breckpoint®

LEAD TOGETHER

LIMITED BENEFITS

Enrollment Guide

Employer Name: Kinetic Personnel Group, Inc.

Group ID #: C002625

Plan Coverage Dates: 01/01/2023 - 12/31/2023

Disponible en Español, favor de comunicarse; 1.844.657.1575

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 breckpoint.linked.exchange. A paper copy of the SBC is also available, free of charge, by calling (toll-free) 1.844.657.1575. To register and view your claim status please go to portal.breckpoint.com.

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 4 DIFFERENT WAYS YOU CAN MAKE YOUR ELECTIONS!

1

GO ONLINE

Visit: breckpoint.linked.exchange
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

TEXT "ENROLL" TO 702-747-8261

You will receive a link to set up your account.

3

GIVE US A CALL

Call our Information Center and one of our knowledgeable representatives will help you. Available Monday through Friday 7:00 am – 4:00 pm PST at 1.844.657.1575. Representantes que hablan inglés y español están disponible.

4

SEE YOUR HR DEPARTMENT

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

EXCITING NEWS!

OPEN ACCESS NETWORK

DRIVING SAVINGS FOR MEC PLANS

MINIMUM ESSENTIAL COVERAGE SOLUTION

Open Access Network improving access & savings

Our Minimum Essential Coverage (MEC) solution is designed to combines with your health benefits plan to extend favorable reimbursement for MEC plans. Unlike traditional MEC plans, our MEC Solution enables members to choose high-quality medical providers and facilities to meet their precise health needs while balancing the financial cost for the member, the plan and the provider.

It's a win-win: members gain open choice to select higher-quality care for fair and reasonable costs, along with lower out-of-pocket costs; providers receive reimbursement based on fair, acceptable market recognized pricing and geography.

It improves member access to quality care, achieves 50-75% cost savings improvement, provides front-end proactive telephonic/ email support for member care questions, and works collaboratively with providers delivering care.

Unlike health plans that offer a specific defined network (e.g., a PPO), our MEC Solution allows members to seek care and treatment for covered services under the plan from any provider. While providers and facilities are not considered "in-network" or "out-of-network," they are granted fair and equitable reimbursements based on the market-sensitive pricing approach.

OUR ADVANTAGES

- Deep cost improvement for each MEC Plan and their members
- No defined network of providers; the open-access model allows members to seek care from any provider
- Proactive, front-end support to guide members to the best providers and high-quality care decisions. Member support can be obtained on-demand via phone or email
  866.762.4455
  mecsupport@valenzhealth.com
- Improved member access to quality care
- Direct provider education, support and collaboration

AXA Provider Network Assistance I 866.762.4455

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**
- **COVID-19 Testing (Swab Only)** *(One per plan year per member)*

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. Complex imaging not covered)*
- **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**
- **Breast Cancer Prevention**
- **Contraceptives**
- **Fluoride Supplements**
- **Folic Acid**
- **Statins**
- **Tobacco Cessation**
- **Vitamin Supplements**
- ***See the full list at breckpointrx.com***

** Please see plan specification document for more details.*

MINIMUM ESSENTIAL COVERAGE (MEC) PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
***NEW!* Network**	AXA Open Access
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	$5,000/$10,000
Preventive & Wellness *Covered with no out-of-pocket expenses.*	100%
Physician and Office Utilizations	N/A
Primary Care Visit	Not Included
Specialist Visit	Not Included
Urgent Care Visit	Not Included
Maternity Pre/Post Natal	Not Included
Mental/Behavioral Health	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 Discount Program *(Powered by Shield PBM)*	Included
Acute Drug Formulary *(Shield PBM)*	Included
Virtual Urgent Care *(Powered by MeMD)*	Included

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings.**
- **This plan has an Open Network provided by AXA Assistance USA. Choose your own provider without the limitations of Network Restrictions.**
- **No waiting periods.**
- **Enhanced Rx Program featuring deeply discounted medications.** *(Powered by Shield PBM, see insert)*
- **Acute Drug Formulary includes 37 medications** *(Powered by Shield PBM, see insert)*
- **Included 24/7 Virtual Urgent Care.** *(Powered by MeMD, see insert)*

Please see plan specification document for more details.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
PRICING	**$77.00**	**$125.80**	**$128.20**	**$157.50**

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	$5,000 Individual $10,000 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 applicable
Office Visits to Non-Specialist	Not covered	Not applicable
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.Complex imaging not covered.*	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
COVID-19 Testing *Swab only. Limited to 1 exam every 12 months.*	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)*		
Preventative Drugs	Covered in Full	
Generic Drugs	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	
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	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	

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Claims Portal: *To register and view your claims status please go to portal.breckpoint.com*

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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PRO PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
NEW! **Network**	AXA Open Access
Out of Network Coverage	N/A
Individual Medical Deductible/Out-of-Pocket Limit	$0/$400
Family Medical Deductible/Out-of-Pocket Limit	$0/$800
Individual/Family Pharmacy Out-of-Pocket Limit	$5,000/$10,000
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.*	**8 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	Not Included
Mental/Behavioral Health	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.*	$150 max/year
Enhanced Rx Discount Program *(Powered by Shield PBM)*	Included
Acute Drug Formulary *(Shield PBM)*	Included
Virtual Urgent Care *(Powered by MeMD)*	Included

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings.**
- **This plan has an Open Network provided by AXA Assistance USA. Choose your own provider without the limitations of Network Restrictions.**
- **Affordable doctor visits & Urgent Care co-pays.**
- **Enhanced Rx Program featuring deeply discounted medications.** *(Powered by Shield PBM, see insert)*
- **Included 24/7 Virtual Urgent Care.** *(Powered by MeMD, see insert)*
- **Acute Drug Formulary includes 37 medications** *(Powered by Shield PBM, 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	**$83.00**	**$144.60**	**$153.40**	**$195.50**

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
Medical Out-of-Pocket (OOP) Maximum *(per plan year, includes deductible)*	$400 Individual $800 Family	Not applicable
Pharmacy Out-of-Pocket (OOP) Maximum	$5,000 Individual $10,000 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 applicable
Office Visits to Non-Specialist *Limit of 8 utilizations** combined with non-specialists, specialists, and urgent care.*	$25 co-payment	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 *Limit of 8 utilizations** combined with non-specialists, specialists, and urgent care*	$35 co-payment	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.Complex imaging not covered.*	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
COVID-19 Testing *Swab only. Limited to 1 exam every 12 months.*	Covered in full	Not applicable
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 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 *(other than office visit)*	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)*		
Preventative Drugs	Covered in Full	
Generic Drugs	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	
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	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	

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

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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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PREFERRED PLAN

THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
NEW! **Network**	AXA Open Access
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	$5,000/$10,000
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 *(2 utilizations per year)*	$75 co-pay
Imaging *(1 utilization per year)*	$75 co-pay
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 Discount Program *(Powered by Shield PBM)*	Included
Acute Drug Formulary *(Shield PBM)*	Included
Virtual Urgent Care *(Powered by MeMD)*	Included

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings.**
- **This plan has an Open Network provided by AXA Assistance USA. Choose your own provider without the limitations of Network Restrictions.**
- **Affordable doctor visits & Urgent Care co-pays.**
- **Added coverage for x-rays & lab services.**
- **Enhanced Rx Program featuring deeply discounted medications.** *(Powered by Shield PBM, see insert)*
- **Acute Drug Formulary includes 37 medications** *(Powered by Shield PBM, see insert)*
- **Included 24/7 Virtual Urgent Care.** *(Powered by MeMD, 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	**$97.00**	**$169.80**	**$184.20**	**$237.50**

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	$5,000 Individual $10,000 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 applicable
Office Visits to Non-Specialist *Limit of 10 utilizations** combined with non-specialists, specialists, and urgent care.*	$25 co-payment	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 *Limit of 10 utilizations** combined with non-specialists, specialists, and urgent care*	$35 co-payment	Not applicable
Prenatal Maternity and Post-Partum Care *(office visit)* *Limit of 10 utilizations** combined with non-specialists, specialists, and urgent care*	$25 co-payment	Not applicable
Mental Health & Alcohol/Drug Abuse Services *(office visit)* *Limit of 10 utilizations** combined with non-specialists, specialists, and urgent care*	$25 co-payment	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.Complex imaging not covered.*	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
COVID-19 Testing *Swab only. Limited to 1 exam every 12 months.*	Covered in full	Not applicable

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 applicable
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 applicable
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 applicable
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 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 *(other than office visit)*	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)*		
Preventative Drugs	Covered in Full	
Generic Drugs	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	
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	Discounts Available	
Preferred Brand Drugs	Discounts Available	
Non-Preferred Brand Drugs	Discounts Available	

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 breckpoint.linked.exchange to log into our member portal.

***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.*

Claims Portal: *To register and view your claims status please go to portal.breckpoint.com*

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	✓
NEW! **Network**	AXA Open Access
Out of Network Coverage	N/A
Individual Medical Deductible/Max Out-of-Pocket	$8,700/$8,700
Family Medical Deductible/Max Out-of-Pocket	$17,400/$17,400
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)*	Included
Rideshare Transport	Not Included
Virtual Urgent Care *(Powered by MeMD)*	Included

PLAN FEATURES

- **Covers preventive and wellness services at no cost including: Annual Wellness Exam, Immunizations, and STI Screenings.**
- **This plan has an Open Network provided by AXA Assistance USA. 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	$498.50*	$897.30*	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)*	$8,700 Individual $17,400 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)*	$8,700 Individual $17,400 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
Mental Health & Alcohol/Drug Abuse Services *(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.Complex imaging not covered.*	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
COVID-19 Testing *Swab only. Limited to 1 exam every 12 months.*	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 applicable
Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Non-Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Specialty Drugs *(Up to a 30-day supply)* *Includes self-injectable, infused and oral specialty drugs, excludes insulin*	100% of MAC after deductible*	Not applicable
Mail Order Delivery *(for your refills for up to a 31-90 day supply)*		
Generic Drugs	100% of MAC after deductible*	Not applicable
Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Non-Preferred Brand Drugs	100% of MAC after deductible*	Not applicable

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Claims Portal: *To register and view your claims status please go to portal.breckpoint.com*

***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. Submit your claims for reimbursement to breckpoint.linked.exchange.

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 $150.00	**100%**
$151.01 - $250.00	**75%**
$251.01 - $1,800.00	**50%**
$1,801.01 - 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	**$26.00**	**$35.70**	**$39.30**	**$49.00**

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 & Inlays	Replacement every 5 years	**Bridges**	Replacement every 5 years
Dentures & 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.

DENTAL PRO

Dental Pro provides affordable dental services through doctors in the DenteMax network. You will have access to covered preventative procedures at no charge. No waiting period applies before benefits can be used. Deductible waived for preventive services.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
NEW! **Network**	DenteMax	Not Covered
Individual / Family Annual Deductible	$50/$150	
Preventive/Diagnostic *(x-rays, cleanings, etc.)*	0% Co-Ins	Not Covered
Basic Restorative *(fillings, root canals, etc.)*	20% Co-Ins *(after deductible)*	
Major Restorative *(crowns, bridges, etc.)*	50% Co-Ins *(after deductible)*	
Orthodontia *(dependents under age 19)*	50% Co-Ins *(after deductible)*	
Orthodontia Lifetime Max	$1,000	Not Covered
Max Benefit Paid / Calendar Year *(dental & orthodontia)*	$1,500	
Reimbursement Level	Based on reduced contracted fees	
Waiting Period	No waiting period	

EXAMPLES OF COVERED BENEFITS

TEETH CLEANING

FILLINGS

ROOT CANAL

DENTAL X-RAYS

Dental Procedure	Limitations	Dental Procedure	Limitations
Exams	Two per calendar year	**Fluoride**	1 per calendar year for people under 20
Prophylaxis *(cleanings)*	Two per calendar year	**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	**Relines, Rebases, Adjustments**	Covered if more than 6 months after installation
Surgeries *(ALL)*	Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.	**Repairs - Bridges & Dentures**	Reviewed if more than once
		Space Maintainers	Limited to non-orthodontic treatment
Crowns and Inlays	Replacement every 5 years	**Bridges**	Replacement every 5 years
Dentures and Partials	Replacement every 5 years	**Sealants**	One treatment per tooth every 3 years up to age 14
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.

	Employee Only	Employee + Child(ren)	Employee + Spouse	Employee + Family
Pricing	**$38.00**	**$57.30**	**$64.70**	**$85.00**

DENTAL PRO PLAN BENEFITS SPECIFICATION

	IN-NETWORK		OUT-OF-NETWORK	
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	100% of billed charges

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.

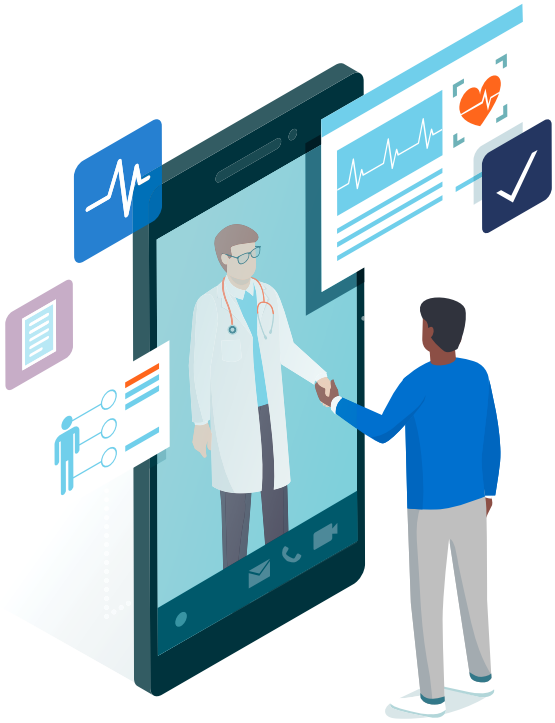
INCLUDED BENEFIT!

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 l6 years of experience. They can give you a personalized treatment plan and send prescriptions right to your pharmacy.

GET MEDICAL CARE DAY OR NIGHT:

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**

2 REQUEST AN EXAM

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

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 I www.memd.me/chat

INCLUDED BENEFIT!

ENHANCED RX PRESCRIPTION MEMBERSHIP WITH ACUTE DRUG FORMULARY

Powered by SHIELD PBM

THE EASIEST WAY TO SAVE ON YOUR MEDICATIONS

Enhanced Rx provides access to a full PBM discount network and additional access to savings online and through concierge service. Discount can also be used at the local pharmacy and include 95 ACA medications and 37 commonly prescribed medications included at no cost!
Visit **Breckpointrx.com** to get started!

1. Pay Before you go

- Save up to 25% more BEFORE going to the pharmacy by pre-paying at www.breckpointrx.com.

2. Mail Order

- Secure home delivery options online with up to 50% savings and enjoy auto-refill.

OR

3. Present your Rx card

- At any retail pharmacy and out of pocket cost is deeply discounted.

NO COST ACUTE DRUG FORMULARY COVERS DRUGS LIKE:

- Amoxicillin
- Atorvastatin
- Azithromycin (Z-Pak)
- Bupropion
- Cholecalciferol
- Ciprofloxacin
- Hydrocortisone
- Junel
- Lovastatin
- Meclizine
- Naproxen
- Nonoxynol
- Prednisone
- Tamoxifen
- Tessalon
- Viorele
- And much more!

See the full list at breckpointrx.com

855.798.2538 **www.breckpointrx.com**

DIRECT VIRTUAL PRIMARY CARE

INCLUDED BENEFIT

Powered by MeMD

MeMD delivers an industry-leading virtual health solution that goes well beyond traditional virtual care. Employees have access 24/7 to MeMD's highly qualified, licensed healthcare providers by phone, mobile app or computer to experience immediate and lasting benefits.

WE'VE GOT YOU COVERED

MeMD uses healthcare providers nationwide who are qualified to diagnose and treat a wide range of medical conditions.

Virtual Primary Care

** Available for children dependents ages 16-26. No age limit for spouse/domestic partner*

- Appointments within 24 hours
- Dedicated Care Navigation team
- Intelligent referrals
- Prescription Discounts
- Wellness Exams

Urgent Care

** Any age can use this service*

- Acute & Episodic Events
- Allergies/Itchy Eyes
- Fever
- Nausea/Vomiting
- Nasal congestion
- Cough/flu
- And more!

Behavioral Health

** Adult therapy (18+), teen therapy (10-17); Some geography maybe limited. 5 visits per month per family enrolled*

- Anxiety
- Bipolar
- Depression
- Grief/Loss
- Addiction
- Panic Attacks
- Eating Disorders
- And More!

GET MEDICAL CARE DAY OR NIGHT:

1 SIGN IN TO MEMD

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

Visit: www.MeMD.me/app-store **EE Plan Code: TPMHJV2G** **Family Plan Code: JHL3X73C**

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

2 REQUEST AN EXAM

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

3 SPEAK WITH A PROVIDER AND GET TREATMENT

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

www.memd.me

breckpoint®

LEAD TOGETHER

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

benefits@breckpoint.com | 844.657.1575 | 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	77.00	☐ Employee Only	83.00
☐ Employee + Child(ren)	125.80	☐ Employee + Child(ren)	144.60
☐ Employee + Spouse	128.20	☐ Employee + Spouse	153.40
☐ Employee + Family	157.50	☐ Employee + Family	195.50

PREFERRED	COST		
☐ Employee Only	97.00	COMPLIANCE MVP	Please call 1.844.300.6497 to enroll.
☐ Employee + Child(ren)	169.80		
☐ Employee + Spouse	184.20		
☐ Employee + Family	237.50		

DENTAL + VISION	COST	DENTAL PRO	COST
☐ Employee Only	26.00	☐ Employee Only	38.00
☐ Employee + Child(ren)	35.70	☐ Employee + Child(ren)	57.30
☐ Employee + Spouse	39.30	☐ Employee + Spouse	64.70
☐ Employee + Family	49.00	☐ Employee + Family	85.00

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®

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.