**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<br>$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 form a provider for the difference between the p ro vide 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 | Medically Necessary 40% of allowable charge | Medically Necessary 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<br>20 visits per calendar year | Not Covered | Out-of-network 100% patient responsibility. 20 visits per calendar year. |
| | Inpatient services | 40% of allowable charge<br>45 days per calendar year | Not Covered | Pre-certification by Sky 100 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 deductible or coinsurance. 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 preventive services |
| | Childbirth/delivery professional services | 40% of allowable charge, per visit | Not Covered | $5,000 deductible |
| | Childbirth/delivery facility services | 40% of allowable charge, per visit | Not Covered | $5,000 deductible |
| **If you need help recovering or have other special health needs** | Home health care | No charge<br>40% of allowable charge, per visit | Not Covered<br>Not Covered | Out-of-network 100% patient responsibility. Pre-certification by Sky 100 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. Out-of-network 100% patient responsibility. |
| | Rehabilitation services | 40% of allowable charge, per visit | Not Covered | Inpatient 45 days per calendar year, outpatient 20 visits per calendar year.<br>Out-of-network 100% patient responsibility. |
| | Habilitation services | 40% of allowable charge, per visit | Not Covered | Inpatient 45 days per calendar year, outpatient 20 visits per calendar year.<br>Out-of-network 100% patient responsibility. |
| | Skilled nursing care | | | |

| 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 network. 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 Sky 100 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: Sky 100s 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 polices, 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 pla n'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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $5,000 |
| Copayments | $0 |
| Coinsurance | $3,200 |
| *What isn't covered* | |
| 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $20 |
| Coinsurance | $3,000 |
| *What isn't covered* | |
| 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 | $0 |
| • Specialist coinsurance | 40% |
| • Hospital (facility) | 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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $800 |
| *What isn't covered* | |
| 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.