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, call **877-230-3747** or go to www.pointctpa.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.pointctpa.com or call **1-866-675-3968** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,750** Individual / **$3,500** Family for Tier 1 Providers **$5,000** Individual / **$10,000** Family for Tier 2 Providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventative Care.	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	**$6,450** Individual / **$12,900** Family for **all** Tiers	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, cost containment penalties, and healthcare this plan doesn't cover.	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.pointctpa.com for a list of network providers.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Common Medical Event	Services You May Need	What You Will Pay Tier 1 (Northwell Direct Providers)	Tier 2 (Anthem Providers)	Tier 3 (Out-of-Network Providers)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Specialist visit	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	
	Preventive care/screening/ immunization	No Charge; deductible waived	Covered 100% after the deductible	Not Covered	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)	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	——————None——————
	Imaging (CT/PET scans, MRIs)	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pointctpa.com.	Generic drugs (Tier 1)	$10 copay after the deductible (retail prescriptions) $25 copay after the deductible (mail-order prescriptions)		Not Covered	Coverage limited to a 30-day supply for retail prescriptions and a 90-day supply for mail-order prescriptions. Preventative medications as defined by the PPACA are covered at no cost. If you use an out-of-network-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost.
	Preferred brand drugs (Tier 2)	$35 copay after the deductible (retail prescriptions) $87.50 copay after the deductible (mail-order prescriptions)			
	Non-preferred brand drugs (Tier 3)	$70 copay after the deductible (retail prescriptions) $175 copay after the deductible (mail-order prescriptions)			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Northwell Direct Providers)	Tier 2 (Anthem Providers)	Tier 3 (Out-of-Network Providers)	
					See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Specialty drugs (Tier 4)	Not Covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Precertification required.
	Physician/surgeon fees	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	——————None——————
If you need immediate medical attention	Emergency room care	Covered 100% after the Tier 1 deductible			——————None——————
	Emergency medical transportation	Covered 100% after the Tier 1 deductible			——————None——————
	Urgent care	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	If you receive services in addition to Urgent Care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required.
	Physician/surgeon fees	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	——————None——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Coverage for Partial Hospitalization, Intensive Outpatient Treatment, and High Intensity Outpatient services are covered 100% after the deductible. (Tier 1 and 2 only) Coverage for Intensive Behavioral Therapy (ABA) is covered 100% after the deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Northwell Direct Providers)	Tier 2 (Anthem Providers)	Tier 3 (Out-of-Network Providers)	
	Inpatient services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required.
If you are pregnant	Office visits	No Charge; deductible waived	Covered 100% after the deductible	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-certification required.
	Childbirth/delivery professional services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	
	Childbirth/delivery facility services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required. Coverage limited to a maximum of 40 visits per Plan Year. There is no coverage for home intravenous infusion services out-of-network.
	Rehabilitation services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required. Coverage limited to a combined maximum of 60 visits each per Plan Year for physical, speech, and occupational therapies.
	Habilitation services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Coverage limited to a combined maximum of 60 visits each per Plan Year for physical, speech, and occupational therapies.
	Skilled nursing care	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required. Coverage limited to a maximum of 30 days per

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Northwell Direct Providers)	Tier 2 (Anthem Providers)	Tier 3 (Out-of-Network Providers)	
					Plan Year.
	Durable medical equipment	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	Pre-certification required for equipment over $1,500.
	Hospice services	Covered 100% after the deductible	Covered 100% after the deductible	Not Covered	——————None——————
If your child needs dental or eye care	Children's eye exam	Not Covered			
	Children's glasses	Not Covered			
	Children's dental check-up	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- 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.)

- Bariatric Surgery
- Chiropractic care
- Hearing Aids (limited to 1 aid per ear once every 3 years)
- Private-duty Nursing
- Infertility Treatment (limited to a lifetime maximum 3 cycles of IVF)

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: 1-866-675-3968. 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: 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**..

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? 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.

* For more information about limitations and exceptions, see the plan or policy document at www.pointctpa.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-808-9008.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-808-9008.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-808-9008.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-808-9008.

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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	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,820**

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

The plan's overall deductible	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,970**

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

The plan's overall deductible	$1,750
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,760**

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