



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, www.fivepointsbenefitplans.com. 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 www.fivepointsmecplans.com or call 1-800-521-7244 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 Student \$0 Dependents	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. This plan does not have an overall deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	Yes. Maternity \$5,000. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$7,350 Student	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 , balance-billing charges, penalties, 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. See www.firsthealth.com or call 1-800-226-5116 for a list of network providers.	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 a out-of-network provider , and you might receive a bill from a provider for the difference between the p r o v i d e r's charge and what your plan pays (balance billing). 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.
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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% of allowable charge, per visit	Not Covered	None
	Specialist visit	40% of allowable charge, per visit	Not Covered	Includes behavioral health medication management visits.
	Preventive care/screening/immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% of allowable charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% of allowable charge	Not Covered	You are responsible for the first 40% of the eligible, expense except for preventive .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-356-3477	Generic drugs	\$7/prescription 40% co-insurance of allowable charge	Not Covered	For retail prescriptions a copayment will be collected for each 30 day supply. 90 day Mail order supply subject to a one time copayment.
	Preferred brand drugs	\$20/prescription 40% co-insurance of allowable charge	Not Covered	For retail prescriptions a copayment will be collected for each 30 day supply. 90 day Mail order supply subject to a one time copayment.
	Non-preferred brand drugs	\$45/prescription 40% co-insurance of allowable charge	Not Covered	For retail prescriptions a copayment will be collected for each 30 day supply. 90 day Mail order supply subject to a one time copayment.
	Specialty drugs	40% of allowable charge	Not Covered	For retail prescriptions a copayment will be collected for each 30 day supply. 90 day Mail order supply subject to a one time copayment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% of allowable charge	Not Covered	Out-of-network 100% patient responsibility
	Physician/surgeon fees	40% of allowable charge	Not Covered	None
If you need immediate medical attention	Emergency room care	<u>Medically Necessary</u> 40% of allowable charge	<u>Medically Necessary</u> 40% of allowable charge	Based on medical necessity
	Emergency medical transportation	Medically Necessary 40% of allowable charge	Not Covered	Based on medical necessity
	Urgent care	40% of allowable charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% of allowable charge	Not Covered	Prior approval required. Benefits will be reduced by \$ 200.00 if pre-admission review is not obtained, and a Participant is hospitalized as an Inpatient.
	Physician/surgeon fees	40% of allowable charge	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% of allowable charge 20 visits per calendar year	Not Covered	Out-of-network 100% patient responsibility. 20 visits per calendar year.
	Inpatient services	40% of allowable charge 45 days per calendar year	Not Covered	Pre-certification by Five Points Benefit Plan is required before benefits are payable. Prior approval required in inpatient services. Benefits will be reduced by \$ 200.00 if pre-admission review is not obtained and does not apply towards <u>deductible</u> or <u>coinsurance</u> . Out-of-network 100% patient responsibility. 45 days per calendar year.
If you are pregnant	Office visits	40% of allowable charge, per visit	Not Covered	Cost sharing does not apply for <u>preventive services</u>
	Childbirth/delivery professional services	40% of allowable charge, per visit	Not Covered	\$5,000 <u>deductible</u>
	Childbirth/delivery facility services	40% of allowable charge, per visit	Not Covered	\$5,000 <u>deductible</u>
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not Covered	Out-of-network 100% patient responsibility. Pre-certification by Five Points Benefit Plan is required before benefits are payable. Prior approval required in inpatient services. Benefits will be reduced by \$ 200.00 if pre-admission review is not obtained.
	<u>Rehabilitation services</u>	40% of allowable charge, per visit	Not Covered	Out-of-network 100% patient responsibility. Inpatient 45 days per calendar year, outpatient 20 visits per calendar year.
	<u>Habilitation services</u>	40% of allowable charge, per visit	Not Covered	Out-of-network 100% patient responsibility. Inpatient 45 days per calendar year, outpatient 20 visits per calendar year.
	<u>Skilled nursing care</u>	40% of allowable charge, per visit	Not Covered	Out-of-network 100% patient responsibility.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	40% of allowable charge	Not Covered	Oxygen/respiratory equipment is covered at 60% in-network. Prior authorization required for continuous glucose monitoring systems in our <u>network</u> . Out-of-network 100% patient responsibility.
	Hospice services	No charge	Not Covered	For inpatient services, see If you have a Hospital stay. Pre-certification by Five Points Benefit Plan is required before benefits are payable. Prior approval required. Benefits will be reduced by \$200.00 if pre-admission review is not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Two vision exam per calendar year
	Children's glasses	No charge	No charge	One frame, one pair of lenses, or contact lenses (as needed) per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No charge	No charge	Two oral exams per year.

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](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services.) This isn't a complete list. (Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing

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). For more information on your rights to continue coverage, contact the [plan](#) at 1-214-434-0109. 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: Five Points Benefit Plans Client Services at 1-800-521-7244. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-44-3272 or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may be eligible for [premium tax Credit](#).

Does this plan meet the Minimum Value Standards? Not applicable

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-7244.

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
- [Specialist](#) [coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles *	\$5,000
Copayments	\$0
Coinsurance	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$8,200

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:
[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,040

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [coinsurance](#) 40%
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

This plan has other deductibles* for specific services included in this coverage example. See Are there other deductibles for specific services? Row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.