breckpoint®
LEAD TOGETHER

Enrollment Guide

SELF-FUNDED
MEDICAL & SUPPLEMENTAL BENEFITS

Employer Name: Shelby Personnel Services
Plan Period: 11/01/2025 - 10/31/2026
Group Number: C012708

Disponible en Español, favor de comunicarse; 1.844.657.1575

WELCOME TO YOUR

MEDICAL & SUPPLEMENTAL BENEFITS GUIDE

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.my.site.com/members. A paper copy of the SBC is also available, free of charge, by calling (toll-free) 1.844.657.1575. To file and check the status of your claim please visit our Claims Portal at breckpoint.my.site.com/providers or by calling our customer service represenative at 1.844.657.1575.

Visit the Breckpoint Benefit Coverage Tool at breckpoint.com/benefits-bct.php to be informed of what services are covered and the copay if applicable, according to your plan.

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.*

TIME TO MAKE YOUR ELECTIONS.

1 CALL US TO ENROLL

Call our Information Center and one of our knowledgeable representatives will help you. Please have your group number for reference when you call. (C012708)
Available Monday through Friday 7:00 am – 4:00 pm PST at 1.844.657.1575.
Representantes que hablan inglés y español están disponible.

2 SEE YOUR HR DEPARTMENT

Please ensure you return your enrollment form to your HR. The enrollment form is included on the last few pages of this packet.

LIMITED-BENEFIT PLAN

Limited-Benefit plans are medical plans with more restricted benefits than major medical insurance, but with lower premiums.

DO I USE THIS PLAN LIKE ANY INSURANCE?

Yes! You'll have a Member ID card that you'll use the same way you would with other plans. See the helpful tips below.

WHAT IS OPEN ACCESS?

Breckpoint will not deny claims based on network participation. We will consider all claims for payment according to your plan specification. Your provider must agree to bill Breckpoint directly for services rendered.

MAKING AN APPOINTMENT

HAVE YOUR ID CARD READY!

It's important that you give your provider current insurance information. Your ID card will provide all the needed information required by a provider! Don't have one? Contact Member Services to receive a copy directly: 1-844-657-1575. *(Mon-Fri 7am-4pm PST)*

WHAT DO I SAY TO MY PROVIDER?

"I have a limited benefit plan with "Open Access". Breckpoint is my plan administrator, please contact them to verify my coverage at 1-844-657-1575."

STILL NEED HELP?

WHAT IF MY PROVIDER SAYS THEY WILL NOT ACCEPT MY INSURANCE?

Please contact AXA's concierge service at **1-866-762-4455** or mecsupport@valenzhealth.com. AXA will provide assistance with contacting the provider as well as providing other providers who will accept your benefits.

ALL YOUR HELPFUL CONTACTS ARE LISTED ON THE BACK OF YOUR ID CARD.

MEMBER SERVICES:
Call this number if you have questions about your plan or need an ID card. Providers can call this number to verify your coverage before an appointment.

PHARMACY HELPLINE:
You or your pharmacist can call this number and connect directly to your RX Discount program for assistance with your prescription needs. They can help you secure the best available discount.

PROVIDER LOCATOR ASSISTANCE:
Call this number if you need help finding a new provider; they can give you a personal directory.

COVERED SERVICES

FOR ALL MEDICAL PLANS

Preventative Health Services

FOR ADULTS

- Abdominal Aortic Aneurysm One-Time Screening (Men 65-75 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 45-75)
- Depression Screening
- Diabetes (Type 2) Screening
- 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 50-80)
- Obesity Screening and Counseling
- Sexually Transmitted Infections Counseling
- Skin Cancer Behavioral Counseling (Adults up to 24 years)
- Statin Preventative Medication (Adults aged 40 to 75years who have 1 or more cardiovascular risk factors)
- Syphilis screening
- Tobacco Use Screening and Counseling
- Tuberculosis Screening
- Unhealthy Alcohol & Drug Use 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 (Adults 21-65)
- 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
- Screening for Diabetes in Pregnancy (Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)
- Screening for Diabetes in Pregnancy
- Gonorrhea Screening
- Hepatitis B Screening
- HIV Screening
- Immunization Vaccines
- Osteoporosis Screening (Woman 65 year and older and postmenopausal women younger than 65 years at increased risk of osteoporosis)
- Perinatal Depression Screening
- Preeclampsia Screening & Preventative Medication
- Rh Incompatibility Screening
- Syphilis screening
- Tobacco Use Counseling
- Vitamin D Supplementation

FOR CHILDREN

- Major Depressive Disorder (MDD) Screening (Adolescents age 12-18)
- 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
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum (Newborns)
- Phenylketonuria (PKU) Screening
- Prevention Skin Cancer Behavioral Counseling
- Sexually Transmitted Infections
- Tobacco Use Interventions
- Visual Acuity Screening (Children ages 3 to 5 years)

Please note this is not an exhaustive list of covered preventive services. For the most current, complete list please visit https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

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.*

PRO PLAN

THIS PLAN INCLUDES:	
Minimum Essential Coverage	✓
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	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	Preventative Only
Imaging	Preventative Only
Emergency Room	Not Included
Emergency Transport	Not Included
Outpatient/In-Patient Services Hospital Admission	Not Included
Rideshare Transport Allows reimbursement for any rideshare transportation to and from medical treatments and appointments	$150 max/year
ACA Drug Formulary	Included
Enhanced Rx Discount Program (Powered by Shield PBM)	Included
Acute Drug Formulary (Powered by Shield PBM)	Included
Virtual Urgent Care (Powered by HealthWallet)	Included

PLAN HIGHLIGHTS

- 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 additional plan features)*
- Acute Drug Formulary includes 37 medications *(Powered by Shield PBM, see additional plan features)*
- Included 24/7 Virtual Urgent Care. *(Powered by HealthWallet, see additional plan features)*
- Need a ride to the doc? Rideshare benefit included!

PRICING	Employee Only	Employee +Child(ren)	Employee + Spouse	Employee + Family
	$77.00	$119.10	$127.90	$170.00

PRO PLAN BENEFIT 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 HealthWallet	Included	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 covered
Maternity - Delivery	Not covered	Not covered
Preventive Care	**Network Care**	**Out-Of-Network Care**
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
Routine Adult Physical Exams and Immunizations Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	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.	Included	Not applicable
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Mammograms For covered females age 40 and over. Limited to 1 exam every 12 months.Complex imaging not covered.	Included	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.	Included	Not applicable
Colorectal Cancer Screening For all members age 45 and over. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Eye Exams (Refraction) For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Included	Not applicable
Voluntary Sterilization - Tubal Ligation Covered as a preventive care service in accordance with Health Care Reform.	Included	Not applicable
COVID-19 Testing Swab only. Limited to 1 exam every 12 months.	Included	Not applicable

PRO PLAN BENEFIT SPECIFICATION

continued

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 Shield PBM	**Access & Discounts Available**	
Retail (Up to a 30-day supply)		
Preventative Drugs	Included	
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 breckpoint.my.site.com/providers*

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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MEDICAL

PREFERRED PLAN

THIS PLAN INCLUDES:	
Minimum Essential Coverage	✓
Network	**AXA Open Access**
Out of Network Coverage	N/A
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	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	$25 co-pay
Mental/Behavioral Health	$25 co-pay
X-Rays & Lab *(2 Utilizations per year)*	$75 co-pay
Imaging *(1 Utilizations 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 transportation to and from medical treatments and appointments	$150 max/year
ACA Drug Formulary	Included
Enhanced Rx Discount Program (Powered by Shield PBM)	Included
Acute Drug Formulary (Powered by Shield PBM)	Included
Virtual Urgent Care (Powered by HealthWallet)	Included

PLAN HIGHLIGHTS

- 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 additional plan features)*
- Acute Drug Formulary includes 37 medications *(Powered by Shield PBM, see additional plan features)*
- Included 24/7 Virtual Urgent Care. *(Powered by HealthWallet, see additional plan features)*
- Need a ride to the doc? Rideshare benefit included!

PRICING	Employee Only	Employee +Child(ren)	Employee + Spouse	Employee + Family
	$93.00	$146.30	$160.70	$214.00

PREFERRED PLAN BENEFIT 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 HealthWallet	Included	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)	$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 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.	Included	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.	Included	Not applicable
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Mammograms For covered females age 40 and over. Limited to 1 exam every 12 months. Complex imaging not covered.	Included	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.	Included	Not applicable
Colorectal Cancer Screening For all members age 45 and over. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Eye Exams (Refraction) For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Included	Not applicable
Voluntary Sterilization - Tubal Ligation Covered as a preventive care service in accordance with Health Care Reform.	Included	Not applicable
COVID-19 Testing Swab only. Limited to 1 exam every 12 months.	Included	Not applicable

PREFERRED PLAN BENEFIT SPECIFICATION

continued

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 1utilization** 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 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 Shield PBM	**Access & Discounts Available**	
Retail (Up to a 30-day supply)		
Preventative Drugs	Included	
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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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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MEDICAL

MVP COMPLIANCE PLAN

THIS PLAN INCLUDES:

Network	**AXA Open Access**
Out of Network Coverage	N/A
Individual Medical Deductible/Out-of-Pocket Limit	$9,100/$9,100
Family Medical Deductible/Out-of-Pocket Limit	$18,200/$18,200
Preventive & Wellness Covered with no out-of-pocket expenses.	100%
Primary Care Visit	Subject to Deductible plus amounts that exceed the Reasonable and Allowed Amount.
Specialist	
Urgent Care Visit	
Maternity Pre/Post Natal Office Visit	
Mental/Behavioral Health Office Visit	
X-Ray & Labs	
Emergency Room	
Emergency Transport	
Inpatient Services	
Outpatient Services	
Hospital Admission	
Rx Prescription Discount (Powered by Shield PBM)	Included
Virtual Urgent Care (Powered by HealthWallet)	Included

PLAN HIGHLIGHTS

- 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 Care *(Powered by HealthWallet, see additional plan features)*
- Rx Benefits Included *(Powered by Shield PBM, see additional plan features)*
- Provides major medical coverage. Please contact our Member Service Department for additional details.

PRICING	Employee Only	Employee +Child(ren)	Employee + Spouse	Employee + Family
	$525.00*	$1,050.00*	Not Offered	Not Offered

*Rate is subject to underwriting. *A Healthcare Questionnaire must be submitted for review. Please call customer service before enrolling in this plan.*

MVP COMPLIANCE PLAN
BENEFIT SPECIFICATION

Plan Features	Network Care	Out-Of-Network Care
Deductible (per plan year)	$9,100 Individual $18,200 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 decductible 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)	$9,100 Individual $18,200 Family	Not applicable
All covered expenses accumulate separately toward the network and out-of-network OOP limit. Pharmacy co-payment expenses apply towards the OOP limit. Only those OOP expenses resulting from the application of coinsurance percentage, deductibles, and co-pays may be used to satisfy the OOP maximum. Once the family payment limit is met, all family members will be considered as having met their payment limit for the remainder of the plan year.		
Payment for Out-of-Network Care	Not applicable	Not applicable
Referral Requirement	Not required	Required for Hospital & Diagnostic Imaging
Physician Services	**Network Care**	**Out-Of-Network Care**
Virtual Urgent Care Powered by HealthWallet	Included	Not applicable
Office Visits to Non-Specialist	Deductible +Resonable & Allowed**	Not applicable
Specialist Office Visits	Deductible +Resonable & Allowed**	Not applicable
Prenatal Maternity and Post-Partum Care (Office Visit)	Deductible +Resonable & Allowed**	Not applicable
Mental Health & Alcohol/Drug Abuse Services (Office Visit)	Deductible +Resonable & Allowed**	Not applicable
Maternity - Delivery*	Deductible +Resonable & Allowed**	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.	Included	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.	Included	Not applicable
Routine Gynecological Exams Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Mammograms For covered females age 40 and over. Limited to 1 exam every 12 months.Complex imaging not covered.	Included	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.	Included	Not applicable
Colorectal Cancer Screening For all members age 45 and over. Limited to 1 exam every 12 months.	Included	Not applicable
Routine Eye Exams (Refraction) For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Included	Not applicable
Voluntary Sterilization - Tubal Ligation Covered as a preventive care service in accordance with Health Care Reform.	Included	Not applicable
COVID-19 Testing Swab only. Limited to 1 exam every 12 months.	Included	Not applicable

MVP COMPLIANCE PLAN
BENEFIT SPECIFICATION
continued

Non-Hospital Based Diagnostic Procedures	Network Care	Out-Of-Network Care
Outpatient Diagnostic Laboratory	Deductible +Resonable & Allowed**	Not applicable
Outpatient Diagnostic X-ray (except for complex imaging services)	Deductible +Resonable & Allowed**	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services* (Including, but not limited to, MRI, MRA, PET, and CT Scans)	Deductible +Resonable & Allowed**	Not applicable
Hospital Based Diagnostic Procedures	**Network Care**	**Out-Of-Network Care**
Diagnostic Laboratory	Deductible +Resonable & Allowed**	Not applicable
Diagnostic X-ray* (except for complex imaging services)	Deductible +Resonable & Allowed**	Not applicable
Diagnostic X-ray for Complex Imaging Services* (Including, but not limited to, MRI, MRA, PET, and CT Scans)	Deductible +Resonable & Allowed**	Not applicable
Emergency Medical Care	**Network Care**	**Out-Of-Network Care**
Urgent Care Provider	Deductible +Resonable & Allowed**	Not applicable
Emergency Room	Deductible +Resonable & Allowed**	Not applicable
Emergency Ambulance	Deductible +Resonable & Allowed**	Not applicable
Non-Emergency Ambulance	Not covered	Not covered
Other Services and Plan Details	**Network Care**	**Out-Of-Network Care**
Hospital Care*	Deductible +Resonable & Allowed**	Not applicable
Mental Health and Alcohol/Drug Abuse Services* (other than office visit)	Deductible +Resonable & Allowed**	Not applicable
Skilled Nursing Facility* Coverage is limited to 120 days per plan year	Deductible +Resonable & Allowed**	Not applicable
Therapy and Rehabilitation Services*	Deductible +Resonable & Allowed**	Not applicable
Durable Medical Equipment*	Deductible +Resonable & Allowed**	Not applicable
Mouth, Jaws, and Teeth* Oral surgery procedures, medical in nature	Deductible +Resonable & Allowed**	Not applicable
Family Planning* Covered only for the diagnosis and treatment of the underlying medical condition.	Deductible +Resonable & Allowed**	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	Deductible +Resonable & Allowed**	Not applicable
Preferred Brand Drugs	Deductible +Resonable & Allowed**	Not applicable
Non-Preferred Brand Drugs	Deductible +Resonable & Allowed**	Not applicable
Specialty Drugs (up to a 30 day supply) includes self-injectable, infused and oral specialty drugs, excludes isulin)	Deductible +Resonable & Allowed**	Not applicable
Mail Order Delivery (for your refills for up to a 31-90 day supply)		
Generic Drugs	Deductible +Resonable & Allowed**	Not applicable
Preferred Brand Drugs	Deductible +Resonable & Allowed**	Not applicable
Non-Preferred Brand Drugs	Deductible +Resonable & Allowed**	Not applicable

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.my.site.com/members to log into our member portal. Claims Portal: To register and view your claims status please go to breckpoint.my.site.com/providers

*Pre-certification required. Failure to obtain Pre-certification may result in a reduction or denial of benefits. Subject to Referenced Based Pricing; member may be balance billed if provider does not accept 150% of Medicare allowable payment. This benefit utilizes open access with no network restrictions.

****Reasonable or Allowed Amount:** Subject to Reference Based Pricing; member may be balance billed if provider does not accept 150% of Medicare allowable payment. This benefit utilizes open access with no network restrictions. 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.

Disclaimer: 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. 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.

INCLUDED BENEFIT

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LEAD TOGETHER

DIRECT VIRTUAL URGENT CARE

powered by HealthWallet

Sickness doesn't sleep. Get the care you need, when you need it, at no cost to you! With on-demand exams from HealthWallet, 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 DOWNLOAD THE APP

- Scan the QR code or visit http://get.thehealthwallet.com/ and download the HeathWallet App to your mobile device.

2 REGISTER

- Open the app and register by selecting "Member ID". Enter your Member ID and Date of Birth (DOB).

3 ACCESS AND SCHEDULE APPOINTMENTS

- After registering, log in to access your health services and schedule an appointment through the app.

SCAN HERE *to download the HealthWallet App*

FOR ASSISTANCE *call 1.866.918.7735 or email support@healthwallet.com*

INCLUDED BENEFIT

breckpoint®
LEAD TOGETHER

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 breckpointrx.com.

2. MAIL ORDER

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

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**
- **Atrovastatin**
- **Azithromycin (Z-pack)**
- **Bupropion**
- **Cholecalciferol**
- **Ciprofloxacin**
- **Hydrocortisone**
- **Junel**
- **Lovastatin**
- **Meclizine**
- **Naproxen**
- **Nonoxynol**
- **Prednisone**
- **Tamoxifen**
- **Tessalon**
- **Viorele**
- **and much more!**

SCAN HERE *to find out more about the BreckpointRx portal*
See the full medication list at ***breckpointrx.com***
855.798.2538

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DENTAL + VISION REIMBURSEMENT PLAN

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.

BENEFIT INFORMATION	
Network	Not applicable
Max Benefit Reimbursement	$1,000
Waiting Period	No waiting period

PROCEDURE COST	REIMBURSEMENT
UP TO $150.00	100%
$150.01 - $250.00	75%
$250.01 - $1,800.00	50%
$1,800.01 - 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 — At Current Reimbursement Level

- Oral Exams
- Routine Cleanings
- Full Mouth X-rays
- Bitewing X-Ray
- Panoramic X-ray
- Fluoride Application
- Sealants
- Histopathologic Exams

Dental Class II - Basic Restorative Care — At Current Reimbursement Level

- 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

Dental Class III - Major Restorative Care — At Current Reimbursement Level

- Crowns
- Dentures
- Bridges
- Inlays/Onlays
- Prosthesis Over Implant
- Repairs to Bridges, Crowns and Inlays
- Denture Adjustments and Repairs

Dental Class IV-Orthodontia *(dependents under 19)* — $500 Lifetime Maximum of Covered Charges

VISION BENEFITS — PLAN PAYS

At Current Reimbursement Level

- Routine Examination Services
- Lenses – including, single, bifocal or trifocal
- Contact Lens
- Frames

PRICING	Employee Only	Employee +Child(ren)	Employee + Spouse	Employee + Family
	$26.00	$35.70	$39.30	$49.00

DENTAL + VISION REIMBURSEMENT
PLAN SPECIFICATIONS

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.

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DENTAL PRO PLAN

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.

	IN-NETWORK	OUT-OF-NETWORK
Network	DenteMax	Not Covered
Individual / Family Annual Deductible	$50/$150	
Preventive/Diagnostic (x-rays, cleanings, etc.)	100%	
Basic Restorative (fillings, root canals, etc.)	80% (after deductible)	
Major Restorative (crowns, bridges, etc.)	50% (after deductible)	
Orthodontia (dependents under age 19)	50% (after deductible)	
Orthodontia Lifetime Max	$1,000	
Max Benefit Paid / Calendar Year (dental & orthodontia)	$1,500	
Reimbursement Level	Based on reduced contracted fees	
Waiting Period	No waiting period	

BENEFITS	IN-NETWORK PLAN PAYS	IN-NETWORK YOU PAY	OUT-OF NETWORK
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	**PLAN PAYS** Not covered **YOU PAY** 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)	**PLAN PAYS** Not covered **YOU PAY** 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)	**PLAN PAYS** Not covered **YOU PAY** 100% of billed charges
Class IV – Orthodontia Lifetime Maximum	50% (deductible applies) $1,000 dependent children to age 19	50% (deductible applies)	**PLAN PAYS** Not covered **YOU PAY** 100% of billed charges

PRICING	Employee Only	Employee +Child(ren)	Employee + Spouse	Employee + Family
	$38.00	$57.30	$65.70	$85.00

DENTAL PRO PLAN SPECIFICATIONS

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.

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.

ENROLLMENT FORM

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

Name:		Phone:
Social Security #:	Date of Birth:	Sex: ☐ Male ☐ Female
Address:		Apt. #:
City:	State:	Zip:
Hire Date:	Employee ID:	

B. MEDICAL BENEFIT PLAN SELECTION
Payroll Deducted Rates - Please select the tier for each product in which you wish to enroll.

☐ PRO PLAN	COST
☐ Employee Only	$77.00
☐ Employee + Child(ren)	$119.10
☐ Employee + Spouse	$127.90
☐ Employee + Family	$170.00

☐ PREFERRED PLAN	COST
☐ Employee Only	$93.00
☐ Employee + Child(ren)	$146.30
☐ Employee + Spouse	$160.70
☐ Employee + Family	$214.00

MVP COMPLIANCE PLAN	Please call 1.844.300.6497 to enroll.

C. ANCILLARY BENEFIT PLAN SELECTION
Payroll Deducted Rates - Please select the tier for each product in which you wish to enroll.

☐ DENTAL + VISION	COST
☐ Employee Only	$26.00
☐ Employee + Child(ren)	$35.70
☐ Employee + Spouse	$39.30
☐ Employee + Family	$49.00

☐ DENTAL PRO PLAN	COST
☐ Employee Only	$38.00
☐ Employee + Child(ren)	$57.30
☐ Employee + Spouse	$65.70
☐ Employee + Family	$85.00

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

ENROLLMENT FORM
continued

E. 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

ACKNOWLEDGEMENT & WAIVER FORM

F. 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:

G. 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.

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