



## MINIMUM ESSENTIAL COVERAGE (MEC) PLAN

### THIS PLAN INCLUDES:

Minimum Essential Coverage	✓
Network	<b>AXA Open Access</b>
Out of Network Coverage	N/A
Individual Medical Deductible/Out-of-Pocket Limit	\$0/None
Family Medical Deductible/Out-of-Pocket Limit	\$0/None
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	Preventative Only
Primary Care Visit	Not Included
Specialist Visit	Not Included
Urgent Care Visit	Not Included
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
ACA Drug Formulary	Included
Enhanced Rx Discount Program (Powered by Shield PBM)	Included
Acute Drug Formulary (Shield PBM)	Included
Virtual Urgent Care (Powered by Walmart Health)	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.
- 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 Walmart Health see additional plan features)

#### WEEKLY PRICING

Employee Only

Employee +Child(ren)

Employee + Spouse

Employee + Family

# MEC 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)	Not applicable	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 Walmart Health	Included	Not applicable
Office Visits to Non-Specialist	Not covered	Not applicable
Specialist Office Visits	Not covered	Not applicable
Prenatal Maternity and Post-Partum Care (Office Visit)	Not covered	Not applicable
Maternity - Delivery	Not covered	Not applicable
Preventive Care	Network Care	Out-Of-Network Care
Preventive care services are covered in accordance with Health Care Reform. Services subject to change as guidelines are revised.		
<b>Routine Adult Physical Exams and Immunizations</b> Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
<b>Well Child Exams and Immunizations</b> Limited to 1 exam every 12 months. Immunizations will be subject to age and developmentally appropriate frequency limitations determined by ACIP.	Included	Not applicable
<b>Routine Gynecological Exams</b> Includes routine tests and related lab fees. Limited to 1 exam every 12 months.	Included	Not applicable
<b>Routine Mammograms</b> For covered females age 40 and over. Limited to 1 exam every 12 months. Complex imaging not covered.	Included	Not applicable
<b>Women's Health</b> 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
<b>Colorectal Cancer Screening</b> For all members age 45 and over. Limited to 1 exam every 12 months.	Included	Not applicable
<b>Routine Eye Exams (Refraction)</b> For covered children age 3 to 5. Coverage is limited to 1 exam every 12 months.	Included	Not applicable
<b>Voluntary Sterilization - Tubal Ligation</b> Covered as a preventive care service in accordance with Health Care Reform.	Included	Not applicable
<b>COVID-19 Testing</b> Swab only. Limited to 1 exam every 12 months.	Included	Not applicable
Diagnostic Procedures	Network Care	Out-Of-Network Care
Outpatient Diagnostic Laboratory	Not covered	Not applicable
Outpatient Diagnostic X-ray (except for complex imaging services)	Not covered	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET, and CT Scans)	Not covered	Not applicable

# MEC PLAN BENEFIT SPECIFICATION

*continued*

Emergency Medical Care	Network Care	Out-Of-Network Care
Urgent Care Provider	Not covered	Not applicable
Emergency Room	Not covered	Not applicable
Emergency Ambulance	Not covered	Not applicable
Other Services and Plan Details	Network Care	Out-Of-Network Care
Hospital Care	Not covered	Not applicable
Mental Health and Alcohol/Drug Abuse Services	Not covered	Not applicable
Skilled Nursing Facility	Not covered	Not applicable
Therapy and Rehabilitation Services	Not covered	Not applicable
Durable Medical Equipment	Not covered	Not applicable
Mouth, Jaws, and Teeth Oral surgery procedures, medical in nature	Not covered	Not applicable
Family Planning	Not covered	Not applicable
Pharmacy – Prescription Drug and Discount Benefits	Powered by 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	

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.linked.exchange](https://breckpoint.linked.exchange) to log into our member portal.

\*\*Utilization is the use of services by persons for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis. Examples of Utilization are the number of office visits a person makes per year, the number of prescription drugs taken, or the number of testing a person receives by a provider.

Claims Portal: To register and view your claims status please go to [portal.breckpoint.com](https://portal.breckpoint.com)

**Pharmacy Plan includes:** Contraceptive drugs and devices obtainable from a pharmacy. Formulary generic FDA-approved women's contraceptives covered 100% in network. Not all drugs are covered.

**What's Not Covered:** This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; cosmetic surgery, including breast reduction; custodial care; dental care and x-rays; donor egg retrieval; experimental and investigational procedures; hearing aids; immunizations for travel or work; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary

services or supplies; orthotics; over-the-counter medications and supplies; reversal of sterilization; services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. This material does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them.

**breckpoint**  
LEAD TOGETHER

# DIRECT VIRTUAL URGENT CARE

powered by  **Virtual Care**

Sickness doesn't sleep. Get the care you need, when you need it, at no cost to you! With on-demand exams from Walmart Health, 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 16 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**

### **SIGN IN TO WALMART HEALTH**

Access your Walmart Health account by downloading the app and entering your plan code:

**Visit:** [www.MeMD.me/app-store](http://www.MeMD.me/app-store) **Plan Code:** MQ967N4T

OR by visiting your Walmart Health website: [www.MeMD.me/group/breckpoint](http://www.MeMD.me/group/breckpoint)

**2**

### **REQUEST AN EXAM**

For non-emergency health issues, you can request an exam using your phone, tablet, or computer.

**3**

### **SPEAK WITH A PROVIDER AND GET TREATMENT**

Your Walmart Health provider will review your chart, ask questions, and recommend a treatment plan.

**855.636.3669**[www.memd.me/chat](http://www.memd.me/chat)



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](https://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](https://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.

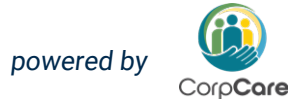
## NO COST ACUTE DRUG FORMULARY COVERS DRUGS LIKE

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

*Included benefit in  
MEC and Preferred  
plans*



# EMPLOYEE ASSISTANCE PROGRAM



## PROVIDES AROUND-THE-CLOCK ACCESS TO LICENSED CLINICAL PROVIDERS

At CorpCare, our mission is to resolve a troubled employee's problems, manage the most effective treatment choices and monitor their progress for the most successful outcome. To accomplish these crucial goals, CorpCare has available over 11,000 professionals nationwide.

## SERVICES WE OFFER

- **24/7 Helpline**
- **Translation Services**
- **National Counselor Network**
- **Employer Services**
- **LifeAdvantage Website**
- **Legal Services**
- **Financial Services**
- **Eldercare/Childcare Services**

## OUTCOMES

CorpCare's Employee Assistance Program (EAP) has helped thousands of employees and dependents resolve personal problems that impact productivity, health, and relationships.

## PREVIEW THESE SERVICES

**1**

### GO TO

<http://www.corpcareeap.com/memberaccess.html>

**2**

### CLICK ON

LifeAdvantages Logo

**3**

### SIGN IN

with Username: BreckPoint

(call 1.800.728.9444 to obtain if you do not already have this information)



# 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 75 years 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](https://breckpointrx.com)

# MEC PLAN

## SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2024 - December 31, 2024

Coverage For: Employee/Family | Plan Type: Open Access

### 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 [breckpoint.linked.exchange](#) 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 [breckpoint.linked.exchange](#) 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
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?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
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?	No. You may seek treatment from any licensed physician/hospital/provider of medical services of your choice and the Plan will pay benefits for covered expenses based upon an Allowable Charge.	This plan treats providers the same in determining payment for all services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. Maximum Allowable Charges (MAC) are used as the maximum allowable charge for all provider services. The fee schedule applies to provider billing codes (CPT's, DRG's, etc.) and will cover most charges made by providers. The reimbursement schedule is 150% of the Medicare reimbursement rate for physicians and 150% of the Medicare reimbursement rate for facilities. This means the reimbursement is set at 50% more under this plan than is paid for providing the same service to a Medicare patient.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care provider's office or clinic</b>	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): <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>
	Primary care visit to treat an injury or illness	Not covered	None
	Specialist visit	Not covered	None
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	None
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.BreckpointRX.com">www.BreckpointRX.com</a>	Preventive drugs	Covered, no additional out of pocket, deductible does not apply (for preventative drugs only)	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	Discounts Available	
	Preferred brand drugs	Discounts Available	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	Discounts Available	
	Specialty drugs	Discounts Available	International & prescription assistance options. Call customer care for additional information.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
<b>If you need immediate medical attention</b>	Emergency room care	Not covered	Not covered
	Emergency medical transportation	Not covered	Not covered
	Urgent care	Not covered	Not covered
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered
	Inpatient services	Mental and Behavioral Health: Not covered Substance Abuse: Not covered	Not covered
<b>If you are pregnant</b>	Office Visits	Not covered	Unless for preventive services.
	Childbirth/delivery professional services	Not covered	Not covered
	Childbirth/delivery facility services	Not covered	Not covered
<b>If you need help recovering or have other special health needs</b>	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
<b>If your child needs dental or eye care</b>	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 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.

### 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	\$0.00
Primary Care Provider	\$0.00
Hospital (facility)	\$0.00
Other	0%
<b>This EXAMPLE event includes services like:</b> 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	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,800
The total Peg would pay is	\$12,800

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	\$0.00
Hospital (facility)	\$0.00
Other	0%
<b>This EXAMPLE event includes services like:</b> 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	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$7,400
The total Joe would pay is	\$7,400

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	\$0.00
Primary Care Provider	\$0.00
Hospital (facility)	\$0.00
Other	0%
<b>This EXAMPLE event includes services like:</b> 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	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,050
The total Mia would pay is	\$1,050

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