breckpoint

LEAD TOGETHER

ENROLLMENT GUIDE

Employer Name:	**Kinetic Personnel Group, Inc.**
Group ID #:	**C002625**
Plan Coverage Dates:	**01/01/2020-12/31/2020**

Disponible en Español, favor de comunicarse; 1.844.300.6497

WELCOME TO YOUR HEALTH BENEFITS

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

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

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

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

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

YOU HAVE 1 WAY YOU CAN MAKE YOUR ELECTIONS!

1

SEE YOUR HR DEPARTMENT

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

GIVE US A CALL

Call our Information Center and one of our knowledgeable representatives will help you. Available Monday through Friday 7:00 am – 5:00 pm PST at 1.844.300.6497. Representantes que hablan inglés y español están disponible.

COVERED SERVICES FOR ALL PLANS

Preventative Health Services

FOR ADULTS

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

FOR WOMEN

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

FOR CHILDREN

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

MINIMUM ESSENTIAL COVERAGE (MEC) PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	Medicare Plus
Out of Network Coverage	N/A
Individual Deductible/Out-of-Pocket Limit	$0/None
Family Deductible/Out-of-Pocket Limit	$0/None
Preventive & Wellness *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
Rx Discount *(Prescription)*	Included
Rideshare Transport *Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.*	Not Included
Virtual Urgent Care (MeMD)	Unlimited

PLAN FEATURES

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

Please see plan specification document for more details.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	$51.00	$91.80	$112.20	$153.00

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
Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	Not applicable	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 copays 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 Primary Physician *(If Available) Powered by MedLion Clinic*	Covered in full	Not covered
Virtual Urgent Care *Powered by MeMD*	Covered in full	Not applicable
Office Visits to Non-Specialist	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 *(Office Visit)*	Not covered	Not applicable
Maternity - Delivery and Post-Partum Care	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 RxValet*	**Network Care**	**Discount Option**
Retail *(Up to a 30-day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
Specialty Drugs *(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs, excludes insulin*	Not covered	Available through RxValet
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
While this information is believed to be accurate as of the print date, it is subject to change. To receive full and up to date policy descriptions, please visit my.breckpoint.com to log into our member portal.		

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

What's Not Covered
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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

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

PRO PLAN

THIS PLAN INCLUDES:	
Minimum Essential Coverage	✓
Network	First Health
Out of Network Coverage	No
Individual Deductible/Out-of-Pocket Limit	$0/$400
Family Deductible/Out-of-Pocket Limit	$0/$800
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.*	**8 utilizations per year**
Primary Care Visit	$25 co-pay
Specialist Visit	$35 co-pay
Urgent Care Visit	$50 co-pay
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
Rx Discount *(Prescription)*	Included
Rideshare Transport *Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.*	$150 max/year
Virtual Urgent Care (MeMD)	Unlimited

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings**
- **Reduce costs with more than 695,000 in-network doctors**
- **National Network included. Visit www.firsthealthlbp.com to locate a Participating Provider**
- **No waiting periods**
- **Affordable Dr. visits & Urgent Care co-pays**
- **No copays with 24/7 Virtual Urgent Care** *(Powered by MeMD, see insert for more information)*
- **Prescription Discount Plan Included** *(Powered by RxValet, see insert for more information)*
- **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	$70.00	$126.00	$154.00	$210.00

PRO 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
Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	$400 Individual $800 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 copays 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 Primary Physician *(if available) Powered by MedLion Clinic*	Covered in full	Not covered
Virtual Urgent Care *Powered by MeMD*	Covered in full	Not covered
Office Visits to Non-Specialist *Limit of 8 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 8 utilizations combined with non-specialists, specialists, and urgent care*	$35 co-payment	Not covered
Prenatal Maternity *(office visit)*	Not covered	Not covered
Maternity - Delivery and Post-Partum Care	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	Not covered	Not covered
Outpatient Diagnostic X-ray *(except for complex imaging services)*	Not covered	Not covered
Outpatient Diagnostic X-ray for Complex Imaging Services *(Including, but not limited to, MRI, MRA, PET, and CT Scans)*	Not covered	Not covered

Emergency Medical Care	Network Care	Out-Of-Network Care
Urgent Care Provider *Limit of 8 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 RxValet*	**Network Care**	**Discount Option**
Retail *(Up to a 30-day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
Specialty Drugs *(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs, excludes insulin*	Not covered	Available through RxValet
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet

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

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

What's Not Covered
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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

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

PRO+ PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	First Health
Out of Network Coverage	No
Individual Deductible/Out-of-Pocket Limit	$0/$1,050
Family Deductible/Out-of-Pocket Limit	$0/$2,100
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**
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 *(3 utilizations per year)*	$75 co-pay
Imaging *(1 utilization per year)*	$75 co-pay
Emergency Room *(1 utilization per year)*	$250 co-pay
Emergency Transport	Not Included
Outpatient/In-Patient Services Hospital Admission	Not Included
Rx Discount *(Prescription)*	Included
Rideshare Transport *Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.*	$150 max/yr
Virtual Urgent Care (MeMD)	Unlimited

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings**
- **Reduce costs with more than 695,000 in-network doctors**
- **National Network included. Visit www.firsthealthlbp.com to locate a Participating Provider**
- **No waiting periods**
- **Affordable Dr. visits & Urgent Care co-pays**
- **Added coverage for X-Rays & Lab services**
- **No copays with 24/7 Virtual Urgent Care** *(Powered by MeMD, see insert for more information)*
- **Prescription Discount Plan Included** *(Powered by RxValet, see insert for more information)*
- **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	$100.00	$180.00	$220.00	$300.00

PRO+ 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
Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	$1,050 Individual $2,100 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 copays 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 Primary Physician *(if available) Powered by MedLion Clinic*	Covered in full	Not covered
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 *(office visit) Limit of 10 utilizations combined with non-specialists, specialists and urgent care.*	$25 co-payment	Not covered
Mental Health & Alcohol/Drug Abuse Services *(office visit)*	$25 co-pyament	Not covered
Maternity - Delivery and Post-Partum Care	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 3 utilizations per member per year combined with laboratory and x-ray.*	$75 co-payment	Not covered
Outpatient Diagnostic X-ray *Limit 3 utilizations per member per year combined with laboratory and x-ray. (except for complex imaging services)*	$75 co-payment	Not covered

Diagnostic Procedures	Network Care	Out-Of-Network Care
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 *Limit 1 utilization per member per year.*	$250 co-payment	$250 copayment *(limited to Medical Emergency requiring immediate care)*
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 Service *(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 RxValet*	**Network Care**	**Discount Option**
Retail *(Up to a 30-day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
Specialty Drugs *(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs, excludes insulin*	Not covered	Available through RxValet
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	Not covered	Available through RxValet
Preferred Brand Drugs	Not covered	Available through RxValet
Non-Preferred Brand Drugs	Not covered	Available through RxValet
While this information is believed to be accurate as of the print date, it is subject to change. To receive full and up to date policy descriptions, please visit my.breckpoint.com to log into our member portal.		

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

What's Not Covered
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer. All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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

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

COMPLIANCE MINIMUM VALUE PLAN (MVP)

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Minimum Value	✓
Network	Medicare Plus
Out of Network Coverage	No
Individual Deductible/Max Out-of-Pocket	$7,600/$7,600
Family Deductible/Max Out-of-Pocket	$15,200/$15,200
Preventive & Wellness *Covered with no out-of-pocket expenses.*	- - -
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 Discount *(Prescription)*	
Rideshare Transport	Not Included
Virtual Urgent Care (MeMD)	Unlimited

PLAN FEATURES

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

Please see plan specification document for more details.

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

**rate is subject to underwriting*

COMPLIANCE MINIMUM VALUE PLAN
BENEFITS SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Primary Care Physician Selection	Not required	Not applicable
Deductible *(per plan year)*	$7,600 Individual $15,200 Family	Not applicable
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 copays 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 Primary Physician *(if available) Powered by MedLion Clinic*	Covered in full	Not covered
Virtual Urgent Care *Powered by MeMD*	Covered in full	Not applicable
Office Visits to Non-Specialist	100% of MAC after deductible*	Not applicable
**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 *(office visit)*	100% of MAC after deductible*	Not applicable
Maternity - Delivery and Post-Partum Care	100% of MAC after deductible*	Not applicable
Preventive Care	**Network Care**	**Out-Of-Network Care**
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*	Not applicable
Emergency Room	100% of MAC after deductible*	$250 co-payment *(limited to Medical Emergency requiring immediate care)*
Emergency Ambulance	100% of MAC after deductible*	Not applicable
Non-Emergency Ambulance	Not covered	Not applicable
Other Services and Plan Details	**Network Care**	**Out-Of-Network Care**
Hospital Care	100% of MAC after deductible*	Not applicable
Mental Health and Alcohol/Drug Abuse Services *(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**	**Discount Option**
Retail *(Up to a 30-day supply)*		
Generic Drugs	100% of MAC after deductible*	Available - Shield PBM
Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Non-Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Specialty Drugs *(Up to a 30-day supply)* *Includes self-injectable, infused and oral specialty drugs, excludes insulin*	100% of MAC after deductible*	Available - Shield PBM
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	100% of MAC after deductible*	Available - Shield PBM
Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM
Non-Preferred Brand Drugs	100% of MAC after deductible*	Available - Shield PBM

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

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

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

What's Not Covered
This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. This material does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them.

DENTAL + VISION

Dental+Vision is a direct reimbursement combination plan that pays for dental and vision expenses. After an initial 30-day waiting period, the tiered reimbursement structure begins at the first dollar and allows you to maximize your potential benefits.

REIMBURSEMENT SCHEDULE

PROCEDURE COST	REIMBURSEMENT
UP TO $150	**100%**
$151 - $250	**75%**
$251 - $1,800	**50%**
$1,801 - up	**0%**

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	$30.00	$54.00	$66.00	$90.00

EXAMPLES OF COVERED BENEFITS

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

Choose to go to any dentist or vision specialist and receive any medically necessary procedure.

DENTAL + VISION PLAN
BENEFITS SPECIFICATION

Benefits		
Network	Not applicable	
Calendar Year Maximum	$1,800*	
Waiting Period	A period of 30 consecutive days after the plans effective date of the plan before benefits will be available for covered services.	
Reimbursement Levels	**Aggregated Expenses**	**Benefit**
Benefits for Dental and Vision are combined. *Benefit is based on an aggregate total of accumulated expenses per Covered Person during the calendar year.	Up to $150.00 $150.01 to $250.00 $250.01 to $1,800.00 $1,800.01 and up	100% 75% 50% 0%
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 Emergency Care to Relieve Pain Root Canal Therapy/Endodontics Periapical X-rays Periodontal Scaling and Root Planing Oral Surgery – Simple Extractions Oral Surgery – all except simple Extractions Anesthetics Space Maintainers 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 Services Routine Examination Services Lenses – including, single, bifocal or trifocal Contact Lens Frames	At Current Reimbursement Level	

Dental Benefit Limitations

Procedure	Limitations	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

Dental Benefit Limitations

Procedure	Limitations	Procedure	Limitations
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 Benefit Limitations

Procedure	Limitations	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.

DENTAL PRO

Dental Pro provides affordable dental services through doctors in the Aetna network. You will have access to covered preventative and diagnostic procedures at no charge after the deductible is met.

COVERAGE	BENEFIT
Network	Aetna Dental Administrators
Out of Network Coverage	No
Individual / Family Deductible	$50/$150
Preventive/Diagnostic *(x-rays, cleanings, etc.)*	0% Co-Ins
Basic Restorative *(fillings, root canals, etc.)*	20% Co-Ins *(after meeting deductible)*
Family Deductible/Max Out of Pocket	50% Co-Ins *(after meeting deductible)*
Orthodontia *(dependents under age 19)*	50% Co-Ins *(after meeting deductible)*
Orthodontia Lifetime Max	$1,000
Max Benefit Paid Per Year *(dental and orthodontia benefits)*	$1,500

EXAMPLES OF COVERED BENEFITS

- TEETH CLEANING
- FILLINGS
- ROOT CANAL
- DENTAL X-RAYS

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	$45.00	$81.00	$99.00	$135.00

30-day waiting period applies before benefits can be used. Deductible waived for preventive services.

DENTAL PRO PLAN
BENEFITS SPECIFICATION

Benefits	In-Network		Out-Of-Network	
Network	Aetna Dental Administrators (ADA)		Not applicable	
Calendar Year Maximum	$1,500		Not applicable	
Annual Deductible Individual Family	 $50 per person $150 per family		Not applicable	
Reimbursement Level	Based on reduced contracted rees		Not applicable	
Waiting Period	A period of 30 consecutive days after the plans effective date of the plan before benefits will be available for covered services.		Not applicable	
Benefits	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I - Preventive & Diagnostic Care Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-Ray Panoramic X-ray Fluoride Application Sealants Histopathologic Exams	100%	No charge	Not covered	100% of billed charges
Class II - Basic Restorative Care Fillings Emergency Care to Relieve Pain Root Canal Therapy/Endodontics Periapical X-rays Periodontal Scaling and Root Planing Oral Surgery – Simple Extractions Oral Surgery – all except simple Extractions Anesthetics Space Maintainers Surgical Extractions of Impacted Teeth	80% deductible applies	20% deductible applies	Not covered	100% of billed charges
Class III - Major Restorative Care Crowns Dentures Bridges Inlays/Onlays Prosthesis Over Implant Repairs to Bridges, Crowns and Inlays Denture Adjustments and Repairs	50% deductible applies	50% deductible applies	Not covered	100% of billed charges
Class IV – Orthodontia Lifetime Maximum	50% deductible applies $1,000 dependent children to age 19	50% deductible applies	Not covered Not covered	100% of billed charges 100% of billed charges

Dental Pro Benefit Limitations

Procedure	Limitations
Exams	Two per calendar year
Prophylaxis (Cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 20
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
Surgeries (ALL)	Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
Crowns and Inlays	Replacement every 5 years

Dental Pro Benefit Limitations

Procedure	Limitations
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
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
Sealants	One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-orthodontic treatment
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.

Dental Pro Benefit Exclusions:

- Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- 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
- 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;
- 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);
- 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.

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

VIRTUAL URGENT CARE

Powered by MeMD

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

Our medical team includes MDs, DOs, NPs & PAs (US-licensed, board-certified medical providers) who average over l6 years of experience. They can give you a personalized treatment plan and send prescriptions right to your pharmacy.

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

HOW IT WORKS

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

HOW TO ENROLL:

STEP 1

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

Visit: www.MeMD.me/app-store
Plan Code: MQ967N4T
OR by visiting your MeMD website:
www.MeMD.me/group/breckpoint
(use Google Chrome for best browsing experience).

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.

PRESCRIPTION SAVINGS PROGRAM

Powered by RxValet

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

VALUE, CHOICE, & SAVINGS WITH RxValet

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

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

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

HOW TO ENROLL:

DOWNLOAD THE RXValet MOBILE APP

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

SAVE WITH HOME DELIVERY!

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

RXValet for PET MEDS

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

breckpoint

LEAD TOGETHER

8918 Spanish Ridge Ave #200, Las Vegas, NV 89148

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

ENROLLMENT FORM

breckpoint
LEAD TOGETHER

A. REQUIRED EMPLOYEE INFORMATION

Complete the Enrollment Form and return to your Human Resources Department.

Name:		Phone:	
Social Security #:	Date of Birth:	Sex: ☐ 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	PRO	COST
☐ Employee Only	$51.00	☐ Employee Only	$70.00
☐ Employee + Child(ren)	$91.80	☐ Employee + Child(ren)	$126.00
☐ Employee + Spouse	$112.20	☐ Employee + Spouse	$154.00
☐ Employee + Family	$153.00	☐ Employee + Family	$210.00
PRO+	**COST**	**COMPLIANCE MVP**	Please call 1.844.300.6497 to enroll.
☐ Employee Only	$100.00		
☐ Employee + Child(ren)	$180.00		
☐ Employee + Spouse	$220.00		
☐ Employee + Family	$300.00		
DENTAL + VISION	**COST**	**DENTAL PRO**	**COST**
☐ Employee Only	$30.00	☐ Employee Only	$45.00
☐ Employee + Child(ren)	$54.00	☐ Employee + Child(ren)	$81.00
☐ Employee + Spouse	$66.00	☐ Employee + Spouse	$99.00
☐ Employee + Family	$90.00	☐ Employee + Family	$135.00

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

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

ACKNOWLEDGEMENT & WAIVER FORM

breckpoint
LEAD TOGETHER

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:

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.