Cost Summary

Annual Deductible	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	$200	$500
Family	$400	$1,000

Out-of-Pocket Maximum	In-Network (Participating)	Out-of-Network (Non-Participating)
Individual	$7,000	$14,000
Family	$14,000	$28,000

Coinsurance (After Deductible)		
Member Pays	10% (Member Coinsurance after Deductible)	40% (Member Coinsurance after Deductible, UCR)
Coinsurance at Student Health Center	Covered in Full (100%)	Not Applicable
Overall Policy Maximum Benefit	No Limit	No Limit

Schedule of Benefits

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Preventive Care Services			
Routine Physical Exam (see Preventive Care Guide)	No	Covered in Full (No Copay)	No Benefit
Routine Care Immunizations (see CDC Guideline)	No	Covered in Full (No Copay)	40% Coinsurance after Ded. (UCR)
Tuberculosis Screening (TB), Titers, QuantiFERON B	No	Covered in Full (No Copay)	Not Covered
Emergency Services | Any provider may be used for a true emergency, no penalty			
Emergency Room Facility & Services (non-emergency reduced 50%; waived if admitted)	No	$250 Copay + 10% Coinsurance after Ded.	$250 Copay + 10% Coinsurance after Ded.
Emergency Ambulance (Ground/Air/Water)	No	10% Coinsurance after Ded.	10% Coinsurance after Ded.
Urgent Care Center	No	$50 Copay + 10% Coinsurance after Ded.	$50 Copay + 40% Coinsurance after Ded. (UCR)
Non-Emergency Ambulance Expense (Ground Transportation Only)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Inpatient Hospital Services			
Room and Board	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Intensive Care	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Hospital Miscellaneous Expenses	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Surgery | Surgeon, Anesthetist & Assistant Surgeon	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Registered Nurse's Services	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Skilled Nursing Facility Benefits	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Preadmission Test	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Organ Transplant	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Mental Health & Substance Use Disorder			
Inpatient Mental Health & Substance Use Disorder	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Outpatient Mental Health & Substance Use Disorder	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services			
Outpatient Surgery | Surgeon, Assistant & Anesthetist	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Physical Therapy (Outpatient Office Visit)	Yes	$20 Copay + 10% Coinsurance after Ded.	$20 Copay + 40% Coinsurance after Ded. (UCR)
Dental Treatment | Injury to Sound, Natural Teeth; Surgical Removal of Impacted Teeth	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Vision Care Services | Annual Retina Exam (Glaucoma/Diabetic Retinopathy)	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Office Visits			
Telehealth or Telemedicine	No	Covered in Full (No Copay, No Deductible)	Not Applicable
Physician's Office Visit | Including Specialist	No	$25 Copay + 10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Allergy Test and Treatment	No	$25 Copay + 10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Chiropractic Care (16 visits/policy year; pre-authorization required after visit 6)	Yes, after visit 6	$25 Copay + 10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Diagnostic Lab, Test and Imaging Services			
Lab Test, X-Ray & Other Tests	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Advanced Imaging Services (CT, MRI and/or PET)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Chemotherapy and Radiation Therapy	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Infusion Therapy	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Maternity and Newborn Care			
Newborn Care	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Maternity	No	10% Coinsurance after Ded. Routine prenatal preventative office visit - No charge	40% Coinsurance after Ded. (UCR)
Complication of Pregnancy	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Abortion	No	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Rehabilitative and Habilitative Services			
Cardiac Rehabilitation	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Pulmonary Rehabilitation	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Inpatient Rehabilitation Facility Expense Benefit	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Rehabilitation Therapy | PT, OT & Speech (20 visits/plan year, combined w/ Habilitation)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Habilitation Services | PT, OT & Speech (20 visits/plan year, combined w/ Rehab Therapy)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Other Covered Services			
Alternative Medicine | Acupuncture, Homeopathy, Chinese Medicine (6 visits/yr)	No	10% Coinsurance after Ded.	Not Available
Home Health Care (12 visits/plan year)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Prosthetic and Orthotic Devices	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Hospice	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Diabetic Services & Supplies (Equipment & Training)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Dialysis	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Durable Medical Equipment (Limited to one durable medical equipment for same/similar purpose; excludes repairs for misuse/abuse.)	Yes	10% Coinsurance after Ded.	40% Coinsurance after Ded. (UCR)
Pediatric Dental and Vision Care Services			
Pediatric Dental Care Benefit | Emergency, Endodontic, Prosthodontic & Necessary Orthodontic Care (through age 19)	No	30% Coinsurance (UCR)	30% Coinsurance (UCR)

Covered Services	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Pediatric Dental Preventive Care | 2 Exams/12 Months (Cleaning, Fluoride, X-ray, Space Maintainers)	No	Covered in Full (UCR)	Covered in Full (UCR)
Pediatric Vision Care Benefit | 1 Exam Covered in Full & 1 Pair of Frames or Contacts Covered in Full up to a $150 Maximum Benefit per Policy Year (through age 19)	No	Covered in Full; Frames/Contacts up to $150 Max Benefit (UCR)	No Benefit
Evacuation and Repatriation			
Medical Evacuation	Yes	Paid in Full to $100,000/Person, per Benefit Period	Paid in Full to $100,000/Person, per Benefit Period
Medical Repatriation	Yes	Paid in Full to $50,000 Lifetime/Person	Paid in Full to $50,000 Lifetime/Person
Repatriation of Mortal Remains	Yes	Paid in Full to $25,000	Paid in Full to $25,000

Pharmacy Benefits

Drug Tier	Prior Auth	In-Network Member Pays	Out-of-Network Member Pays
Retail Pharmacy — 30-day supply (must be on the plan formulary)			
Tier 1 — Preventive / Generic Rx (30-day supply only, on plan formulary)	No	**$10 Copay**	**50% Coinsurance after $15 Copay**
Tier 2 — Preferred Brand Rx (30-day supply only, on plan formulary)	No	**$30 Copay**	**50% Coinsurance after $20 Copay**
Tier 3 — Non-Preferred Brand Rx (30-day supply only; Prior Authorization may apply above $300)	May apply (above $300)	**$50 Copay**	**50% Coinsurance after $70 Copay**
Tier 4 — Specialty Rx (30-day supply only; Prior Authorization may apply above $300)	May apply (above $300)	**$100 Copay**	**50% Coinsurance after $100 Copay**

Important Notes

1. Failure to obtain required authorization may result in penalties, including a 50% reduction of allowed charges or denial of the claim.
2. In a true emergency (such as a severe injury or life-threatening condition), you may go to the nearest emergency room with no out-of-network penalty or claim denial.
3. If authorization is required following an emergency admission, it must be obtained within 48 hours or by the next business day.
4. This plan provides a 30-day Prescription Drug supply benefit only; supplies greater than 30 days at one time are not covered. Certain Prescription Drugs, including higher-cost drugs, may require Prior Authorization based on the Plan's formulary, clinical criteria, and utilization management requirements. No fixed monetary penalty applies solely because a prescription's cost exceeds $300.
5. **Electronic claims should be submitted via MBA TPA's EDI Payer ID 52682. Mailed claims should be sent to Five Points' claims address: 6006 North Mesa Street, Suite 108, Coronado Tower, El Paso, TX 79912. Claims status and customer service calls should be directed to Five Points at +1.915.803.4198.**
6. Coverage Area: USA only. This plan is not an international plan.

Monthly Premium

Student Premium (Age-Banded, Monthly)	
	Monthly Premium
Student — Age 17-24	$200.00 / month
Student — Age 25-29	$308.33 / month
Student — Age 30-45	$566.67 / month
Dependent Add-Ons (added to the student's premium above)	
+ Spouse	$1,129.17 / month
+ Child (each)	$291.67 / month
Family Add-On (Spouse + Unlimited Children combined; added to the student's premium above)	
+ Family	$2,258.33 / month

Monthly premium is based on the student's age; Spouse and/or Child are added on top of the student rate above. If adding both a Spouse and one or more Children, the combined Family Add-On rate below may be used instead of stacking the Spouse and each Child add-on individually — it is also added on top of the student rate, not a stand-alone total. Example: a 25-year-old student with a spouse pays $308.33 + $1,129.17 = $1,437.50/month. Example: a 29-year-old student (Age 25-29 band) with a spouse and two children pays $308.33 + $2,258.33 (Family Add-On) = $2,566.66/month.