



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.fivepointsbenefitplans.com or call 1-800-521-7244 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 Optum Rx Only	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>Plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes	You have to meet a <u>deductible</u> for specific service.
Are there other <u>deductibles</u> for specific services?	Yes	\$500 OptumRx <u>Deductible</u> Only.
What is the <u>out-of-pocket limit</u> for this plan?		No <u>out-of-pocket limit</u>.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.firsthealth.com or call 1-800-226-5116 for a list of network providers.	This plan uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware your network <u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a specialist?	No	You can see the specialist you choose without a referral.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Five Points Benefit Plans: First Health PPO

Coverage Period: 01/01/2021-12/31/2021
Coverage for: Employer US Only Plan - \$75 | Plan Type: PPO

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	\$25 Co-Pay 40% Co-insurance	100% Member Responsibility	Unlimited Visits Per Year
	Specialist visit	\$75 Co-Pay 40% Co-insurance	100% Member Responsibility	Includes behavioral health medication management visits. Primary Care Physician (PCP) referral is NOT required for most specialty care. Unlimited Visits Per 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. 1 Annual Exam Per Year
If you have a test	Diagnostic test other than (x-ray, blood work, labs)	\$75 Co-Pay 40% Coinsurance	100% Member Responsibility	Unlimited Visits Per Year (Hospital Excluded)
	Imaging (CT/PET scans, MRIs)	\$150 Co-Pay 40% Coinsurance	100% Member Responsibility	Unlimited Visits Per Year (Hospital Excluded)
If you need drugsto treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	\$10 Co-Pay with <u>Deductible</u>	100% Member Responsibility	\$500 annual <u>deductible</u> Up to \$300 Per Month Max Per Drug
	Preferred brand drugs	40% Coinsurance with <u>Deductible</u>		
	Non-preferred brand drugs	40% Coinsurance with <u>Deductible</u>		
	<u>Specialty drugs</u>	40% Coinsurance with <u>Deductible</u>		

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		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	Not Covered
	Emergency medical transportation	Not Covered	100% Member Responsibility	Not Covered
	Urgent care	\$100 Co-Pay 40% Coinsurance	100% Member Responsibility	Unlimited Visits
If you have a hospital stay	Facility fee (e.g., hospital room).	\$200 Co-pay 40% Coinsurance	100% Member Responsibility	1 Day Max Annually \$100 Max Benefit Per Day
	Physician/surgeon fees.		100% Member Responsibility	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	\$150 Co-Pay 40% Coinsurance	100% Member Responsibility	1 Day Max Annually \$200 Max Benefit
	Inpatient Services	\$200 Co-pay 40% Coinsurance	100% Member Responsibility	
If you are pregnant	Office visit	\$25 Co-Pay 40% Coinsurance	100% Member Responsibility	Specialist Visit (OB/GYN). Unlimited Visits
	Childbirth/Delivery Professional Services	Not Covered	100% Member Responsibility	Not Covered
	Childbirth/Delivery Facility Services		100% Member Responsibility	
If you have in or outpatient surgery	Facility fee (e.g., ambulatory, surgery center).	Not Covered	100% Member Responsibility	Not Covered
	Physician/surgeon fees.		100% Member Responsibility	

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		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 Complete Care 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 |
| • Chiropractic Care | • Routine eye care (adult) | • Dental care (adult) | • Long-term care | |

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 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	\$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:	\$49.79

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:	\$0.00
In this example, Joe would pay:	\$33.78

Veronica Goes to Urgent Care (in-network urgent care visit)	
Deductible	\$0
Copay	\$100
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:	\$14.97
In this example, Veronica would pay:	\$109.98