



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.pointctpa.com or call 1-866-675-3968. 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 1-866-675-3968 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,500 individual / \$7,000 family for Preferred Providers \$7,000 individual / \$14,000 family for Non-Preferred 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 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. Preventive care services 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.
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 ?	\$4,500 individual / \$9,000 family for Preferred Providers and \$9,000 individual / \$18,000 family for Non-Preferred Providers.	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, and health care 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 or call 1-866-675-3968 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 .

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

 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Specialist visit	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Preventive care/screening/immunization	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	Diagnostic test (x-ray, blood work)	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.truescripts.com .	Generic drugs	10% coinsurance after the deductible	N/A	Deductible & Out-of-pocket limits apply. You must pay the difference in cost between a Generic drug and Brand name drug when a medical professional has not specified a Brand-name drug or has not indicated that the Brand-name drug is necessary, until the out-of-pocket is met. Specialty drugs are limited to a max 30-day supply and require a prior authorization. The specialty drug formulary changes from time to time. To see if your prescription is covered under the plan, as well as the level of coverage, please contact TrueScripts at 844-257-1955.
	Preferred brand drugs	10% coinsurance after the deductible		
	Non-preferred brand drugs	10% coinsurance after the deductible		
	Specialty drugs	10% coinsurance after the deductible		

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required.
	Physician/surgeon fees	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
If you need immediate medical attention	Emergency room care	10% coinsurance after the deductible	Paid at the In-Network level of benefits.	Cost sharing may apply for services performed in the emergency room (such as labs, X-rays).
	Emergency medical transportation	10% coinsurance after the deductible	Paid at the In-Network level of benefits.	-----None-----
	Urgent care	10% coinsurance after the deductible	30% coinsurance after the deductible	Cost sharing may apply for services performed in the urgent care (such as labs, X-rays).
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Physician/surgeon fees	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required for Partial Hospitalization and Residential Care services.
	Inpatient services	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required.
If you are pregnant	Office visits	10% coinsurance after the deductible	30% coinsurance after the deductible	Cost sharing does not apply for preventive services . Depending on the type of services, deductible , copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Childbirth/delivery facility services	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required. Coverage limited to 40 visits per Calendar Year for each Participant.
	Rehabilitation services	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required.
	Habilitation services	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
	Skilled nursing care	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required. Coverage limited to 30 days per Calendar Year for each Participant.
	Durable medical equipment	10% coinsurance after the deductible	30% coinsurance after the deductible	Pre-certification required for durable medical equipment more than \$1,500.
	Hospice services	10% coinsurance after the deductible	30% coinsurance after the deductible	-----None-----
If your child needs dental or eye care	Children's eye exam	10% coinsurance after the deductible	Not Covered	-----None-----
	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"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • 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.)		
<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids 	<ul style="list-style-type: none"> • Routine eye care (Adult)

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

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](#).

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, kwijijgo 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](#) \$3,500
- [Specialist coinsurance](#) 10%
- 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,460

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 10%
- 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,720

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 10%
- 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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