



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](http://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](http://www.pointctpa.com) or call 1-866-675-3968 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<p><b>\$0</b> Individual / <b>\$0</b> Family for Tier 1 Providers</p> <p><b>\$0</b> Individual / <b>\$0</b> Family for Tier 2 Providers</p> <p><b>\$500</b> Individual / <b>\$1,000</b> Family for Tier 3 Providers</p>	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 per person for prescription drug coverage. This does not apply to Tier 1 drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><b>\$2,500</b> Individual / <b>\$5,000</b> Family for Tier 1 &amp; 2 Providers</p> <p><b>\$3,500</b> Individual / <b>\$7,000</b> Family for Tier 3 Providers</p>	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.pointctpa.com">www.pointctpa.com</a> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> 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.

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)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$15 copay; deductible does not apply	\$15 copay; deductible does not apply	30% coinsurance after the deductible	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	<a href="#">Specialist</a> visit	\$30 copay; deductible does not apply	\$30 copay; deductible does not apply	30% coinsurance after the deductible	
	<a href="#">Preventive care/screening/immunization</a>	No Charge; deductible does not apply	No Charge; deductible does not apply	30% coinsurance after the deductible	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	<a href="#">Diagnostic test</a> (x-ray, blood work) <b>Lab</b>	<u>Free Standing</u> : \$60 copay; deductible does not apply <u>Hospital</u> : \$60 copay; deductible does not apply	<u>Free Standing</u> : \$60 copay; deductible does not apply <u>Hospital</u> : \$60 copay; deductible does not apply	Not Covered	Coverage for a designated in-network lab services are covered at no charge.
	<b>X-ray</b>	<u>Free Standing</u> : No Charge; deductible does not apply <u>Hospital</u> : No Charge; deductible does not apply	<u>Free Standing</u> : No Charge; deductible does not apply <u>Hospital</u> : No Charge; deductible does not apply	30% coinsurance after the deductible	
	Imaging (CT/PET scans, MRIs)	<u>Free Standing</u> : No Charge; deductible does not apply <u>Hospital</u> : No Charge; deductible does not apply	<u>Free Standing</u> : No Charge; deductible does not apply <u>Hospital</u> : No Charge; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pointctpa.com](http://www.pointctpa.com).

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.pointctpa.com">www.pointctpa.com</a> .	Generic drugs (Tier 1)	\$15 copay; deductible does not apply (retail prescriptions) \$37.50 copay; deductible does not apply (mail-order prescriptions)			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.  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.
	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)	\$75 copay after the deductible (retail prescriptions) \$187.50 copay after the deductible (mail-order prescriptions)		Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Not Covered			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 copay; deductible does not apply	\$250 copay; deductible does not apply	30% coinsurance after the deductible	Precertification required.
	Physician/surgeon fees	No Charge; deductible does not apply	No Charge; deductible does not	30% coinsurance after the deductible	—————None—————

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pointctpa.com](http://www.pointctpa.com).

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)	
			apply		
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 copay; deductible does not apply			—————None—————
	<a href="#">Emergency medical transportation</a>	No charge; deductible does not apply			—————None—————
	<a href="#">Urgent care</a>	\$30 copay; deductible does not apply	\$30 copay; deductible does not apply	30% coinsurance after the deductible	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)	\$500 copay; deductible does not apply	\$500 copay; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.
	Physician/surgeon fees	No charge; deductible does not apply	No charge; deductible does not apply	30% coinsurance after the deductible	—————None—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay; deductible does not apply	\$15 copay; deductible does not apply	30% coinsurance after the deductible	Coverage for Partial Hospitalization, Intensive Outpatient Treatment, and High Intensity Outpatient services is no charge. (Tier 1 and 2 only)  Coverage for Intensive Behavioral Therapy (ABA) services is no charge.
	Inpatient services	\$500 copay; deductible does not apply	\$500 copay; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.
If you are pregnant	Office visits	No Charge; deductible does not apply	No Charge; deductible does not apply	30% coinsurance after the deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	No Charge; deductible does not apply	No Charge; deductible does not apply	30% coinsurance after the deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pointctpa.com](http://www.pointctpa.com).

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)	
	Childbirth/delivery facility services	\$500 copay; deductible does not apply	\$500 copay; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30 copay; deductible does not apply	\$30 copay; deductible does not apply	30% coinsurance after the deductible	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.
	<a href="#">Rehabilitation services</a>	\$30 copay; deductible does not apply	\$30 copay; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.  Coverage limited to a combined maximum of 90 visits each per Plan Year for physical, speech, and occupational therapies.
	<a href="#">Habilitation services</a>	Covered 100% after the deductible	Covered 100% after the deductible	30% coinsurance after the deductible	Coverage limited to a combined maximum of 90 visits each per Plan Year for physical, speech, and occupational therapies.
	<a href="#">Skilled nursing care</a>	\$500 copay; deductible does not apply	\$500 copay; deductible does not apply	30% coinsurance after the deductible	Pre-certification required.  Coverage limited to a maximum of 30 days per Plan Year.
	<a href="#">Durable medical equipment</a>	No Charge; deductible does not apply	No Charge; deductible does not apply	Not Covered	Pre-certification required for equipment over \$1,500.
	<a href="#">Hospice services</a>	\$500 copay; deductible does not apply	\$500 copay; deductible does not apply	30% coinsurance after the deductible	—————None—————

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pointctpa.com](http://www.pointctpa.com).

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)	
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](#).)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult and Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|--|---|

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

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids (limited to 1 aid per ear once every 3 years)</li> <li>• Private-duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment (limited to a lifetime maximum 3 cycles of IVF)</li> </ul> |
|--|--|---|

**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](http://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](http://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](http://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](#).

#### 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, kwijigo holne' 1-888-808-9008.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.pointctpa.com](http://www.pointctpa.com).

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> coinsurance	\$30
■ Hospital (facility) coinsurance	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$560</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> coinsurance	\$30
■ Hospital (facility) coinsurance	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$400</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> coinsurance	\$30
■ Hospital (facility) coinsurance	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.