**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Service **Coverage Period: 01/01/2021–12/31/2021:**

**Five Points Benefit Plans, LLC - PPO Plan Coverage for: Student Health Association Plan** – **Western Tech $99**

**The Summary of Benefits and Coverage (SBC) document of your 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

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your coverage, or to get a copy of the complete terms of coverage, [www.fivepointsbenefitplans.com](http://www.fivepointsMECplan.com). For general definitions of common terms, such as allowed amount, **balance billing, coinsurance, copayment, deductible,** provider, or other underlined terms see the glossary which you can view at www.healthcare.gov/sbc-glossary, [**www.dol.gov/ebsa/pdf/SBCUnifomGlossary.com**](http://www.dol.gov/ebsa/pdf/SBCUnifomGlossary.com) **or** call 1-866-882-2034 to request a copy.

# Important Questions Answers Why This Matters:

**Generally, you must pay all of the costs from providers up to the deductible amount before his**

# What is the overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)?

**Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?**

**Are there other**  **$500 Prescription**

**$5,000 Maternity**

**Yes**

**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. $500 deductibles for prescriptions and $5,000 deductible**

**for Maternity.**

You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for costs of services for this plan.

# [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services?

**Yes** $500 for Prescriptions and $5,000 for Maternity.

# What is the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) for this [plan](https://www.healthcare.gov/sbc-glossary/#plan)?

**What is not included in**

**the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?**

**Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?**

**No out-pocket-limit**

**Premiums and health care this plan doesn’t cover.**

**Yes. See www.firsthealth.com or call 1-800-226-5116 for a list of network providers**.

**No out-pocket-limit**

Even though you pay these expenses, they do not count toward the out-of-pocket limit.

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). 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to No** The most you will pay is 40% and the co-payment to see a **specialist** but only In-network.

see a **specialist?**

|  |
| --- |
|  |

**1 of 6**

All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance)  costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Common Medical Event** | **Services You May Need** | **What You WillPay** | | **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**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care (PCP) visit to treat an injury or illness | 40% and a $25 co-pay | 100% Member Responsibility | 40% and a $25 co-pay |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | 40% and a $75 co-pay | 100% Member Responsibility | Includes behavioral health medication management visits. Primary Care Physician (PCP) referral is NOT required for most specialty care. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)[/screening](https://www.healthcare.gov/sbc-glossary/#screening)/ immunization | No charge – 100% Covered | 100% Member Responsibility | 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](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 40% and a $75 co-pay | 100% Member Responsibility | **You are responsible for the first 40% and co-pay of the eligible expense. Prior authorization Required.** |
| Imaging(CT/PET scans, MRIs) | 40% and a $150 co-pay | 100% Member Responsibility | **You are responsible for the first 40% and co-pay of the eligible expense. Prior authorization Required.** |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.optumrx.com](http://www.optumrx.com/) | Generic drugs | $7/prescription retail;  $14/prescription mail-order | 100% Member Responsibility | $500 Deductible Applies. |
| Preferred brand drugs | $20/prescription retail;  $50/prescription mail-order |
| Non-preferred brand drugs | $45/prescription retail;  $110/prescription mail-order |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Visit [www.optumrx.com](http://www.optumrx.com/) for details. |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility | Prior approval required for in-network. If prior approval is not received you are responsible100%. **40% and a $200 co-pay, up to $1,000 per day 2 day max.** |
| Physician/surgeon fees | **40% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | **40% and a $100 co-pay, $150 max benefit, 1 visit per year** | 100% Member Responsibility | **40% and a $100 co-pay, $150 max benefit, 1 visit per year** |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | Not Covered. | 100% Member Responsibility | Not Covered. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | **40% and a $75 co-pay** | 100% Member Responsibility | **40% and a $75 co-pay** |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **40% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility | Prior approval required for in-network. If prior approval is not received you are responsible100%. **40% and a $200 co-pay, up to $1,000 per day 2 day max.** |
| Physician/surgeon fees | **40% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **40% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility | Prior approval required for in-network-providers **40% and a $200 co-pay, up to $1,000 per day 2 day max.** |
| Inpatient services | **40% and a $200 co-pay, up to $1,000 per day 2 day max.** | 100% Member Responsibility | Prior approval required for in-network-providers **40% and a $200 co-pay, up to $1,000 per day 2 day max.** |
| **If you are pregnant** | Office visits | **40% and a $35 co-pay.** | 100% Member Responsibility | **40% and a $35 co-pay.** |
| Childbirth/delivery professional services | **40% and a $5,000 deductible.** | 100% Member Responsibility | **40% and a $5,000 deductible.** |
| Childbirth/delivery facility services | **40% and a $5,000 deductible.** | 100% Member Responsibility | **40% and a $5,000 deductible.** |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 100% Member Responsibility | 100% Member Responsibility | Not Covered. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **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 help recovering or have other special health needs** |  |  |  |  |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Not Covered. | 100% Member Responsibility | Not Covered. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | Not Covered. | 100% Member Responsibility | Not Covered. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | Not Covered. | 100% Member Responsibility | Not Covered. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | Not Covered | 100% Member Responsibility | Not Covered. |
| **If your child needs dental or eye care** | Children’s eye exam | Not Covered | 100% Member Responsibility | Not covered |
| Children’s glasses | Not Covered | Not covered | Not covered |
| Children’s dental check-up | Not Covered | Not covered | Not covered |

# Excluded Services & Other Covered Services:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services Your Gold** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Does NOT Cover (Check your policy or plan document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | | | |
| * Cosmetic Surgery * Weight loss programs |    | Long-term care Private-duty nursing |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document. Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Does NOT Cover** | | | | |
| * Acupuncture * Bariatric surgery * There is no coverage outside the Continental US |    | Hearing aids (limited to member sage19 or younger)  Infertility treatment  Non-emergency care when travelling outside the US |  |  |

**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 Five Points Benefit Plans, LLC at 1-915-803-4198. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: Five Points MEC Plan Member LLC Services at 1-915-803-4198. You may also contact the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or visit their website at [www.dol.gov/ebsa/healthreform.](http://www.dol.gov/ebsa/healthreform) Additionally, a consumer assistance program can help you file your appeal.

# Does this plan provide Minimum Essential Coverage? Yes

If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#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 Standards? No

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

# Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-915-803-4198.

––––––––––––––––––––––*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](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical are. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles,](https://www.healthcare.gov/sbc-glossary/#deductible) [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans.](https://www.healthcare.gov/sbc-glossary/#plan) 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)

**Managing Joe’s type 2Diabetes**

(a year of routine in-network care of a well-controlled condition)

**Veronica’s Simple Fracture**

(in-network emergency room visit and follow up care)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$5,000** | * **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$0** | * **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$0** |
| * [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***copayment*** | **$0** | * [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***copayment*** | **$75** | * [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) ***copayment*** | **$75** |
| * **Hospital(facility) Out Patient Only** | **$0** | * **Hospital(facility)** | **40%** | * **Hospital (facility) – Out Patient Only** | **40%** |
| * **Other *cost share*** | **40%** | * **Other *cost share*** | **40%** | * **Other *cost share*** | **40%** |

**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)*

**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)*

**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**

**$12,730**

**Total Example Cost**

**$7,400**

**Total Example Cost**

**$1,920**

# In this example, Peg would pay:

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

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $5,000 |
| Copayments | $0 |
| Coinsurance\*\* | 40% |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The Most Peg would pay is** | **$8,092 less** |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | **$75** |
| Coinsurance | 40% |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,035** |

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | **$75** |
| Coinsurance | 40% |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Veronica would pay is** | **$843** |