Summary of Benefits and Coverage: What This Plan Covers & What You Pay For Covered Service

Five Points Health Benefit Plans, LLC - PPO Plan

Coverage Period: 01/01/2024-12/31/24

Coverage for: Student Health Association Plan – Basic $75

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 Prescription**	Generally, you must pay all of 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**	You have to meet a deductible for specific service.
Are there other deductibles for specific services?	**Yes**	**$500 OptumRx Deductible.**
What is the out-of-pocket limit for this plan?	**No out-of-pocket limit.**	
What is not included in the out-of-pocket limit?	**Premiums and health care this plan doesn't cover.**	N/A
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% of the contracted rate to see a specialist for covered services, but only In-network.

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 (PCP) visit to treat an injury or illness**	**40% or less coinsurance.**	**100% Member Responsibility**	**Unlimited Visits Per Year**
	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. 1 visit per Calendar Year.**
	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**	**Unlimited Visits Per Year**
	Imaging (CT/PET scans, MRIs)	**40% or less coinsurance.**	**100% Member Responsibility**	**Max Benefit: $150 Annually**
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	**Generic drugs**	**$2 Co-Pay with No Deductible**	**100% Member Responsibility**	**$500 annual deductible** **Up to $300 Per Month Max Per Drug**
	Preferred brand drugs	**40% Coinsurance, after annual deductible is met**		
	Non-preferred brand drugs	**40% Coinsurance, after annual deductible is met**		
	Specialty drugs	**40% Coinsurance, after annual deductible is met**		
If you have in or outpatient surgery	**Facility fee** (e.g., ambulatory, surgery center).	**Not Covered**	**100% Member Responsibility**	**N/A**
	Physician/surgeon fees.	**Not Covered**	**100% Member 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)	
If you need immediate medical attention	Emergency room care	Not Covered	100% Member Responsibility	Up to $150 per visit. 1 visit per Calendar Year
	Emergency medical transportation	Not Covered	100% Member Responsibility	None
	Urgent care	40% or less coinsurance.	100% Member Responsibility	Max Benefit: $150 Annually
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
	Inpatient Services	Not Covered	100% Member Responsibility	
If you are pregnant	Office visit	40% Member Responsibility	100% Member Responsibility	Specialist Visit (OB/GYN). 1 Visit Per Year
	Childbirth/Delivery Professional Services	Not Covered	100% Member Responsibility	N/A
	Childbirth/Delivery Facility Services	Not Covered	100% Member Responsibility	N/A

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 to see a doctor without leaving your home	24/7 Telemedicine (Teladoc)	FREE for the entire family	100% Member Responsibility	Unlimited Access to doctors 24/7
If your child needs dental or eye care	Children's eye exam	Not Covered	100% Member Responsibility	N/A
	Children's glasses	Not Covered	100% Member Responsibility	N/A
	Children's Dental Check-up	Not Covered	100% Member Responsibility	N/A
If you need help recovering or have other special health needs	Home health care	Not Covered	100% Member Responsibility	Not Covered
	Rehabilitation services	Not Covered	100% Member Responsibility	Not Covered
	Habilitation services	Not Covered	100% Member Responsibility	Not Covered
	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

Excluded Services & Other Covered Services

Services Your Student Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Long-term Care
- Acupuncture
- Bariatric Surgery
- Hearing Aids (limited to members age 19 or younger)
- Weight Loss Programs
- Private Duty Nursing
- Infertility Treatment
- Coverage Outside the US (Except Telemedicine)

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 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. 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?

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.

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.

Dave Has Strep Throat (in-network primary care visit)	
Deductible	**$0**
Copay	**$25**
Coinsurance	**40%**
This EXAMPLE event includes:	
- Primary Care doctor visit	
Total Billed Amount For Services:	**$223.00**
Repriced Contracted Rate:	**$86.97**
Plan Responsibility:	**$37.18**
In this example, Dave would pay:	**$24.79**

Joe Needs an X-Ray (in-network x-ray of shoulder)	
Deductible	**$0**
Copay	**$75**
Coinsurance	**40%**
This EXAMPLE event includes:	
- Diagnostic tests (x-ray)	
Total Cost For Services:	**$88.80**
Repriced Contracted Rate:	**$33.78**
Plan Responsibility:	**$20.26**
In this example, Joe would pay:	**$13.52**

Veronica Goes to Urgent Care (in-network urgent care visit)	
Deductible	**$0**
Copay	**$75**
Coinsurance	**40%**
This EXAMPLE event includes:	
- Urgent Care Visit - IV Hydration - Injections - Diagnostic Tests (Urinalysis)	
Total Cost For Services:	**$384.00**
Repriced Contracted Rate:	**$124.95**
Plan Responsibility:	**$29.97**
In this example, Veronica would pay:	**$19.98**