



breckpoint

LEAD TOGETHER

ENROLLMENT GUIDE

Employer Name: Health Management, Inc,
Group ID #: C000318
Plan Coverage Dates: 01/01/2020-12/31/2020

Disponible en Español, favor de comunicarse; 1.844.300.6497

WELCOME TO YOUR HEALTH BENEFITS

To ensure you and your family have access to quality health coverage solutions, your employer has chosen to offer an eligible employer-sponsored health plan made available through the Breckpoint platform.

Custom-designed around the unique health and wellness needs of its employees, your new benefits plan provides a variety of valuable coverage options.

You can choose to enroll in the plan or to decline coverage. To help you consider your options and make the best-informed decision, this guide provides an overview of the benefits being offered.

Additional information about these benefits and a Summary of Benefits Coverage (SBC) can be found at my.breckpoint.com. A paper copy of the SBC is also available, free of charge, by calling (toll-free) 1.844.657.1575.

IMPORTANT: *You may be required to make an election to enroll or decline coverage during your enrollment period. You may also be subject to a waiting period before your coverage can begin.*

YOU HAVE 2 DIFFERENT WAYS YOU CAN MAKE YOUR ELECTIONS!

1

GIVE US A CALL

Call our Information Center and one of our knowledgeable representatives will help you.

Available Monday through Friday 7:00 am – 5:00 pm PST at 1.844.300.6497. Representantes que hablan inglés y español están disponible.

2

SEE YOUR HR DEPARTMENT

Complete the Enrollment Form with your elections and give to your HR representative.

COVERED SERVICES FOR ALL PLANS

Preventative Health Services

FOR ADULTS

- Abdominal Aortic Aneurysm One-Time Screening
(Men of specified ages who have ever smoked)
- Unhealthy Alcohol Misuse Screening and Counseling
- Aspirin Use to Prevent Cardiovascular Disease
- Blood Pressure Screening
- Cholesterol Screening
(Adults of certain ages or at a higher risk)
- Colorectal Cancer Screening
(Adults over 50)
- Depression Screening
- Diabetes (Type 2) Screening
(Adults with high blood pressure)
- HIV Screening
- Healthy Diet Counseling
- Hepatitis B Screening
- Hepatitis C Screening
- Immunization Vaccines
- Lung Cancer Screening
(Adults up to 24 years)
- Obesity Screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling
(Adults up to 24 years)
- Statin Preventative Medication
(Adults ages 40-75 with no history of CVD)
- Syphilis screening
- Tobacco Use Screening and Counseling
- Tuberculosis Screening
- Vitamin D Supplementation
- Fall Prevention Intervention
(Adults over 65 at a higher risk)
- HIV Pre-Exposure Medication

FOR WOMEN

- Bacteriuria Screening
(Pregnant women)
- Breast Cancer Chemoprevention Counseling
- Breast Cancer Genetic Test Counseling (BRCA)
- Breast Cancer Mammography Screenings
(Once a year for women over 40)
- Breast Cancer Preventative Medication
- Breastfeeding Support and Counseling
- Cervical Cancer Screening
(Sexually active women)
- Chlamydia Infection Screening
- Contraception
(Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling)
- Domestic Violence Screening and Counseling
- Folic Acid Supplements
- Hepatitis B Screening
- Immunization Vaccines
- Syphilis screening
- Tobacco Use Counseling
- Vitamin D Supplementation
- Gonorrhea Screening
- HIV Screening
- Osteoporosis Screening
(Woman 65 year and older)
- Perinatal Depression Screening
- Preeclampsia Screening & Preventative Medication
- Rh Incompatibility Screening
- Gestational Diabetes Screening
(Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)

FOR CHILDREN

- Depression Screening
- Fluoride Chemoprevention Supplements
(Infants & children up to age 5 years)
- Gonorrhea Prophylactic Medication
(Newborns)
- Hemoglobinopathies or Sickle Cell Screening
(Newborns)
- HIV Screening
- Hypothyroidism Screening
(Newborns)
- Immunization Vaccines
- Obesity Screening and Counseling
- Phenylketonuria (PKU) Screening
- Sexually Transmitted Infections
- Prevention Skin Cancer Behavioral Counseling
- Tobacco Use Interventions
- Visual Acuity Screening
(Children ages 3 to 5 years)



MINIMUM ESSENTIAL COVERAGE (MEC) PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	Medicare Plus
Out of Network Coverage	N/A
Individual Deductible/Out-of-Pocket Limit	\$0/None
Family Deductible/Out-of-Pocket Limit	\$0/None
Preventive & Wellness <i>Covered with no out-of-pocket expenses.</i>	100%
Physician and Office Utilizations <i>May be subject to a maximum combined number of utilizations per year. No coverage after utilization limit exhausted.</i>	- - -
Primary Care Visit	Not Included
Specialist Visit	Not Included
Urgent Care Visit	Not Included
Maternity Pre/Post Natal <i>(office visit)</i>	Not Included
Mental/Behavioral Health <i>(office visit)</i>	Not Included
X-Rays & Lab	Not Included
Imaging	Not Included
Emergency Room	Not Included
Emergency Transport	Not Included
Outpatient/In-Patient Services Hospital Admission	Not Included
Rx Discount <i>(Prescription)</i>	Included
Rideshare Transport <i>Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.</i>	Not Included
Virtual Urgent Care (MeMD)	Unlimited

PLAN FEATURES

- ▶ **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings**
- ▶ **This plan has an Open Network. Choose your own provider without the limitations of Network restrictions.**
- ▶ **No waiting periods**
- ▶ **No copays with 24/7 Virtual Urgent Care**
(Powered by MeMD, see insert for more information)
- ▶ **Prescription Program Included** *(Powered by RxValet, see insert for more information)*

Please see plan specification document for more details.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	\$46.00	\$82.80	\$101.20	\$138.00

MEC PLAN

BENEFITS SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible <i>(per plan year)</i>	\$0 Individual \$0 Family	Not applicable
Member Coinsurance <i>(applies to all expenses unless otherwise stated)</i>	0%	Not applicable
Out-of-Pocket (OOP) Maximum <i>(per plan year, includes deductible)</i>	Not applicable	Not applicable
<i>All covered expenses accumulate separately toward the network and out-of-network OOP limit.</i>		
<i>Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the OOP maximum.</i>		
<i>Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the plan year.</i>		
Payment for Out-of-Network Care	Not applicable	Not applicable
Referral Requirement	Not required	Not applicable
Physician Services	Network Care	Out-Of-Network Care
Virtual Primary Physician <i>(If Available) Powered by MedLion Clinic</i>	Covered in full	Not covered
Virtual Urgent Care <i>Powered by MeMD</i>	Covered in full	Not applicable
Office Visits to Non-Specialist	Not covered	Not applicable
<i>Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.</i>		
Specialist Office Visits	Not covered	Not applicable
Prenatal Maternity <i>(Office Visit)</i>	Not covered	Not applicable
Maternity - Delivery and Post-Partum Care	Not covered	Not applicable
Preventive Care	Network Care	Out-Of-Network Care
<i>Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.</i>		
Routine Adult Physical Exams and Immunizations <i>Includes routine tests and related lab fees. Limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Well Child Exams and Immunizations <i>Limited to 1 exam every 12 months. Immunizations will be subject to age and developmentally appropriate frequency limitations determined by ACIP.</i>	Covered in full	Not applicable
Routine Gynecological Exams <i>Includes routine tests and related lab fees. Limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Routine Mammograms <i>For covered females age 40 and over. Limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Women's Health <i>Includes: Screening for gestational diabetes, HPV, counseling for sexually transmitted infections, counseling and screening for HIV, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, patient education and counseling. Limitations may apply.</i>	Covered in full	Not applicable
Routine Digital Rectal Exam / Prostate-Specific Antigen Test <i>For covered males age 18 and over. Limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Colorectal Cancer Screening <i>For all members age 50 and over. Limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Routine Eye Exams (Refraction) <i>For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.</i>	Covered in full	Not applicable
Voluntary Sterilization - Tubal Ligation <i>Covered as a preventive care service in accordance with Health Care Reform.</i>	Covered in full	Not applicable

Diagnostic Procedures	Network Care	Out-Of-Network Care
Outpatient Diagnostic Laboratory	Not covered	Not applicable
Outpatient Diagnostic X-ray <i>(except for complex imaging services)</i>	Not covered	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services <i>(Including, but not limited to, MRI, MRA, PET, and CT Scans)</i>	Not covered	Not applicable
Emergency Medical Care	Network Care	Out-Of-Network Care
Urgent Care Provider	Not covered	Not applicable
Emergency Room	Not covered	Not applicable
Emergency Ambulance	Not covered	Not applicable
Non-Emergency Ambulance	Not covered	Not applicable
Other Services and Plan Details	Network Care	Out-Of-Network Care
Hospital Care	Not covered	Not applicable
Mental Health and Alcohol/Drug Abuse Services	Not covered	Not applicable
Skilled Nursing Facility	Not covered	Not applicable
Therapy and Rehabilitation Services	Not covered	Not applicable
Durable Medical Equipment	Not covered	Not applicable
Mouth, Jaws, and Teeth <i>Oral surgery procedures, medical in nature</i>	Not covered	Not applicable
Family Planning	Not covered	Not applicable
Pharmacy – Prescription Drug and Discount Benefits <i>Powered by RxValet</i>	Network Care	Discount Option
Retail <i>(Up to a 30-day supply)</i>		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
Specialty Drugs <i>(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs, excludes insulin</i>	Not covered	Available through RxValet
Mail Order Delivery <i>(for your refills for up to a 31-90 day supply)</i>		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet

While this information is believed to be accurate as of the print date, it is subject to change. To receive full and up to date policy descriptions, please visit my.breckpoint.com to log into our member portal.

Pharmacy Plan includes:

Contraceptive drugs and devices obtainable from a pharmacy. Formulary generic FDA-approved women's contraceptives covered 100% in network. Not all drugs are covered.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies;

reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. This material does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them.

COMPLIANCE MINIMUM VALUE PLAN (MVP)

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓	
Minimum Value	✓	
Network	Medicare Plus	
Out of Network Coverage	No	
Individual Deductible/Max Out-of-Pocket	\$7,600/\$7,600	
Family Deductible/Max Out-of-Pocket	\$15,200/\$15,200	
Preventive & Wellness <i>Covered with no out-of-pocket expenses.</i>	---	
Primary Care Visit	100% of MAC* After Deductible *Subject to the maximum charge allowed ("MAC" or "Allowable Amount")	
Specialist Visit		
Urgent Care Visit		
Maternity Pre/Post Natal <i>(Office Visit)</i>		
Mental/Behavioral Health <i>(Office Visit)</i>		
X-Rays & Labs		
Emergency Room		
Emergency Transport		
Inpatient Services		
Outpatient Services		
Hospital Admission		
Rx Discount <i>(Prescription)</i>		
Rideshare Transport		Not Included
Virtual Urgent Care (MeMD)		Unlimited

PLAN FEATURES

-  **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings**
-  **This plan has an Open Network. Choose your own provider without the limitations of Network restrictions.**
-  **No waiting periods**
-  **No copays with 24/7 Virtual Urgent Care**
(Powered by MeMD, see insert for more information)
-  **Prescription Discount Plan Included** *(Powered by Shield PBM)*
-  **Provides major medical coverage. Please contact our Member Service Department for additional details**

Please see plan specification document for more details.

	Employee Only	Each Additional Child	Employee + Spouse	Employee + Family
PRICING	\$498*	\$498*	Not Offered	Not Offered

*rate is subject to underwriting

COMPLIANCE MINIMUM VALUE PLAN

BENEFITS SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible (per plan year)	\$7,600 Individual \$15,200 Family	Not applicable
<i>As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.</i>		
<i>Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the plan year.</i>		
Member Coinsurance (applies to all expenses unless otherwise stated)	0%	Not applicable
Out-of-Pocket (OOP) Maximum (per plan year, includes deductible)	\$7,600 Individual \$15,200 Family	Not applicable
<i>All covered expenses accumulate separately toward the network and out-of-network OOP limit.</i>		
<i>Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the OOP maximum.</i>		
<i>Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the plan year.</i>		
Payment for Out-of-Network Care	Not applicable	Not applicable
Referral Requirement	Not required	Not applicable
Physician Services	Network Care	Out-Of-Network Care
Virtual Primary Physician (if available) Powered by MedLion Clinic	Covered in full	Not covered
Virtual Urgent Care Powered by MeMD	Covered in full	Not applicable
Office Visits to Non-Specialist	100% of MAC after deductible*	Not applicable
<i>*Subject to the maximum charge allowed ("MAC" or "Allowable Amount"). See below and the Plan Documents for additional information regarding allowable amount and potential balance billing where the employee will be responsible for any amount charged over allowable amount.</i>		
<i>Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.</i>		
Specialist Office Visits	100% of MAC after deductible*	Not applicable
Prenatal Maternity (office visit)	100% of MAC after deductible*	Not applicable
Maternity - Delivery and Post-Partum Care	100% of MAC after deductible*	Not applicable
Preventive Care	Network Care	Out-Of-Network Care
<i>Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.</i>		
Routine Adult Physical Exams and Immunizations Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	Not applicable
Well Child Exams and Immunizations Limited to 1 exam every 12 months. Immunizations will be subject to age and developmentally appropriate frequency limitations determined by ACIP.	Covered in full	Not applicable
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Covered in full	Not applicable
Routine Mammograms For covered females age 40 and over. Limited to 1 exam every 12 months.	Covered in full	Not applicable
Women's Health Includes: Screening for gestational diabetes, HPV, counseling for sexually transmitted infections, counseling and screening for HIV, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, patient education and counseling. Limitations may apply.	Covered in full	Not applicable
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 18 and over. Limited to 1 exam every 12 months.	Covered in full	Not applicable
Colorectal Cancer Screening For all members age 50 and over. Limited to 1 exam every 12 months.	Covered in full	Not applicable
Routine Eye Exams (Refraction) For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Covered in full	Not applicable
Voluntary Sterilization - Tubal Ligation Covered as a Preventive Care service in accordance with Health Care Reform.	Covered in full	Not applicable

Diagnostic Procedures	Network Care	Out-Of-Network Care
Outpatient Diagnostic Laboratory	100% of MAC after deductible*	Not applicable
Outpatient Diagnostic X-ray <i>(except for complex imaging services)</i>	100% of MAC after deductible*	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services <i>(Including, but not limited to, MRI, MRA, PET, and CT Scans)</i>	100% of MAC after deductible*	Not applicable
Emergency Medical Care	Network Care	Out-Of-Network Care
Urgent Care Provider	100% of MAC after deductible*	Not applicable
Emergency Room	100% of MAC after deductible*	\$250 co-payment <i>(limited to Medical Emergency requiring immediate care)</i>
Emergency Ambulance	100% of MAC after deductible*	Not applicable
Non-Emergency Ambulance	Not covered	Not applicable
Other Services and Plan Details	Network Care	Out-Of-Network Care
Hospital Care	100% of MAC after deductible*	Not applicable
Mental Health and Alcohol/Drug Abuse Services <i>(other than office visit)</i>	100% of MAC after deductible*	Not applicable
Skilled Nursing Facility <i>Coverage is limited to 120 days per plan year.</i>	100% of MAC after deductible*	Not applicable
Therapy and Rehabilitation Services	100% of MAC after deductible*	Not applicable
Durable Medical Equipment	100% of MAC after deductible*	Not applicable
Mouth, Jaws, and Teeth <i>Oral surgery procedures, medical in nature.</i>	100% of MAC after deductible*	Not applicable
Family Planning <i>Covered only for the diagnosis and treatment of the underlying medical condition.</i>	100% of MAC after deductible*	Not applicable
Pharmacy – Prescription Drug and Discount Benefits <i>Powered by Shield PBM</i>	Network Care	Discount Option
Retail <i>(Up to a 30-day supply)</i>		
Generic Drugs	100% of MAC after deductible*	Available - Shield PBM
Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Non-Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Specialty Drugs <i>(Up to a 30-day supply)</i> <i>Includes self-injectable, infused and oral specialty drugs, excludes insulin</i>	100% of MAC after deductible*	Available - Shield PBM
Mail Order Delivery <i>(for your refills for up to a 31-90 day supply)</i>		
Generic Drugs	100% of MAC after deductible*	Available - Shield PBM
Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Non-Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM

While this information is believed to be accurate as of the print date, it is subject to change. To receive full and up to date policy descriptions, please visit my.breckpoint.com to log into our Member Portal.

***MAC or Allowable Amount:**

MAC or Allowable Amount is used interchangeably to refer to the maximum charge allowed for all provider services. Please keep in mind that providers are not required to accept the Plan's Allowable Amount as payment in full and may balance bill you for the difference between the Plan's Allowable Amount and the provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or excluded under the Plan, as well as any applicable deductibles, coinsurance, and/or copayment amounts.

Pharmacy Plan includes:

Contraceptive drugs and devices obtainable from a pharmacy. Formulary generic FDA-approved women's contraceptives covered 100% in network. Not all drugs are covered.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids;

immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. This material does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them.



VIRTUAL URGENT CARE

Powered by MeMD

You and your family will have access to MeMD – your new telehealth service. Telehealth allows you to reach a medical provider by phone, app or webcam when access to your regular doctor is not available, at **no cost to you**. This may be used for many of the issues provided by urgent care facilities.

Our medical team includes MDs, DOs, NPs & PAs (US-licensed, board-certified medical providers) who average over 16 years of experience. They can give you a personalized treatment plan and send prescriptions right to your pharmacy.

The program will be available to you, your spouse or domestic partner, and children up to the age of 26. Available 24 / 7/ 365. A webcam may be required in certain states.

HOW IT WORKS

Once online you will be asked to register and log on. After you've created your account it's simple to request a real-time video, app or phone consultation with one of MeMD's providers. Your provider will review your medical history and perform a video exam or phone consultation within minutes. You will then receive a medical record and care instructions electronically, with any necessary prescriptions sent to your local pharmacy. The entire telehealth visit is completed on average within 30 minutes or less.

HOW TO ENROLL:



Access your MeMD account by downloading the app and entering your plan code when prompted

Visit: www.MeMD.me/app-store

Plan Code: MQ967N4T

OR by visiting your MeMD website:

www.MeMD.me/group/breckpoint
(use Google Chrome for best browsing experience).



Request an exam

For non-emergency health issues, you can request an exam using your phone, tablet, or computer.



Speak with a provider and get treatment

Your MeMD provider will review your chart, ask questions, and recommend a treatment plan.



PRESCRIPTION SAVINGS PROGRAM

Powered by RxValet

RxValet is committed to ensuring that no one goes without the medications they need because of high-cost prescriptions. We offer prescription medications and diabetic testing supplies at affordable prices, as well as provide helpful tools members can use to stay healthy. No discount cards needed. Members can easily search for medications using our app or our website, MyRxValet.com, and choose how they want to save. RxValet can help employers reduce healthcare plan premiums by providing an alternative, low-cost pharmacy solution.

VALUE, CHOICE, & SAVINGS WITH RxValet

- Deeply discounted prices, competitive comparisons
- 60,000 retail pharmacies and FREE standard shipping with home delivery
- Mobile application for easy on-the-go use
- FREE medication reminders to help members stay healthy
- Employer group member code for additional discounts

WHY DO I HAVE TO PAY ONLINE OR PAY USING THE RXValeT APP FIRST?

We know this is a new concept, but once you try it, you will love it. Our prices are pre-negotiated through our partner. When you purchase through RxValet, we create an electronic RxValet benefit card to use at any pharmacy. You will owe nothing and have no co-pay. Our prices are guaranteed. Think of RxValet as a pay-as-you-go benefit card. In a traditional prescription benefit plan you pay co-pays and a monthly premium. With RxValet, there is no premium. You only pay for the medications your family needs, as you need them.

HOW TO ENROLL:

DOWNLOAD THE RXValeT MOBILE APP

- 1 Search for your medications
- 2 Pay with a credit card
- 3 Print, text, or email Your RxValet prescription card then take to your pharmacy as proof-of-purchase.

SAVE WITH HOME DELIVERY!

- 1 Have your doctor e-scribe directly to Advanced Pharmacy, Greenville, SC. e-scribe#: 4229971 or fax 888-870-3823

RXValeT for PET MEDS

- 1 **SEARCH.** Search from our huge medication database by visiting us online at MyRxValetForPets.com to find your pet's medication.
- 2 **SELECT.** Enter the correct dosage and quantity, and you will instantly get the cost of that medication.
- 3 **SAVE.** Save up to 50% or more when prepaying online. Just show your RxValet for Pets card as proof-of-purchase.



breckpoint

LEAD TOGETHER

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leadtogether@breckpoint.com | 800.592.0047 | www.breckpoint.com

ENROLLMENT FORM



breckpoint

LEAD TOGETHER

A. REQUIRED EMPLOYEE INFORMATION Complete the Enrollment Form and return to your Human Resources Department.

Name:		Phone:	
Social Security #:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		Apt. #:	
City:	State:	Zip:	

B. BENEFIT PLAN SELECTION Payroll Deducted Rates - Please select the tier for each product in which you wish to enroll.

MEC	COST	COMPLIANCE MVP	Please call 1.844.300.6497 to enroll.
<input type="checkbox"/> Employee Only	\$46.00		
<input type="checkbox"/> Employee + Child(ren)	\$82.80		
<input type="checkbox"/> Employee + Spouse	\$101.20		
<input type="checkbox"/> Employee + Family	\$138.00		

C. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner

D. REQUIRED SIGNATURE You **MUST** sign and date to be enrolled in coverage

Election of Coverage: I have read and understand the coverage options I have elected. I understand completion of this enrollment form in no way implies I will be accepted for coverage. I understand coverage will take effect only if this enrollment form is approved by the plan sponsor and the plan has been properly funded, provided I meet any eligibility or coverage effective date requirements listed in the plan documents.

Accept coverage options as selected

Date:	Signature:
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Any changes made to the Enrollment Form will require the changes to be dated and initialed by employee.

ACKNOWLEDGEMENT & WAIVER FORM



E. REQUIRED SIGNATURE You **MUST** sign and date if you wish to decline coverage.

Waiver of Coverage: I, the undersigned employee, understand and acknowledge that: I have been offered an opportunity by my Employer to enroll in affordable employer-sponsored health coverage that meets the minimum value standard set forth in the Patient Protection and Affordable Care Act (ACA) for the applicable period:

- I will not qualify for government credits and subsidies to purchase individual health insurance on a state or federal marketplace or exchange
- I may not cover dependents under the Employer's plan, and
- I may not be able to enroll in the Employer's plan until the next open enrollment, except in a qualified change in status or other limited circumstances.

Decline all coverage options

Date:

Signature: