breckpoint

LEAD TOGETHER

# ENROLLMENT GUIDE

**Employer Name:** Davis Staffing, Inc.
**Group ID #:** C003198
**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 4 DIFFERENT WAYS YOU CAN MAKE YOUR ELECTIONS!

1

### GO ONLINE

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

2

### TEXT ENROLL TO 702-529-5229

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 – 5:00 pm PST at 1.844.300.6497. 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.

# 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**<br>*Covered with no out-of-pocket expenses.* | 100% |
| **Physician and Office Utilizations**<br>*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**<br>*Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.* | Not Included |
| **Virtual Urgent Care (MeMD)** | Unlimited |
| **Rx Care**<br>*Powered by Best Choice Rx. See the Rx Care insert for more detail.* | Copays from $10 |
| **Primary Care Virtual Clinic Membership**<br>*Powered by MedLion Clinic. See the MedLion Clinic Membership insert for more detail.* | 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 Rx Care, see insert for more information)*

*Please see plan specification document for more details.*

| | Employee Only | Employee + Child(ren) | Employee + Spouse | Employee + Family |
|---|---|---|---|---|
| **WEEKLY PRICING** | $8.47 | $16.94 | $21.17 | $29.64 |

# 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<br>$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** *(per plan year)* | $5,000 | Not applicable |
| *All covered expenses accumulate separately toward the network and out-of-network OOP limit.* | | |
| *Pharmacy co-payment expenses apply towards the Pharmacy OOP limit. Only those Medical OOP expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the Medical 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 Best Choice Rx* | **Network Care** | **Discount Option** |
| **Retail** *(Up to a 30-day supply)* | | |
| **Generic Drugs** | Copay starting at $10 | Included |
| **Preferred Brand Drugs** | Copay starting at $50 | Included |
| **Non-Preferred Brand Drugs** | Copay starting at $100 | Included |
| **Specialty Drugs** *(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs or any other drug above $200, excludes insulin and does not apply to Pharmacy max out-of-pocket.* | International & prescription assistance options - call customer care for additional information | Included |
| **Mail Order Delivery** *(for your refills for up to a 31-90 day supply)* | | |
| **Generic Drugs** | Copay starting at $10 | Included |
| **Preferred Brand Drugs** | Copay starting at $50 | Included |
| **Non-Preferred Brand Drugs** | Copay starting at $100 | Included |
| *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.

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

# **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**<br>*Covered with no out-of-pocket expenses.* | 100% |
| **Physician and Office Utilizations**<br>*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**<br>*Allows reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments.* | $150 max/year |
| **Virtual Urgent Care (MeMD)** | Unlimited |
| **Rx Care**<br>*Powered by Best Choice Rx. See the Rx Care insert for more detail.* | Copays from $10 |
| **Primary Care Virtual Clinic Membership**<br>*Powered by MedLion Clinic. See the MedLion Clinic Membership insert for more detail.* | 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 Rx Care, 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 |
|---|---|---|---|---|
| **WEEKLY PRICING** | $12.84 | $24.81 | $30.79 | $42.76 |

# 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<br>$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<br>$800 Family | Not applicable |
| **Pharmacy Out-of-Pocket (OOP) Maximum** *(per plan year)* | $5,000 | Not applicable |
| *All covered expenses accumulate separately toward the network and out-of-network OOP limit.* | | |
| *Pharmacy co-payment expenses apply towards the Pharmacy OOP limit. Only those Medical OOP expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the Medical 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**<br>*For covered males age 18 and over. Limited to 1 exam every 12 months.* | Covered in full | Not covered |
| **Colorectal Cancer Screening**<br>*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 Best Choice Rx* | **Network Care** | **Discount Option** |
| **Retail** *(Up to a 30-day supply)* | | |
| **Generic Drugs** | Copay starting at $10 | Included |
| **Preferred Brand Drugs** | Copay starting at $50 | Included |
| **Non-Preferred Brand Drugs** | Copay starting at $100 | Included |
| **Specialty Drugs** *(Up to a 30-day supply) Includes self-injectable, infused and oral specialty drugs or any other drug above $200, excludes insulin and does not apply to Pharmacy max out-of-pocket.* | International & prescription assistance options - call customer care for additional information | Included |
| **Mail Order Delivery** *(for your refills for up to a 31-90 day supply)* | | |
| **Generic Drugs** | Copay starting at $10 | Included |
| **Preferred Brand Drugs** | Copay starting at $50 | Included |
| **Non-Preferred Brand Drugs** | Copay starting at $100 | Included |

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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.

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

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

# COMPLIANCE MINIMUM VALUE PLAN (MVP)

## THIS PLAN INCLUDES:

| | |
|---|---|
| **Minimum Essential Coverage** | ✓ |
| **Minimum Value** | ✓ |
| **Network** | Medicare Plus |
| **Out of Network Coverage** | No |
| **Individual 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<br><br>**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 |
| **Primary Care Virtual Clinic Membership** *Powered by MedLion Clinic. See the MedLion Clinic Membership insert for more detail.* | 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* | Employee + Child(ren)* |
|---|---|---|
| **MONTHLY PRICING** | $139.85 | $896.40 |
| **WEEKLY PRICING** | $32.27 | $206.86 |

*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<br>$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<br>$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 |
|---|---|---|---|---|
| **WEEKLY PRICING** | $6.90 | $12.43 | $15.19 | $20.71 |

### 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.<br>*Benefit is based on an aggregate total of accumulated expenses per Covered Person during the calendar year. | Up to $150.00<br>$150.01 to $250.00<br>$250.01 to $1,800.00<br>$1,800.01 and up | 100%<br>75%<br>50%<br>0% |
| **Benefits** | **Plan Pays** | |
| **Dental Class I - Preventive & Diagnostic Care**<br>Oral Exams<br>Routine Cleanings<br>Full Mouth X-rays<br>Bitewing X-Ray<br>Panoramic X-ray<br>Fluoride Application<br>Sealants<br>Histopathologic Exams | At Current Reimbursement Level | |
| **Dental Class II - Basic Restorative Care**<br>Fillings<br>Emergency Care to Relieve Pain<br>Root Canal Therapy/Endodontics<br>Periapical X-rays<br>Periodontal Scaling and Root Planing<br>Oral Surgery – Simple Extractions<br>Oral Surgery – all except simple Extractions<br>Anesthetics<br>Space Maintainers<br>Surgical Extractions of Impacted Teeth | At Current Reimbursement Level | |
| **Dental Class III - Major Restorative Care**<br>Crowns<br>Dentures<br>Bridges<br>Inlays/Onlays<br>Prosthesis Over Implant<br>Repairs to Bridges, Crowns and Inlays<br>Denture Adjustments and Repairs | At Current Reimbursement Level | |
| **Vision Services**<br>Routine Examination Services<br>Lenses – including, single, bifocal or trifocal<br>Contact Lens<br>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.*

# 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.

# RX CARE ENHANCED PRESCRIPTION MEMBERSHIP

**Powered by Best Choice Rx**

Rx Care provides a one-stop-shop path to your discounted pharmaceutical needs, convenient online tools and the best-in-class member services. Membership in Rx Care is the best way to save big on the most common medications. Rx Care delivers comprehensive solutions to high-cost medications with the convenience of a concierge service.

## RX CARE

Cutting-Edge Savings in One All-Inclusive Benefit

### Traditional Pay at Local Pharmacy Formulary

1. Co-Pays from $10-$200
2. Member ID Cards and Electronic Fulfillment Included
3. Thousands of Available Prescriptions
4. Member Saves up to 30% Off U & C

### Membership Includes Online Access to

- **Pre-pay Online, for Local Pick-up**
  (20% to 50% less than paying co-pay at pharmacy)
- **Home Delivery Valet Service**
  (33% to 60% less than paying co-pay at pharmacy)
- **International Pharmacy Program**
  (50% to 70% less than paying co-pay at pharmacy)
- **Prescription Assistance Program**
  (70% to 90% less than paying co-pay at pharmacy)
- **Diabetic Testing Supplies**
  (Testing programs available at no charge, up to three times-a-day)

| Tier 1 | Tier 2 | Tier 3 | Tier 4 |
|---|---|---|---|
| Generic & Low Cost Brand $10 - $50 copay | Higher Cost Generic & Brand $50 - $100 copay | High Cost Brand $100-$200 copay | High Cost Specialty - International and Prescription Assistance options |

# ENROLLMENT FORM

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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 | WEEKLY COST | PRO | WEEKLY COST |
|---|---|---|---|
| ☐ Employee Only | $8.47 | ☐ Employee Only | $12.84 |
| ☐ Employee + Child(ren) | $16.94 | ☐ Employee + Child(ren) | $24.81 |
| ☐ Employee + Spouse | $21.17 | ☐ Employee + Spouse | $30.79 |
| ☐ Employee + Family | $29.64 | ☐ Employee + Family | $42.76 |

| COMPLIANCE MVP | Please call 1.844.300.6497 to enroll. | DENTAL + VISION | WEEKLY COST |
|---|---|---|---|
| Employee Only | $139.85/mnth OR $32.27/wk | ☐ Employee Only | $6.90 |
| Employee + Child(ren) | $896.40/mnth OR $206.86/wk | ☐ Employee + Child(ren) | $12.43 |
| | | ☐ Employee + Spouse | $15.19 |
| | | ☐ Employee + Family | $20.71 |

## C. REQUIRED DEPENDENT INFORMATION

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

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

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

☐ **Accept coverage options as selected**

| | |
|---|---|
| Date: | Signature: |

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

# ACKNOWLEDGEMENT & WAIVER FORM

breckpoint
LEAD TOGETHER

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

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

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

☐ **Decline all coverage options**

| Date: | Signature: |
|---|---|

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