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 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 which you can view at www.healthcare.gov/sbc-glossary, **www.dol.gov/ebsa/pdf/SBCUnifomGlossary.com or** call 1-866-882-2034 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500 Student** **$500 Dependent (s)**	Generally, you must pay all of the costs from providers up to the deductible amount before his 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?	**There is a $500 Deductible**	**You have to meet $500 deductible for prescription drug coverage on page 2.**
Are there other deductibles for specific services?	**YES**	You have a $500 OTUM RX to meet **deductible** for PRESCRIPTION services.
What is the out-of-pocket limit for this plan?	**No out-pocket-limit**	There is No out-pocket-limit for this plan.
What is not included in the out-of-pocket limit?	**Premiums and health care this plan doesn't cover.**	Even though you pay these expenses, they do not 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 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 to see a specialist?	No	The most you will pay is 40% to see a **specialist** for covered services but only In-network.

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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care (PCP) visit to treat an injury or illness	40% or less	100% Member Responsibility	None
	Specialist visit	40% or less coinsurance	100% Member Responsibility	Includes behavioral health medication management visits, Primary Care Physician (PCP) referral is NOT required for most specialty care. *
	Preventive care/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 other than (x-ray, blood work, labs)	40% or less coinsurance	100% Member Responsibility	$150 max per day, Prior Authorization required for any scheduled service that is over $500.
	Imaging (CT/PET scans, MRIs)	40% or less coinsurance	100% Member Responsibility	You are responsible for the first 40% of the eligible expense. Prior authorization Required. Up to $150 per visit, 1 visit per year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$7/prescription retail; $14/prescription mail-order	100% Member Responsibility	**There is $500 Annual Deductible.**
	Preferred brand drugs	$20/prescription retail; $50/prescription mail-order		
	Non-preferred brand drugs	$45/prescription retail; $110/prescription mail-order		
	Specialty drugs	Visit www.optumrx.com for details.		

*Prior Authorization required for any single scheduled service that is over $500

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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 in or outpatient surgery	Facility fee (e.g., ambulatory, surgery center)	Not Covered	100% Member Responsibility	Not Covered
	Physician/surgeon fees	Not Covered	100% Member Responsibility	
If you need immediate medical attention	Emergency room care	Not Covered	100% Member Responsibility	Not Covered
	Emergency medical transportation	Not Covered	100% Member Responsibility	Not Covered
	Urgent care	40% or less coinsurance	100% Member Responsibility	Up to $150 per visit, 1 visit per year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	100% Member Responsibility	Not Covered
	Physician/surgeon fees	Not Covered	100% Member Responsibility	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% or less coinsurance	100% Member Responsibility	Prior approval required for in-network-providers
	Inpatient services	Not Covered	100% Member Responsibility	Not Covered
If you are pregnant	Office visits (OBGYN Only)	40% Member Responsibility	100% Member Responsibility	Up to $150 per visit, 1 visit per year.
	Childbirth/delivery professional services	Not Covered	100% Member Responsibility	Not Covered
	Childbirth/delivery facility services	Not Covered	100% Member Responsibility	Not Covered
If you need help recovering or have other special health needs	Home health care	Not Covered	100% Member Responsibility	Not Covered

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	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Rehabilitation services	Not Covered	100% Member Responsibility	Not Covered
	Habilitation services			
	Skilled nursing care	Not Covered	100% Member Responsibility	Not Covered
	Durable medical equipment	Not Covered	100% Member Responsibility	Not Covered
	Hospice services	Not Covered	100% Member Responsibility	Not Covered
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	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 Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Cosmetic Surgery • Weight loss programs	• Long-term care • Private-duty nursing

Please see your plan document.	Your 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. 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 MEC Plan, LLC Member Services at 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. 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 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 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 1-915-803-4198.

——————————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 might cover medical are. 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)

- Not Covered $0
- Not Covered $0
- Not Covered $0
- Not Covered $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	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,730
The Most Peg would pay is	**$12,730**

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

- **The plan's overall deductible** $0
- **Specialist** ***copayment*** $0
- **Hospital(facility) – Out Patient Only** 40%
- **Other** ***cost share*** 40%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	40%
What isn't covered	
Limits or exclusions	$4,440
The total Joe would pay is	**$2,960**

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

- **The plan's overall deductible** $0
- **Specialist** ***copayment*** $0
- **Hospital (facility) – Out Patient Only** 40%
- **Other** ***cost share*** 40%

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	**$1,920**

In this example, Veronica would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	40%
What isn't covered	
Limits or exclusions	$1,152
The total Veronica would pay is	**$768**