



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit at [my.breckpoint.com](http://my.breckpoint.com) or call (844) 798-4878. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at [my.breckpoint.com](http://my.breckpoint.com) or call (844) 798-4878 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	\$2,500.00 individual participating <u>providers</u> \$7,500.00 family participating <u>providers</u>	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. In-network preventive care (adult & child)	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$2,500.00 individual participating <u>providers</u> \$7,500.00 family participating <u>providers</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. Refer to your I.D. card to identify the <u>network logo</u> . Please visit <a href="http://my.breckpoint.com">my.breckpoint.com</a> , click on FIND A PROVIDER and select the appropriate <u>network logo that matches your I.D. card</u> . See your plan document for more information on your participating <u>provider</u> . You may also call (844) 798-4878 if you have any questions.	Be aware your network <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ).
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> . Remember, benefits are not covered if you choose a non-Participating <u>provider specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	Not covered	Will be subject to age and developmentally appropriate frequency limitations determined by the U.S. Preventive Services Task Force (USPSTF), unless specifically stated this Schedule of Benefits, and can be located using the following website(s): <a href="http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/">http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</a> You are only eligible for non-participating preventive services (preventive care) if the preventive service is not provided by a participating provider.
	Dedicated primary care virtual clinic	No charge, <u>deductible</u> does not apply	Not covered	Powered by MedLion Clinic. Dedicated primary care physicians available via video, phone or text included in plan at no additional charge (if included in your plan and where available). See MedLion Clinic membership document for more information.
	Virtual Urgent Care (Powered by MeMD)	No charge, <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
	Primary care visit to treat an injury or illness	\$25.00 <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
	<u>Specialist</u> visit	\$35.00 <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
	Rideshare transport	No charge, <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u> - Reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments up to \$150.00 per covered family per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$75.00 <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
	Imaging (CT/PET scans, MRIs)	\$75.00 <u>copayment</u> then no charge after <u>deductible</u>	Not covered	Subject to <u>deductible</u> and <u>copayment</u>
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.rxvalet.com">www.rxvalet.com</a>	Preventive drugs	At pharmacy & mail order: No charge, deductible does not apply	Not covered	Not subject to <u>deductible</u> – Covers up to a 30 day supply (retail) & 31-90 day supply (mail order). All prescription brand drugs not paid for by the Plan are available at a discount off of retail through Rx Valet.
	Generic drugs	At pharmacy & mail order: \$10.00 <u>copayment</u>		
	Preferred brand drugs	Not covered	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	For medical emergency: \$250.00 <u>copayment</u> then no charge after <u>deductible</u>	Not covered	Limited to 3 visits per covered person per year. Subject to <u>deductible</u> and <u>copayment</u>
	<u>Emergency medical transportation</u>	\$150.00 <u>copayment</u> then no charge after <u>deductible</u>	Not covered	Limited to 3 utilizations per covered person per year. Subject to <u>deductible</u> and <u>copayment</u>
	<u>Urgent care</u>	\$50.00 <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Office visits: \$25.00 <u>copayment</u> , <u>deductible</u> does not apply Intermediate care: Not covered  Substance Abuse: Office visits: \$25.00 <u>copayment</u> , <u>deductible</u> does not apply Intermediate care: Not covered	Not covered	Not subject to <u>deductible</u>
	Inpatient services	Mental and Behavioral Health: Not covered  Substance Abuse: Not covered	Not covered	Not covered
If you are pregnant	Office Visits	\$25.00 <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Not subject to <u>deductible</u>
	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered	Not covered
If you need help recovering or have other special health needs	<u>Home health care</u>	Not covered	Not covered	Not covered
	<u>Rehabilitation services</u>	Not covered	Not covered	Not covered
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	Not covered	Not covered	Not covered
	<u>Durable medical equipment</u>	Not covered	Not covered	Not covered
	<u>Hospice service</u>	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Unless mandated by the Affordable Care Act.
	Children's glasses	Not covered	Not covered	Unless mandated by the Affordable Care Act.
	Children's dental check-up	Not covered	Not covered	Unless mandated by the Affordable Care Act.

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

- Check your policy or plan document

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan sponsor at **(844) 798-4878** or the plan's Claims administrator at (844) 798-4878, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? [Yes]

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

### Does this plan meet the Minimum Value Standard? [No]

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's overall deductible** \$5,000.00
- **Primary Care Provider copayment** \$25.00
- Hospital (facility) **coinsurance**: Not covered
- Other 0%

**This EXAMPLE event includes services like:**

Primary care office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<b>Deductibles</b>	\$625
<b>Copayments</b>	\$175
<b>Coinsurance</b>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$11,400
<b>The total Peg would pay is</b>	<b>\$12,200</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The **plan's overall deductible** \$5,000.00
- **Primary Care Provider copayment** \$25.00
- Hospital (facility) **coinsurance**: Not covered
- Other 0%

**This EXAMPLE event includes services like:**

Primary care office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<b>Deductibles</b>	\$0
<b>Copayments</b>	\$295
<b>Coinsurance</b>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,340
<b>The total Joe would pay is</b>	<b>\$5,635</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's overall deductible** \$5,000.00
- **Primary Care Provider copayment** \$25.00
- Hospital (facility) **coinsurance**: Not covered
- Other 0%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,050</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<b>Deductibles</b>	\$0
<b>Copayments</b>	\$250
<b>Coinsurance</b>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$350
<b>The total Mia would pay is</b>	<b>\$600</b>