MEDICAL

MVP COMPLIANCE PLAN

THIS PLAN INCLUDES:	
Network	**AXA Open Access**
Out of Network Coverage	N/A
Individual Medical Deductible/Out-of-Pocket Limit	$8,700/$8,700
Family Medical Deductible/Out-of-Pocket Limit	$17,400/$17,400
Individual/Family Pharmacy Out-of-Pocket Limit	$5,000/$10,000
Preventive & Wellness Covered with no out-of-pocket expenses.	100%
Primary Care Visit	100% MAC* After Deductible **Subject to the maximum charge allowed ("MAC" or "Allowable 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 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.
- No co-pays with 24/7 Virtual Care *(Powered by Walmart Health, 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.

MONTHLY 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)	$8,700 Individual $17,400 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)	$8,700 Individual $17,400 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 Walmart Health	Included	Not applicable
Office Visits to Non-Specialist	100% of MAC after deductible*	Not applicable
Specialist Office Visits	100% of MAC after deductible*	Not applicable
Prenatal Maternity and Post-Partum Care (Office Visit)	100% of MAC after deductible*	Not applicable
Mental Health & Alcohol/Drug Abuse Services (Office Visit)	100% of MAC after deductible*	Not applicable
Maternity - Delivery	100% of MAC after deductible*	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	100% of MAC after deductible*	Not applicable
Outpatient Diagnostic X-ray (except for complex imaging services)	100% of MAC after deductible*	Not applicable
Outpatient Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET, and CT Scans)	100% of MAC after deductible*	Not applicable
Hospital Based Diagnostic Procedures	**Network Care**	**Out-Of-Network Care**
Diagnostic Laboratory	100% of MAC after deductible*	Not applicable
Diagnostic X-ray (except for complex imaging services)	100% of MAC after deductible*	Not applicable
Diagnostic X-ray for Complex Imaging Services (Including, but not limited to, MRI, MRA, PET, and CT Scans)	100% of MAC after deductible*	Not applicable
Emergency Medical Care	**Network Care**	**Out-Of-Network Care**
Urgent Care Provider	100% of MAC after deductible*	Not applicable
Emergency Room	100% of MAC after deductible*	Not applicable
Emergency Ambulance	100% of MAC after deductible*	Not applicable
Non-Emergency Ambulance	Not covered	Not applicable
Other Services and Plan Details	**Network Care**	**Out-Of-Network Care**
Hospital Care	100% of MAC after deductible*	Not applicable
Mental Health and Alcohol/Drug Abuse Services (other than office visit)	100% of MAC after deductible*	Not applicable
Skilled Nursing Facility Coverage is limited to 120 days per plan year	100% of MAC after deductible*	Not applicable
Therapy and Rehabilitation Services	100% of MAC after deductible*	Not applicable
Durable Medical Equipment	100% of MAC after deductible*	Not applicable
Mouth, Jaws, and Teeth Oral surgery procedures, medical in nature	100% of MAC after deductible*	Not applicable
Family Planning Covered only for the diagnosis and treatment of the underlying medical condition.	100% of MAC after deductible*	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	100% of MAC after deductible*	Not applicable
Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Non-Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Specialty Drugs (up to a 30 day supply) includes self-injectable, infused and oral specialty drugs, excludes isulin)	100% of MAC after deductible*	Not applicable
Mail Order Delivery (for your refills for up to a 31-90 day supply)		
Generic Drugs	100% of MAC after deductible*	Not applicable
Preferred Brand Drugs	100% of MAC after deductible*	Not applicable
Non-Preferred Brand Drugs	100% of MAC after deductible*	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.linked.exchange to log into our member portal. Claims Portal: To register and view your claims status please go to portal.breckpoint.com

***MAC or Allowable 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.

COMPLIANCE MINIMUM VALUE PLAN

SUMMARY OF BENEFITS & COVERAGE

Coverage Period: January 01, 2024 - December 31, 2024
Coverage For: Employee/Child(ren) | **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 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?	$8,700.00 individual participating providers $17,400.00 family participating providers	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care (adult & child)	For example, this plan covers certain preventive services without cost-sharing and before you meet your 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?	$8,700.00 individual participating providers $17,400.00 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?	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 125% of the Medicare reimbursement rate for physicians and 145% of the Medicare reimbursement rate for facilities. This means the reimbursement is set at 25% and 45% more under this plan than is paid for providing the same service to a Medicare patient. Any provider charge in excess of the MAC will not be a covered expense under the terms of this plan and will be the responsibility of the covered person. Allowable charges for covered services that do not have the Medicare equivalent pricing will be 45% of the billed charges.

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	No charge, 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/**
	Primary care visit to treat an injury or illness	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Specialist visit	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Chiropractic services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Imaging (CT/PET scans, MRIs)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ShieldPBM.com**	Preventive drugs	At pharmacy & mail order: No charge, deductible does not apply	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 Shield PBM.
	Generic drugs	At pharmacy: No charge after deductible, balance over MAC is not eligible Mail order: No charge after deductible, balance over MAC is not eligible	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 Shield PBM. You are responsible for provider charges over MAC.
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs	No charge after dedcutible, balance over MAC is not eligible	Covers up to a 30 day supply (retail). Mail order is not covered. Call Shield PBM or visit their website for more information. You are responsible for provider charges over MAC.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Physician/surgeon fees	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need immediate medical attention	Emergency room care	For medical emergency: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Emergency medical transportation	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Urgent care	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Physician/surgeon fees	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental and Behavioral Health: Office visits: No charge after deductible, balance over MAC is not eligible Intermediate care: No charge after deductible, balance over MAC is not eligible Substance Abuse: Office visits: No charge after deductible, balance over MAC is not eligible Intermediate care: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Inpatient services	Mental and Behavioral Health: No charge after deductible, balance over MAC is not eligible Substance Abuse: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
If you are pregnant	Office Visits	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Childbirth/delivery professional services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Childbirth/delivery facility services	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Rehabilitation services	Occupational Therapy OR Speech Therapy OR Physical Therapy: No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Habilitation services	No charge after deductible, balance over MAC is not eligible	Services are limited to 20 visits per covered person per year. You are responsible for provider charges over MAC.
	Skilled nursing care	No charge after deductible, balance over MAC is not eligible	Limited to 120 days beginning no later than 14 days after a 3 day hospital confinement. You are responsible for provider charges over MAC.
	Durable medical equipment	No charge after deductible, balance over MAC is not eligible	You are responsible for provider charges over MAC.
	Hospice service	No charge after deductible, balance over MAC is not eligible	Terminal illness with death expectancy in 6 months or less. You are responsible for provider charges over MAC.
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
- Cosmetic surgery
- Dental care (adult & child) unless mandated by the Affordable Care Act
- Experimental treatments or procedures
- 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
- 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.)

- Chiropractic care
- Habilitation Services limited to 20 visits per covered person per/year
- Temporomandibular Joint Dysfunction Syndrome (TMJ)

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? Yes. 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	**$8,700.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
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	$8,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,700**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$8,700.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
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	$7,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
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	**$8,700.00**
Primary Care Provider coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
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	$1,050
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

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