded Service |
| | Emergency medical transportation | Not Covered | Not Covered | Excluded Service |
| | Urgent care | Not Covered | Not Covered | Excluded Service |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered | Excluded Service |

* For more information about limitations and exceptions, see the plan or policy document at www.fbg.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10/visit for office visit setting; All other outpatient services Not Covered | Not Covered | Limited to a combined 6 visits per person per calendar year (combined with maternity and primary care visits) |
| | Inpatient services | Not Covered | Not Covered | Excluded Service |
| **If you are pregnant** | Office visits | $10/visit | Not Covered | Cost sharing does not apply for preventive services. Limited to a combined 6 visits per person per calendar year (combined with primary care and mental health/substance abuse visits). Visits bundled under a global fee are not covered. They must be billed separately. |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | Excluded Service |
| | Rehabilitation services | Not Covered | Not Covered | Excluded Service |
| | Habilitation services | Not Covered | Not Covered | Excluded Service |
| | Skilled nursing care | Not Covered | Not Covered | Excluded Service |
| | Durable medical equipment | Not Covered | Not Covered | Excluded Service |
| | Hospice services | Not Covered | Not Covered | Excluded Service |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Excluded Service |
| | Children's glasses | Not Covered | Not Covered | Excluded Service |
| | Children's dental check-up | Not Covered | Not Covered | Excluded Service |

* For more information about limitations and exceptions, see the plan or policy document at www.fbg.com.

**Excluded Services & Other Covered Services:**

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Cosmetic surgery | • Dental care (Adult) | • Dental care (Child) |
| • Durable medical equipment | • Emergency services | • Eye care (Child) |
| • Habilitation services | • Hearing aids | • Home health |
| • Hospice | • Hospital stays | • Imaging |
| • Infertility treatment | • Long-term care | • Maternity |
| • Mental Health services | • Non-emergency care when traveling outside the U.S | • Private-duty nursing |
| • Rehabilitation | • Routine eye care (Adult) | • Routine foot care |
| • Skilled nursing care | • Surgery | • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • | • | • |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

* For more information about limitations and exceptions, see the plan or policy document at www.fbg.com.

### Does this plan meet the Minimum Value Standards? **No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-495-1190.

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

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## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$75**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Costo total hipotético** | **$12,700** |
|---|---|

**En este ejemplo, Peg pagaría:**

| *Costo compartido* | |
|---|---|
| Deducibles | $0 |
| Copagos | $400 |
| Coseguro | $0 |
| *What isn't covered* | |
| Limits or exclusions | $11,100 |
| **The total Peg would pay is** | **$11,500** |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well- controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$75**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $3,900 |
| **The total Joe would pay is** | **$4,400** |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$75**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,300 |
| **The total Mia would pay is** | **$2,600** |

The plan would be responsible for the other costs of these EXAMPLE covered services.