

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, visit 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.fivepointsbenefitplans.com or call 1-915-803-4198 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 Optum Rx Only	You must pay all of the costs from OptumRx 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 only OptumRx.
Are there other deductibles for specific services?	Yes	\$500 OptumRx Deductible Only
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.	No 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	You can see the specialist you choose without a referral (PPO Plan).

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	\$10 Copay	100% Member Responsibility	Unlimited Visits Per Year
	Specialist visit	\$15 Copay	100% Member Responsibility	Includes behavioral health medication management visits. Primary Care Physician (PCP) referral is NOT required. Unlimited Visits Per Year
	Preventive care/screening/immunization	No Charge – 100% Covered	100% Member Responsibility	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Annual Exam Per Year
If you have a test	Diagnostic test * (x-ray, labs) *Hospital Excluded	\$10 Copay	100% Member Responsibility	Unlimited Visits Per Year
	Imaging* (CT/PET scans, MRIs) *Hospital Excluded	\$150 Copay	100% Member Responsibility	2 Visits Per Year, Max Benefit \$400 Per Visit
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	\$10 Copay with No Deductible	100% Member Responsibility	\$500 annual deductible Up to \$300 Per Month Max Per Drug
	Preferred brand drugs	40% Coinsurance with Deductible		
	Non-preferred brand drugs	40% Coinsurance with Deductible		
	Specialty drugs	40% Coinsurance with Deductible		

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	\$150 Copay	100% Member Responsibility	5 Visits Per Calendar Year \$200 Max Benefit Per Visit
	Emergency medical transportation	Not Covered	100% Member Responsibility	Not Covered
	Urgent care	\$75 Copay	100% Member Responsibility	Unlimited Visits
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 Copay	100% Member Responsibility	3 Days Max Visits \$300 Max Benefit Per Day
	Physician/surgeon fees		100% Member Responsibility	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	100% Member Responsibility	Not Covered
	Inpatient services	\$200 Copay	100% Member Responsibility	3 Days Max Visits \$300 Max Benefit Per Day
If you are pregnant	Office visits	\$15 Copay	100% Member Responsibility	Regular Specialist Visit (OB/GYN) Unlimited Visits
	Childbirth/delivery professional services	\$200 Copay	100% Member Responsibility	3 Days Max Visits \$300 Max Benefit Per Day
	Childbirth/delivery facility services		100% Member Responsibility	
If you have in or outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 Copay (Inpatient) \$150 Copay (Outpatient)	100% Member Responsibility	2 Days Max Per Calendar Year \$200 Max Benefit Per Day
	Physician/surgeon fees		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 your child needs dental or eye care	Children’s eye exam	\$15 Copay	100% Member Responsibility	Unlimited Visits
	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 **Plan** Generally 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) | • Routine Foot Care |
| • Dental care (adult) | | | | |

Your Rights to COBRA Coverage

Five Points can help you if you want to continue your coverage after it ends. For more information on your rights to COBRA coverage, contact your human resources department or 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

The 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 Health Benefit Plans, LLC Member 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 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.

**Dave Has a Sore Throat
(In-Network Primary Care Visit)**

Deductible **\$0**
Copay **\$10**
Coinsurance **0%**

This EXAMPLE event includes services like:

Primary Care Doctor Visit

**Joe Needs an X-Ray
(In-Network X-Ray of Shoulder)**

Deductible **\$0**
Copay **\$10**
Coinsurance **0%**

This EXAMPLE event includes services like:

Diagnostic Tests (X-Ray)

**Veronica Goes to Urgent Care
(In-Network Urgent Care Visit)**

Deductible **\$0**
Copay **\$75**
Coinsurance **0%**

This EXAMPLE event includes services like:

Urgent Care Visit
 IV Hydration
 Injections
 Diagnostic Tests (Urinalysis)

Total Billed Amount For Services:	\$223.00
Repriced Contracted Rate:	\$86.97
Plan Responsibility:	\$76.97
The total Dave would pay is	\$10.00

Total Billed Amount For Services:	\$88.00
Repriced Contracted Rate:	\$33.78
Plan Responsibility:	\$23.78
The total Joe would pay is	\$10.00

Total Billed Amount for Services	\$384.00
Repriced Contracted Rate:	\$124.95
Plan Responsibility:	\$49.95
The total Mia would pay is	\$75.00