

PREFERRED PLAN

SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2022 - December 31, 2022
Coverage For: Employee/Family | **Plan Type:** Open Network

What this Plan Covers & What You Pay for Covered Services

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 medical out-of-pocket limit for this plan? | \$725.00 individual participating providers \$1,450.00 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 the prescription out-of-pocket limit for this plan? | \$5,000.00 individual participating providers \$10,00.00 family participating providers | The prescription 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 prescription out-of-pocket limits until the overall family prescription out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Not applicable | This plan does not have an out-of-pocket limit on your expenses. |
| 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 |
|---------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care provider's office or clinic | Preventive care/screening/immunization | Covered, no additional out of pocket, deductible does not apply | 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. |
| | Primary care visit to treat an injury or illness | \$25.00 copayment | 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 | Primary Care visits, Specialist visits, and urgent care visits are limited to a combined 10 visits per covered person per year. |
| | Rideshare transport | Covered, no additional out of pocket, deductible does not apply | Reimbursement for any rideshare, cab or other transportation to and from medical treatments and appointments up to \$150.00 per covered family per year. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$75.00 copayment | Limited to 2 utilization per covered person per year. |
| | Imaging (CT/PET scans, MRIs) | \$75.00 copayment | Limited to 1 utilization per covered person per year. |

| Common Medical Event | Services you may need | What you will pay | Limitations, Exceptions, & Other Important Information |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BreckpointRX.com | Preventive drugs | At pharmacy & mail order: No charge, deductible does not apply | Not subject to deductible – 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. |
| | Generic drugs | At pharmacy & mail order: copayment starting at \$5.00 | |
| | Preferred brand drugs | At pharmacy & mail order: copayment starting at \$50.00 | Not subject to deductible – 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. |
| | Non-preferred brand drugs | At pharmacy & mail order: copayment starting at \$100.00 | |
| | Specialty Drugs | Not covered | International & prescription assistance options. Call customer care for additional information. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered |
| | Physician/surgeon fees | Not covered | Not covered |
| If you need immediate medical attention | Emergency room care | Not covered | Not covered |
| | Emergency medical transportation | Not covered | Not covered |
| | Urgent care | \$50.00 copayment | 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 |
| | Physician/surgeon fees | Not covered | Not covered |

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

Other Ancillary Products:

- In addition to benefits under this plan, you have other service options including telehealth and other service providers. Please see your enrollment guide or HR Representative for more information.

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 | \$25 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$12,610 |
| The total Peg would pay is | \$12,635 |

| 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 | \$100 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$6,800 |
| The total Joe would pay is | \$6,900 |

| 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 | From \$1,050 to \$5,600 |
| In this example, Mia would pay: | |
| Cost Sharing | |
| Deductibles | \$0 |
| Copayments | \$25 to \$75 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$350 to \$2,050 |
| The total Mia would pay is | \$600 to \$3,325 |

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