breckpoint®

LEAD TOGETHER

ENROLLMENT GUIDE

Employer Name: Health Management, Inc.

Group ID #: C000318

Plan Coverage Dates: 1/1/2021 - 12/31/2021

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 GO ONLINE

Visit: www.my.breckpoint.com. Click Register and set up your account using your group ID number, social security number, and date of birth. Review your options & choose your coverage.

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)*
- **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)*
- **Fall Prevention Intervention** *(Adults over 65 at a higher risk)*
- **Healthy Diet Counseling**
- **Hepatitis B Screening**
- **Hepatitis C Screening**
- **HIV Pre-Exposure Medication**
- **HIV 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**
- **Unhealthy Alcohol Misuse Screening and Counseling**
- **Vitamin D Supplementation**

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**
- **Gestational Diabetes Screening** *(Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)*
- **Gonorrhea Screening**
- **Hepatitis B Screening**
- **HIV Screening**
- **Immunization Vaccines**
- **Osteoporosis Screening** *(Woman 65 year and older)*
- **Perinatal Depression Screening**
- **Preeclampsia Screening & Preventative Medication**
- **Rh Incompatibility Screening**
- **Syphilis screening**
- **Tobacco Use Counseling**
- **Vitamin D Supplementation**

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**
- **Prevention Skin Cancer Behavioral Counseling**
- **Sexually Transmitted Infections**
- **Tobacco Use Interventions**
- **Visual Acuity Screening** *(Children ages 3 to 5 years)*

ACA COVERED MEDICATIONS

95 common medications included at no cost! Medications such as:

- **Aspirin**
- **Bowel Preparation**
- **Brest Cancer Prevention**
- **Contraceptives**
- **Fluoride Supplements**
- **Folic Acid**
- **Statins**
- **Tobacco Cessation**
- **Vitamin Supplements**
- ***See the full list at breckpointRX.com!***

MINIMUM ESSENTIAL COVERAGE (MEC) PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	Medicare Plus
Out of Network Coverage	N/A
Individual Medical Deductible/Out-of-Pocket Limit	$0/None
Family Medical Deductible/Out-of-Pocket Limit	$0/None
Individual/Family Pharmacy Out-of-Pocket Limit	$7,500/$15,000
Preventive & Wellness *Covered with no out-of-pocket expenses.*	100%
Physician and Office Utilizations *May be subject to a maximum combined number of utilizations per year. No coverage after utilization limit exhausted.*	- - -
Primary Care Visit	Not Included
Specialist Visit	Not Included
Urgent Care Visit	Not Included
Maternity Pre/Post Natal *(office visit)*	Not Included
Mental/Behavioral Health *(office visit)*	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
Rideshare Transport *Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.*	Not Included
Enhanced Rx Program *(Powered by Shield PBM)*	$5-$200 co-pay
Virtual Urgent Care *(Powered by MeMD)*	Unlimited
NEW! Teledentistry *(Powered by Teledentistry.com)*	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.**
- **Enhanced Rx Program included with co-pays starting at $5.** *(Powered by Shield PBM, see insert)*
- **Unlimited 24/7 Virtual Urgent Care.** *(Powered by MeMD, see insert)*
- **NEW! Teledentistry helps patients seek the correct treatment.** *(Powered by Teledentistry.com, see insert)*

Please see plan specification document for more details.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	**$49.00**	**$80.00**	**$82.00**	**$113.00**

MEC PLAN BENEFITS SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible *(per plan year)*	$0 Individual $0 Family	Not applicable
Member Coinsurance *(applies to all expenses unless otherwise stated)*	0%	Not applicable
Medical Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	Not applicable	Not applicable
Pharmacy Out-of-Pocket (OOP) Maximum	$7,000 Individual $15,000 Family	Not applicable
All covered expenses accumulate separately toward the network and out-of-network OOP limit.		
Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and co-pays may be used to satisfy the OOP maximum.		
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.		
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 Urgent Care *Powered by MeMD*	Covered in full	Not covered
Office Visits to Non-Specialist	Not covered	Not applicable
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits	Not covered	Not applicable
Prenatal Maternity and Post-Partum Care *(Office Visit)*	Not covered	Not applicable
Maternity - Delivery	Not covered	Not applicable
Preventive Care	**Network Care**	**Out-Of-Network Care**
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
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	Not covered	Not applicable
Outpatient Diagnostic X-ray *(except for complex imaging services)*	Not covered	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services *(Including, but not limited to, MRI, MRA, PET, and CT Scans)*	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 *Oral surgery procedures, medical in nature*	Not covered	Not applicable
Family Planning	Not covered	Not applicable
Pharmacy – Prescription Drug and Discount Benefits *Powered by Shield PBM*	**Access & Discounts Available**	
Retail *(Up to a 30-day supply)*		
Generic Drugs	Co-pay starting at $10	
Preferred Brand Drugs	Co-pay starting at $50	
Non-Preferred Brand Drugs	Co-pay starting at $100	
Specialty Drugs *(Up to a 30-day supply)* *Includes self-injectable, infused and oral specialty drugs, excludes insulin*	International & prescription assistance options - call customer care for additional information	
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	Co-pay starting at $10	
Preferred Brand Drugs	Co-pay starting at $50	
Non-Preferred Brand Drugs	Co-pay starting at $100	

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****__Utilization__ *is the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis. Examples of Utilization are the number of office visits a person makes per year, the number of prescription drugs taken, or the number of testing a person receives by a provider.*

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.

PREFERRED PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	First Health
Out of Network Coverage	No
Individual Medical Deductible/Out-of-Pocket Limit	$0/$725
Family Medical Deductible/Out-of-Pocket Limit	$0/$1,450
Individual/Family Pharmacy Out-of-Pocket Limit	$7,500/$15,000
Preventive & Wellness *Covered with no out-of-pocket expenses.*	100%
Physician and Office Utilizations *May be subject to a maximum combined number of utilizations per year. No coverage after utilization limit exhausted.*	**10 utilizations per year (UPY)**
Primary Care Visit	$25 co-pay
Specialist Visit	$35 co-pay
Urgent Care Visit	$50 co-pay
Maternity Pre/Post Natal *(office visit)*	$25 co-pay
Mental/Behavioral Health *(office visit)*	$25 co-pay
X-Rays & Lab	$75 co-pay, 2 UPY
Imaging	$75 co-pay, 1 UPY
Emergency Room	Not Included
Emergency Transport	Not Included
Outpatient/In-Patient Services Hospital Admission	Not Included
Rideshare Transport *Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.*	$150 max/year
Enhanced Rx Program *(Powered by Shield PBM)*	$5-$200 co-pay
Virtual Urgent Care *(Powered by MeMD)*	Unlimited
NEW! Teledentistry *(Powered by Teledentistry.com)*	Unlimited

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings.**
- **National Network included with more than 695,000 in-network doctors. Visit www.firsthealthlbp.com to locate a Provider.**
- **Affordable doctor visits & Urgent Care co-pays.**
- **Added coverage for x-rays & lab services.**
- **Enhanced Rx Program Included with co-pays starting at $5.** *(Powered by Shield PBM, see insert)*
- **Unlimited 24/7 Virtual Urgent Care.** *(Powered by MeMD, see insert)*
- **NEW! Teledentistry helps patients seek correct treatment.** *(Powered by Teledentistry.com, see insert)*
- **Need a ride to the doc? Rideshare benefit included!**

Please see plan specification document for more details.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	**$84.00**	**$136.50**	**$150.50**	**$203.00**

PREFERRED PLAN BENEFITS SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible *(per plan year)*	$0 Individual $0 Family	Not applicable
Member Coinsurance *(applies to all expenses unless otherwise stated)*	0%	Not applicable
Medical Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	$725 Individual $1,450 Family	Not applicable
Pharmacy Out-of-Pocket (OOP) Maximum	$7,000 Individual $15,000 Family	Not applicable
All covered expenses accumulate separately toward the network and out-of-network OOP limit.		
Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and co-pays may be used to satisfy the OOP maximum.		
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.		
Payment for Out-of-Network Care	Not applicable	Not covered
Referral Requirement	Not required	Not applicable
Physician Services	**Network Care**	**Out-Of-Network Care**
Virtual Urgent Care *Powered by MeMD*	Covered in full	Not covered
Office Visits to Non-Specialist *Limit of 10 utilizations** combined with non-specialists, specialists, and urgent care.*	$25 co-payment	Not covered
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits *Limit of 10 utilizations combined with non-specialists, specialists, and urgent care*	$35 co-payment	Not covered
Prenatal Maternity and Post-Partum Care *(office visit)*	$25 co-payment	Not covered
Mental Health & Alcohol/Drug Abuse Services *(office visit)*	$25 co-pyament	Not covered
Maternity - Delivery	Not covered	Not covered
Preventive Care	**Network Care**	**Out-Of-Network Care**
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
Routine Adult Physical Exams and Immunizations *Includes routine tests and related lab fees. Limited to 1 exam every 12 months.*	Covered in full	Not covered
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 covered
Routine Gynecological Exams *Includes routine tests and related lab fees. Limited to 1 exam every 12 months.*	Covered in full	Not covered
Routine Mammograms *For covered females age 40 and over. Limited to 1 exam every 12 months.*	Covered in full	Not covered
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 covered
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 covered
Colorectal Cancer Screening *For all members age 50 and over. Limited to 1 exam every 12 months.*	Covered in full	Not covered
Routine Eye Exams (Refraction) *For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.*	Covered in full	Not covered
Voluntary Sterilization - Tubal Ligation *Covered as a preventive care service in accordance with Health Care Reform.*	Covered in full	Not covered

Diagnostic Procedures	Network Care	Out-Of-Network Care
Outpatient Diagnostic Laboratory *Limit 2 utilizations per member per year combined with laboratory and x-ray.*	$75 co-payment	Not covered
Outpatient Diagnostic X-ray *Limit 2 utilizations per member per year combined with laboratory and x-ray. (except for complex imaging services)*	$75 co-payment	Not covered
Outpatient Diagnostic X-ray for Complex Imaging Services *Limit 1 utilization per member per year. (Including, but not limited to, MRI, MRA, PET, and CT Scans)*	$75 co-payment	Not covered
Emergency Medical Care	**Network Care**	**Out-Of-Network Care**
Urgent Care Provider *Limit of 10 utilizations combined with non-specialists, specialists, and urgent care.*	$50 co-payment	Not covered
Emergency Room	Not covered	Not covered
Emergency Ambulance	Not covered	Not covered
Non-Emergency Ambulance	Not covered	Not covered
Other Services and Plan Details	**Network Care**	**Out-Of-Network Care**
Hospital Care	Not covered	Not covered
Mental Health and Alcohol/Drug Abuse Services *(other than office visit)*	Not covered	Not covered
Skilled Nursing Facility	Not covered	Not covered
Therapy and Rehabilitation Services	Not covered	Not covered
Durable Medical Equipment	Not covered	Not covered
Mouth, Jaws, and Teeth *Oral surgery procedures, medical in nature*	Not covered	Not covered
Family Planning	Not covered	Not covered
Pharmacy – Prescription Drug and Discount Benefits *Powered by Shield PBM*	**Access & Discounts Available**	
Retail *(Up to a 30-day supply)*		
Generic Drugs	Co-pay starting at $10	
Preferred Brand Drugs	Co-pay starting at $50	
Non-Preferred Brand Drugs	Co-pay starting at $100	
Specialty Drugs *(Up to a 30-day supply)* *Includes self-injectable, infused and oral specialty drugs, excludes insulin*	International & prescription assistance options - call customer care for additional information	
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	Co-pay starting at $10	
Preferred Brand Drugs	Co-pay starting at $50	
Non-Preferred Brand Drugs	Co-pay starting at $100	

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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.

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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 Medical Deductible/Max Out-of-Pocket	$7,600/$7,600
Family Medical Deductible/Max Out-of-Pocket	$15,200/$15,200
Preventive & Wellness *Covered with no out-of-pocket expenses.*	100%
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 *(Office Visit)*	
Mental/Behavioral Health *(Office Visit)*	
X-Rays & Labs	
Emergency Room	
Emergency Transport	
Inpatient Services	
Outpatient Services	
Hospital Admission	
Rx Prescription Discount *(Powered by Shield PBM)*	
Rideshare Transport	Not Included
Rx Benefits *(Powered by Shield PBM)*	Included
Virtual Urgent Care *(Powered by 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 co-pays with 24/7 Virtual Urgent Care.** *(Powered by MeMD, see insert for more information)*
- **Rx Benefits 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	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	$498*	$896.40*	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
As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible.		
Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the plan year.		
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
All covered expenses accumulate separately toward the network and out-of-network OOP limit.		
Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and co-pays may be used to satisfy the OOP maximum.		
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.		
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 Urgent Care *Powered by MeMD*	Covered in Full	Not applicable
Office Visits to Non-Specialist	100% of MAC after deductible*	Not applicable
**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.*		
Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury.		
Specialist Office Visits	100% of MAC after deductible*	Not applicable
Prenatal Maternity and Post-Partum Care *(office visit)*	100% of MAC after deductible*	Not applicable
Maternity - Delivery	100% of MAC after deductible*	Not applicable
Preventive Care	**Network Care**	**Out-Of-Network Care**
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
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 *(except for complex imaging services)*	100% of MAC after deductible*	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services *(Including, but not limited to, MRI, MRA, PET, and CT Scans)*	100% of MAC after deductible*	Not applicable
Emergency Medical Care	**Network Care**	**Out-Of-Network Care**
Urgent Care Provider	100% of MAC after deductible*	100% of MAC after deductible*
Emergency Room	100% of MAC after deductible*	Not applicable
Emergency Ambulance	100% of MAC after deductible*	Not applicable
Non-Emergency Ambulance	Not applicable	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 *(other than office visit)*	100% of MAC after deductible*	Not applicable
Skilled Nursing Facility *Coverage is limited to 120 days per plan year.*	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 *Oral surgery procedures, medical in nature.*	100% of MAC after deductible*	Not applicable
Family Planning *Covered only for the diagnosis and treatment of the underlying medical condition.*	100% of MAC after deductible*	Not applicable
Pharmacy – Prescription Drug and Discount Benefits *Powered by Shield PBM*	**Network Care**	**Out-Of-Network Care**
Retail *(Up to a 30-day supply)*		
Generic Drugs	100% of MAC after deductible*	Not Covered
Preferred Brand Drugs	100% of MAC after deductible*	Not Covered
Non-Preferred Brand Drugs	100% of MAC after deductible*	Not Covered
Specialty Drugs *(Up to a 30-day supply)* *Includes self-injectable, infused and oral specialty drugs, excludes insulin*	100% of MAC after deductible*	Not Covered
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	100% of MAC after deductible*	Not Covered
Preferred Brand Drugs	100% of MAC after deductible*	Not Covered
Non-Preferred Brand Drugs	100% of MAC after deductible*	Not Covered
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 co-payment 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.

DENTAL + VISION

Dental+Vision is a direct reimbursement combination plan that pays for dental and vision expenses. With no waiting period, the tiered reimbursement structure begins at the first dollar and allows you to maximize your potential benefits. Choose to go to any dentist or vision specialist and receive any medically necessary procedure.

EXAMPLES OF COVERED BENEFITS

- TEETH CLEANING
- ROOT CANAL
- FILLINGS
- DENTAL X-RAYS
- ANNUAL EYE EXAM
- FRAMES
- LENSES
- CONTACT LENSES

BENEFIT INFORMATION	
Network	Not applicable
Max Benefit Reimbursement	$1,000
Waiting Period	No waiting period
PROCEDURE COST	**REIMBURSEMENT**
UP TO $150	**100%**
$151 - $250	**75%**
$251 - $1,800	**50%**
$1,801 - up	**0%**

Benefits for Dental and Vision are combined.
*Benefit is based on an aggregate total of accumulated expenses per Covered Person during the calendar year.

Dental Benefits	Plan Pays
Dental Class I - Preventive & Diagnostic Care • Oral Exams • Routine Cleanings • Full Mouth X-rays • Bitewing X-Ray • Panoramic X-ray • Fluoride Application • Sealants • Histopathologic Exams	At Current Reimbursement Level
Dental Class II - Basic Restorative Care • Fillings • Periapical X-rays • Anesthetics • Space Maintainers • Emergency Care to Relieve Pain • Root Canal Therapy/Endodontics • Periodontal Scaling and Root Planing • Oral Surgery – Simple Extractions • Oral Surgery – all except simple Extractions • Surgical Extractions of Impacted Teeth	At Current Reimbursement Level
Dental Class III - Major Restorative Care • Crowns • Dentures • Bridges • Inlays/Onlays • Prosthesis Over Implant • Repairs to Bridges, Crowns and Inlays • Denture Adjustments and Repairs	At Current Reimbursement Level
Vision Benefits	**Plan Pays**
• Routine Examination Services • Lenses – including, single, bifocal or trifocal • Contact Lens • Frames	At Current Reimbursement Level

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	$30.00	$49.20	$54.80	$74.00

DENTAL + VISION PLAN BENEFIT LIMITATIONS

Dental Procedure	Limitations	Dental Procedure	Limitations
Exams	Two per calendar year	**Prophylaxi** *(Cleanings)*	Two per calendar year
Fluoride	1 per calendar year for people under 20	**Sealants**	One treatment per tooth every three years up to age 14
x-Rays (routine)	Bitewings: 2 per calendar year	**X-Rays** *(non-routine)*	Full mouth: 1 every 36 consecutive months., Panorex: 1 every 36 consecutive months
Crowns and Inlays	Replacement every 5 years	**Bridges**	Replacement every 5 years
Dentures and Partials	Replacement every 5 years	**Surgeries** *(ALL)*	Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
Relines, Rebases	Covered if more than 6 months after installation	**Adjustments**	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once	**Repairs - Dentures**	Reviewed if more than once
Prosthesis Over Implant	1 per 60 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non- precious metals. No porcelain or white/tooth colored material on molar crowns or bridges	**Missing Tooth Limitation**	Teeth missing prior to coverage under the Dental Plan are not covered. Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
Space Maintainers	Limited to non-orthodontic treatment		
Vision Procedure	**Limitations**	**Vision Procedure**	**Limitations**
Complete Eye Exam	One per calendar year	**Frames**	One frame every two calendar Years.
Frame-type Lenses	One per calendar year	**Contact Lens**	One per calendar year

Dental + Vision Benefit Exclusions:

- Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.
- In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

Dental Specific Benefit Exclusions:

- Services performed primarily for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to accepted dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);

Vision Specific Benefit Exclusions:

- Artificial eyes, if medically necessary, are covered under the Medical Plan.
- Charges for orthoptics (eye muscle exercises) vision training or surgical treatment of the eye.
- Charges for Radial keratotomy or other eye surgery for improvement of visual acuity or refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting.

This benefit summary highlights some of the benefits available under Plan Document and Summary Plan Description.

INCLUDED BENEFIT!

VIRTUAL URGENT CARE

Powered by MeMD

Sickness doesn't sleep. Get the care you need, when you need it, at no cost to you! With on-demand exams from MeMD, you, your spouse, and children can be treated 24/7 for routine health issues like:

- Cold, flu, sore throats, sinus infections
- Allergies, itchy eyes, pink eye
- Nausea, vomiting, diarrhea
- UTIs, abdominal pain
- Skin infections, rashes
- Travel medications
- Short-term prescription refills
- General advice and consultation

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.

GET MEDICAL CARE DAY OR NIGHT:

STEP 1

SIGN IN TO MEMD

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

Visit: www.MeMD.me/app-store Plan Code: MQ967N4T

OR by visiting your MeMD website: **www.MeMD.me/group/breckpoint**

STEP 2

REQUEST AN EXAM

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

STEP 3

SPEAK WITH A PROVIDER AND GET TREATMENT

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

855-636-3669 | helpdesk@memd.me

INCLUDED BENEFIT!

ENHANCED RX PROGRAM

Powered by SHIELD PBM

THE EASIEST WAY TO SAVE ON YOUR MEDICATIONS

You won't have to worry about the expensive cost of 95 common medications. That's because a No-cost MEC (Minimal Essential Coverage) Medication Program includes 95 ACA (Affordable Care Act) drugs at no-cost, plus great discounts on all other medications. Consider us your pharmacy savings advocate. Our live Customer Care team is here to help you find the lowest price on medications available.

Go to BreckpointRx.com, enter your **MEMBER ID** and **GROUP ID** to Register.

OUR PROGRAM COVERS:

- Amoxicillin
- Azithromycin (Z-Pak)
- Ciprofloxacin
- Hydrocortisone
- Meclizine
- Naproxen
- Prednisone
- Tessalon
- And more!

DRUGS LIKE:

- Atorvastatin
- Bupropion
- Cholecalciferol
- Junel
- Lovastatin
- Nonoxynol
- Tamoxifen
- Viorele
- and Much More!

3 WAYS TO SAVE

1. **RX CARD** - Present your printed or electronic membership card at any retail pharmacy (over 67,000 in network) and if on the formulary – pay nothing. If it is not on the $0.00 formulary, your out-of-pocket cost is based on a deeply discounted price.
2. **PAY BEFORE YOU GO** - save up to 25% more BEFORE going to the pharmacy by pre-paying for your medications and take advantage of a broader online network.
3. **MAIL ORDER** – secure home delivery options online with up to a 50% savings and enjoy auto-refill feature for your recurring prescriptions and maintenance medications.

855.798.2538 | info@BreckpointRx.com

INCLUDED BENEFIT!

TELEDENTISTRY

Powered by TELEDENTISTRY Your Dentist, Anytime Anywhere®

YOUR DENTIST, ANYTIME, ANYWHERE

Emergency Room visits often provide little more than painkillers and antibiotics to dental patients. This costs more than three times as much as a routine dental visit. Teledentistry modernizes the dental exam process and puts employees in touch with a dentist, anytime, anywhere. The smartphone app provides 24/7/365 access to a dentist during a dental emergency and assists employees with choosing a dentist to see for definitive care.

HOW TELEDENTISTRY.COM WORKS

STEP 1 — The employee calls Teledentistry.com using their smartphone or tablet app.

STEP 2 — The agent relays the policy holder to the 24/7 dentist network.

STEP 3 — A video consult is held with the dentist and if needed, prescriptions are ordered.

STEP 4 — The patient is referred to a local dentist for follow-up care.

725.527.7797 | support@teladentistry.com

https://teladentistry.com/portal/clinic/patientSignup.php?clinic=156

ENROLLMENT FORM

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

Name:		Phone:
Social Security #:	Date of Birth:	Sex: ☐ Male ☐ 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	PREFERRED	COST
☐ Employee Only	$49.00	☐ Employee Only	$84.00
☐ Employee + Child(ren)	$80.00	☐ Employee + Child(ren)	$136.50
☐ Employee + Spouse	$82.00	☐ Employee + Spouse	$150.50
☐ Employee + Family	$113.00	☐ Employee + Family	$203.00
COMPLIANCE MVP	Please call 1.844.300.6497 to enroll.	DENTAL + VISION	COST
		☐ Employee Only	$30.00
		☐ Employee + Child(ren)	$49.20
		☐ Employee + Spouse	$54.80
		☐ Employee + Family	$74.00

C. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ 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:

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

ACKNOWLEDGEMENT & WAIVER FORM

breckpoint®
LEAD TOGETHER

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:

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

COMPLIANCE MINIMUM VALUE PLAN

SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2021 - December 31, 2021
Coverage For: Employee/Child(ren) | **Plan Type:** Medicare Plus

What this Plan Covers & What You Pay for 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 at my.breckpoint.com or call (844) 798-4878. 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 my.breckpoint.com or call (844) 798-4878 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$7,600.00 individual participating providers $15,200.00 family participating providers	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care (adult & child)	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?	$7,600.00 individual participating providers $15,200.00 family participating providers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; amounts over allowed amount; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	No. You may seek treatment from any licensed physician/hospital/provider of medical services of your choice and the Plan will pay benefits for covered expenses based upon an Allowable Charge.	This plan treats providers the same in determining payment for all services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your deductible has been met, if a deductible applies. Maximum Allowable Charges (MAC) are used as the maximum allowable charge for all provider services. The fee schedule applies to provider billing codes (CPT's, DRG's, etc.) and will cover most charges made by providers. The reimbursement schedule is 125% of the Medicare reimbursement rate for physicians and 145% of the Medicare reimbursement rate for facilities. This means the reimbursement is set at 25% and 45% more under this plan than is paid for providing the same service to a Medicare patient. Any provider charge in excess of the MAC will not be a covered expense under the terms of this plan and will be the responsibility of the covered person. Allowable charges for covered services that do not have the Medicare equivalent pricing will be 45% of the billed charges.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge, deductible does not apply	Will be subject to age and developmentally appropriate frequency limitations determined by the U.S. Preventive Services Task Force (USPSTF), unless specifically stated this Schedule of Benefits, and can be located using the following website(s): **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**
	Primary care visit to treat an injury or illness	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Specialist visit	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Chiropractic services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Imaging (CT/PET scans, MRIs)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ShieldPBM.com**	Preventive drugs	At pharmacy & mail order: No charge, deductible does not apply	Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail through Shield PBM.
	Generic drugs	At pharmacy: No charge after deductible, balance over MAC is not eligible Mail order: No charge after deductible, balance over MAC is not eligible	Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail through Shield PBM. You are responsible for provider charges over MAC.
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs	No charge after deductible, balance over MAC is not eligible	Covers up to a 30 day supply (retail). Mail order is not covered. Call Shield PBM or visit their website for more information. You are responsible for provider charges over MAC.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Physician/surgeon fees	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need immediate medical attention	Emergency room care	For medical emergency: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Emergency medical transportation	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Urgent care	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Physician/surgeon fees	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Office visits: No charge after deductible, balance over MAC is not eligible Intermediate care: No charge after deductible, balance over MAC is not eligible Substance Abuse: Office visits: No charge after deductible, balance over MAC is not eligible Intermediate care: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Inpatient services	Mental and Behavioral Health: No charge after deductible, balance over MAC is not eligible Substance Abuse: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you are pregnant	Office Visits	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Childbirth/delivery professional services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Childbirth/delivery facility services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Rehabilitation services	Occupational Therapy OR Speech Therapy OR Physical Therapy: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Habilitation services	No charge after deductible, balance over MAC is not eligible	Services are limited to 20 visits per covered person per year. You are responsible for provider charges over MAC.
	Skilled nursing care	No charge after deductible, balance over MAC is not eligible	Limited to 120 days beginning no later than 14 days after a 3 day hospital confinement. You are responsible for provider charges over MAC.
	Durable medical equipment	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Hospice service	No charge after deductible, balance over MAC is not eligible	Terminal illness with death expectancy in 6 months or less. You are responsible for provider charges over MAC.
If your child needs dental or eye care	Children's eye exam	Not covered	Unless mandated by the Affordable Care Act.
	Children's glasses	Not covered	Unless mandated by the Affordable Care Act.
	Children's dental check-up	Not covered	Unless mandated by the Affordable Care Act.

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult & child) unless mandated by the Affordable Care Act
- Experimental treatments or procedures
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult & child) unless mandated by the Affordable Care Act
- Routine foot care
- Weight loss programs (unless plan provisions are met)

Other Covered Services:

(Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Habilitation Services limited to 20 visits per covered person per/year
- Temporomandibular Joint Dysfunction Syndrome (TMJ)

Other Ancillary Products:

- In addition to benefits under this plan, you have other service options including telehealth and other service providers. Please see your enrollment guide or HR Representative for more information.

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 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: the plan sponsor at (844) 798-4878 or the plan's Claims administrator at (844) 798-4878, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? Yes. 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.

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

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	**$7,900.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (prenatal care), Childbirth/ Delivery Professional Services, Childbirth/Delivery Facility Services, Diagnostic tests (ultrasounds and blood work), Specialist visit (anesthesia)	
Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,900**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$7,900.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (including disease education), Diagnostic tests (blood work), Prescription drugs, Durable medical equipment (glucose meter)	
Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$7,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$7,400**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$7,900.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other	**0%**
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	**$1,050**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,050
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

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

MEC PLAN

SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2021 - December 31, 2021
Coverage For: Employee/Family | **Plan Type:** Medicare Plus

What this Plan Covers & What You Pay for 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 at my.breckpoint.com or call (844) 798-4878. 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 my.breckpoint.com or call (844) 798-4878 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0.00 individual $0.00 family participating providers	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No. There are no other specific deductibles.	There is no 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 medical out-of-pocket limit for this plan?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is the prescription out-of-pocket limit for this plan?	$5,000.00 individual participating providers $10,00.00 family participating providers	The prescription out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own prescription out-of-pocket limits until the overall family prescription out-of-pocket limit has been met.
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?	No. You may seek treatment from any licensed physician/hospital/provider of medical services of your choice and the Plan will pay benefits for covered expenses based upon an Allowable Charge.	This plan treats providers the same in determining payment for all services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Maximum Allowable Charges (MAC) are used as the maximum allowable charge for all provider services. The fee schedule applies to provider billing codes (CPT's, DRG's, etc.) and will cover most charges made by providers. The reimbursement schedule is 150% of the Medicare reimbursement rate for physicians and 150% of the Medicare reimbursement rate for facilities. This means the reimbursement is set at 50% more under this plan than is paid for providing the same service to a Medicare patient.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	Covered, no additional out of pocket, deductible does not apply	Will be subject to age and developmentally appropriate frequency limitations determined by the U.S. Preventive Services Task Force (USPSTF), unless specifically stated this Schedule of Benefits, and can be located using the following website(s): **http://www.uspreventiveservicestaskforce.org/Page/Name/ uspstf-a-and-b-recommendations/**
	Primary care visit to treat an injury or illness	Not covered	None
	Specialist visit	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.BreckpointRX.com**	Preventive drugs	Covered, no additional out of pocket, deductible does not apply (for preventative drugs only)	Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail.
	Generic drugs	At pharmacy & mail order: copayment starting at $5.00	
	Preferred brand drugs	At pharmacy & mail order: copayment starting at $50.00	Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail.
	Non-preferred brand drugs	At pharmacy & mail order: copayment starting at $100.00	
	Specialty drugs	Not covered	International & prescription assistance options. Call customer care for additional information.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
If you need immediate medical attention	Emergency room care	Not covered	Not covered
	Emergency medical transportation	Not covered	Not covered
	Urgent care	Not covered	Not covered
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered
	Inpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered
If you are pregnant	Office Visits	Not covered	Unless for preventive services.
	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
	Rehabilitation services	Not covered	Not covered
	Habilitation services	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered
	Hospice service	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Unless mandated by the Affordable Care Act.
	Children's glasses	Not covered	Unless mandated by the Affordable Care Act.
	Children's dental check-up	Not covered	Unless mandated by the Affordable Care Act.

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (adult & child) unless mandated by the Affordable Care Act
- Experimental treatments or procedures
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult & child) unless mandated by the Affordable Care Act
- Routine foot care
- Temporomandibular Joint Dysfunction Syndrome (TMJ)
- Weight loss programs (unless plan provisions are met)

Other Ancillary Products:

- In addition to benefits under this plan, you have other service options including telehealth and other service providers. Please see your enrollment guide or HR Representative for more information.

Other Covered Services:

(Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Check your policy or 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 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: the plan sponsor at (844) 798-4878 or the plan's Claims administrator at (844) 798-4878, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? 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.

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

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	**$0.00**
Primary Care Provider	**$0.00**
Hospital (facility)	**$0.00**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (prenatal care), Childbirth/Delivery Professional Services, Childbirth/Delivery Facility Services, Diagnostic tests (ultrasounds and blood work), Specialist visit (anesthesia)	
Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$0.00**
Primary Care Provider	**$0.00**
Hospital (facility)	**$0.00**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (including disease education), Diagnostic tests (blood work), Prescription drugs, Durable medical equipment (glucose meter)	
Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,400
The total Joe would pay is	**$7,400**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$0.00**
Primary Care Provider	**$0.00**
Hospital (facility)	**$0.00**
Other	**0%**
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	**$1,050**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,050
The total Mia would pay is	**$1,050**

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

PREFERRED PLAN

SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2021 - December 31, 2021
Coverage For: Employee/Family | **Plan Type:** Limited Benefits

What this Plan Covers & What You Pay for 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 at my.breckpoint.com or call (844) 798-4878. 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 my.breckpoint.com or call (844) 798-4878 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0.00 individual/$0.00 family participating providers	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No. There are no other specific deductibles.	There is no 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 medical out-of-pocket limit for this plan?	$725.00 individual participating providers $1,450.00 family participating providers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is the prescription out-of-pocket limit for this plan?	$5,000.00 individual participating providers $10,00.00 family participating providers	The prescription out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own prescription out-of-pocket limits until the overall family prescription out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; amounts over allowed amount; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Refer to your I.D. card to identify the network logo. Please visit my.breckpoint.com, **click on FIND A PROVIDER and select the appropriate network logo that matches your I.D. card.** See your plan document for more information on your participating provider. You may also call (844) 798-4878 if you have any questions.	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. 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).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral. Remember, benefits are not covered if you choose a non-Participating provider specialist.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	Covered, no additional out of pocket, deductible does not apply	Not covered	Will be subject to age and developmentally appropriate frequency limitations determined by the U.S. Preventive Services Task Force (USPSTF), unless specifically stated this Schedule of Benefits, and can be located using the following website(s): **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** You are only eligible for non-participating preventive services (preventive care) if the preventive service is not provided by a participating provider.
	Primary care visit to treat an injury or illness	$25.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
	Specialist visit	$35.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
	Rideshare transport	Covered, no additional out of pocket, deductible does not apply	Not covered	Reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments up to $150.00 per covered family per year.
If you have a test	Diagnostic test (x-ray, blood work)	$75.00 copayment	Not covered	Limited to 2 utilization per covered person per year.
	Imaging (CT/PET scans, MRIs)	$75.00 copayment	Not covered	Limited to 1 utilization per covered person per year.

Common Medical Event	Services you may need	What you will pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.BreckpointRX.com**	Preventive drugs	At pharmacy & mail order: No charge, deductible does not apply	Not covered	Not subject to deductible – Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail.
	Generic drugs	At pharmacy & mail order: copayment starting at $5.00		
	Preferred brand drugs	At pharmacy & mail order: copayment starting at $50.00	Not covered	Not subject to deductible – Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail.
	Non-preferred brand drugs	At pharmacy & mail order: copayment starting at $100.00		
	Specialty Drugs	Not covered	Not covered	International & prescription assistance options. Call customer care for additional information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Not covered
	Emergency medical transportation	Not covered	Not covered	Not covered
	Urgent care	$50.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered	Not covered
	Inpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered	Not covered
If you are pregnant	Office Visits	Not covered	Not covered	Not covered
	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered	Not covered
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered	Not covered
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice service	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Unless mandated by the Affordable Care Act.
	Children's glasses	Not covered	Not covered	Unless mandated by the Affordable Care Act.
	Children's dental check-up	Not covered	Not covered	Unless mandated by the Affordable Care Act.

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (adult & child) unless mandated by the Affordable Care Act
- Experimental treatments or procedures
- Habilitation Services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult & child) unless mandated by the Affordable Care Act
- Routine foot care
- Temporomandibular Joint Dysfunction Syndrome (TMJ)
- Weight loss programs (unless plan provisions are met)

Other Covered Services:

(Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Check your policy or plan document

Other Ancillary Products:

- In addition to benefits under this plan, you have other service options including telehealth and other service providers. Please see your enrollment guide or HR Representative for more information.

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 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: the plan sponsor at (844) 798-4878 or the plan's Claims administrator at (844) 798-4878, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standard? 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.

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

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	**$0.00**
Primary Care Provider copayment	**$25.00**
Hospital (facility) coinsurance	**Not Covered**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (prenatal care), Childbirth/Delivery Professional Services, Childbirth/Delivery Facility Services, Diagnostic tests (ultrasounds and blood work), Specialist visit (anesthesia)	
Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,610
The total Peg would pay is	**$12,635**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$0.00**
Primary Care Provider copayment	**$25.00**
Hospital (facility) coinsurance	**Not Covered**
Other	**0%**
This EXAMPLE event includes services like: Primary care office visits (including disease education), Diagnostic tests (blood work), Prescription drugs, Durable medical equipment (glucose meter)	
Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,800
The total Joe would pay is	**$6,900**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$0.00**
Primary Care Provider copayment	**$25.00**
Hospital (facility) coinsurance	**Not Covered**
Other	**0%**
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	**From $1,050 to $5,600**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$25 to $75
Coinsurance	$0
What isn't covered	
Limits or exclusions	$350 to $2,050
The total Mia would pay is	**$600 to $3,325**

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