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 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 or call (844) 798-4878 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0.00 individual / $0.00 family participating providers	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No. There are no other specific deductibles.	There is no deductible. See a list of covered preventive services at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,050.00 individual participating providers $2,100.00 family participating providers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; amounts over allowed amount; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Refer to your I.D. card to identify the network logo. Please visit **my.breckpoint.com, click on FIND A PROVIDER and select the appropriate network logo that matches your I.D. card.** See your plan document for more information on your participating provider. You may also call (844) 798-4878 if you have any questions.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral. Remember, benefits are not covered if you choose a non-Participating provider specialist.

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)	
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge	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): http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ 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	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	Not covered	---------- none ----------
	Primary care visit to treat an injury or illness	$25.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
	Specialist visit	$35.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
	Rideshare transport	No charge	Not covered	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)	
If you have a test	Diagnostic test (x-ray, blood work)	$75.00 copayment	Not covered	Limited to 3 visits per covered person per year.
	Imaging (CT/PET scans, MRIs)	$75.00 copayment	Not covered	Limited to 1 visit per covered person per year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.rxvalet.com**	Preventive drugs	At pharmacy & mail order: No charge for preventive drugs only	Not covered	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need immediate medical attention	Emergency room care	For medical emergency: $250.00 copayment	Not covered	Limited to 1 visit per covered person per year.
	Emergency medical transportation	Not covered	Not covered	Not covered
	Urgent care	$50.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Office visits: $25.00 copayment Intermediate care: Not covered Substance Abuse: Office visits: $25.00 copayment Intermediate care: Not covered	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person 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)	
	Inpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered	Not covered
If you are pregnant	Office Visits	$25.00 copayment	Not covered	Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year.
	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	Home health care	Not covered	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered	Not covered
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice service	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. 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** 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.

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** **$0.00**
- **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$175
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,410
The total Peg would pay is	**$11,585**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0.00**
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,640
The total Joe would pay is	**$6,890**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0.00**
- **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)*

Total Example Cost	**$1,050**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$350
The total Mia would pay is	**$600**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.