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 1-800-521-7244 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**	***No Deductible for Generic, $500 OptumRx Deductible Only for Tier II, III, & IV**
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).

*No Deductible for Generic/Tier I, $500 OptumRx Deductible Only for Tier II, II, & IV

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 – Tier II, III, & IV Only **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		

**No Deductible for Generic/Tier I, $500 OptumRx Deductible Only for Tier II, II, & IV

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

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

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)

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

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	**$384.00**
Repriced Contracted Rate:	$124.95
Plan Responsibility:	$49.95
The total Mia would pay is	**$75.00**