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, 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 **866-675-3968** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Per Calendar Year In-Network: $2,000/per person $4,000/per family (2 or more). Out-of-Network: $4,000/per person $8,000/per family (2 or more).	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
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. 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?	Per Calendar Year In-Network: $2,000/per person $4,000/per family (2 or more). Out-of-Network: Unlimited	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties, 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 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
		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	Covered 100% After Deductible	50% Coinsurance After Deductible	Some services such as lab and x-ray will include additional member costs.
	Specialist visit	Covered 100% After Deductible	50% Coinsurance After Deductible	Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/ immunization	No charge, Deductible Waived	50% Coinsurance After 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)	Covered 100% After Deductible	50% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is 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)	Covered 100% after deductible /prescription (retail and mail order)	N/A	30-day and 90-day supply (retail); 90 day supply (mail order)
	Preferred brand drugs (Tier 2)	Covered 100% after deductible /prescription (retail and mail order)		
	Non-preferred brand drugs (Tier 3)	Covered 100% after deductible /prescription (retail and mail order)		
	Specialty drugs (Tier 4)	Covered 100% after deductible /prescription (retail only)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is required.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Covered 100% After Deductible	50% Coinsurance After Deductible	None
If you need immediate medical attention	Emergency room care	Covered 100% After Deductible	Paid at the In-Network Level of Benefits	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	Covered 100% After Deductible	Paid at the In-Network Level of Benefits	In-network deductible applies to Out-of-network benefits
	Urgent care	Covered 100% After Deductible	50% Coinsurance After Deductible	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is required.
	Physician/surgeon fees	Covered 100% After Deductible	50% Coinsurance After Deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered 100% After Deductible	50% Coinsurance After Deductible	None
	Inpatient services	Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is required.
If you are pregnant	Office visits	No charge, Deductible Waived	50% Coinsurance After Deductible	None
	Childbirth/delivery professional services	Covered 100% After Deductible	50% Coinsurance After Deductible	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	Covered 100% After Deductible	50% Coinsurance After Deductible	None
If you need help recovering or have other special health needs	Home health care	Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is required.
	Rehabilitation services	Covered 100% After Deductible	50% Coinsurance After Deductible	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				Mental Health Services.
	Habilitation services	Covered 100% After Deductible	50% Coinsurance After Deductible	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	Covered 100% After Deductible	50% Coinsurance After Deductible	60 Maximum visits per calendar year; Precertification is required.
	Durable medical equipment	Diabetic Supplies: No charge, Deductible Waived; All other equipment: Covered 100% After Deductible	50% Coinsurance After Deductible	Precertification is required (over $1,500).
	Hospice services	No charge, Deductible Waived	No charge, Deductible Waived	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.)

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye car(Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs
- Routine eye care (Adult)

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

- Abortion
- Hearing Aids (one per ear every 3 calendar
- Non-emergency care when traveling outside

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (20 visits) • Chiropractic care (20 visits)	years)	the U.S. •

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 1-866-989-3033.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-989-3033.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-989-3033.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-866-989-3033.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-989-3033.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-989-3033.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-989-3033.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-989-3033.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$2,000
Specialist	$0
Hospital (facility)	0%
Other	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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$2,000
Specialist	$0
Hospital (facility)	0%
Other	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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$2,000
Specialist	$0
Hospital (facility)	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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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