**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/college-health-plans / or by calling 1-915-803-4198. 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.healthcare.gov/sbc-glossary/ or call 1-915-803-4198 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For each Plan Year, In-Network: individual $200 Out-of-Network: individual $500. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. preventive care; plus In-network office visits and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: individual $5,000.Out-of-Network: individual: Unlimited | The out–of–pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.fivepointsbenefitplans.com or call 1-915-803-4198 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. |

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 | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 visit to treat an injury or illness | $30 copay/visit | 50% coinsurance | None |
| | Specialist visit | $30 copay/visit | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No your charge | 50% coinsurance | 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 (x-ray, blood work) | 10% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at fivepointsbenefitplans.com | Generic drugs | $15 copay/prescription deductible doesn't apply | 50% coinsurance after $15 copay/prescription deductible doesn't apply | Covers 30 day supply (retail). 31-90 day supply may be available. Includes contraceptive drugs & devices obtainable from a pharmacy. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Prescriptions above $250 require Preauthorization. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Preferred brand drugs | 30% coinsurance | 50% coinsurance after $20 copay/prescription deductible doesn't apply | |
| | Non-preferred brand drugs | 40% coinsurance | 50% coinsurance after $70 copay/prescription deductible doesn't apply | |
| | Specialty drugs | 50% coinsurance | 50% coinsurance after $100 copay/prescription deductible doesn't apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance, after $100 copay/visit deductible doesn't apply | 50% coinsurance, after $100 copay/visit deductible doesn't apply | Services must be provided in a free-standing facility. Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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 | $250 copay/visit (waived if admitted) | $250 copay/visit (waived if admitted) | No coverage for non-emergency use. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | $50 copay/visit | 50% coinsurance | No coverage for non-urgent use |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Preauthorization required for non-maternity/non-accidental condition. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/visit (office visit), 10% coinsurance (other outpatient services) | 50% coinsurance (office visit and other outpatient services) | Preauthorization required for other outpatient services and inpatient services. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Inpatient services | 10% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | No charge | 50% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) |
| | Childbirth/delivery professional services | 10% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 50% coinsurance | Within 10 days from discharge. Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Rehabilitation services | 10% coinsurance | 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. Inpatient: maximum 45 days/ Outpatient: maximum 20 visits allowed per calendar year |

| Common Medical Event | Services You May Need | What You Will Pay<br>In-Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Habilitation services | 10% coinsurance | 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. Inpatient: maximum 45 days, Outpatient: maximum 20 visits allowed per calendar year |
| | Skilled nursing care | 10% coinsurance | 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| | Durable medical equipment | 10% coinsurance | 50% coinsurance | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 10% coinsurance | 50% coinsurance | Preauthorization required. Failure to obtain preauthorization may result in denied coverage or up to $400 penalty. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 50% coinsurance | Coverage limited to one exam/plan year up to age 19. |
| | Children's glasses | No charge | 50% coinsurance | Coverage limited to one pair of glasses or lenses/plan year up to age 19. |
| | Children's dental check-up | No charge | 50% coinsurance | Limited to 2 exams per policy year. |

**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
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture – limited to 6 visits combined with other alternative care services
- Bariatric surgery
- Chiropractic care- limited to 6 visits per benefit period
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing – inpatient only
- Infertility treatment

**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: U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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 Benefit LLC at 1-915-803-4198.

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Not applicable.**
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.

***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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$11,500** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $40 |
| Coinsurance | $1,126 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,366** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$4,700** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $500 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,100** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 10% |
| Other coinsurance | 10% |

**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** | **$2,500** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $200 |
| Copayments | $250 |
| Coinsurance | $205 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$650** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Non-Discrimination:

Five Points Benefit complies with applicable Federal civil rights law and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aid/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting the Civil Rights Coordinator.

Civil Right Coordinator,

6006 N Mesa St 108, El Paso, TX 79912

Tel: 1-915-803-4198/ Fax: 915-519-0261

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaints Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F , HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697(TDD).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-915-803-4198