




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.cpg.org/mtdocs or call (800) 480-9967. 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.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | <u>Network:</u> \$3,500 Individual / \$7,000 Family <u>Out-of-Network:</u> \$7,000 Individual / \$14,000 Family | 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. The network and out-of-network deductibles accumulate separately. |
| Are there services covered before you meet your deductible ? | Yes, for example, network preventive care, emergency room care, urgent care, and certain telehealth services. | 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 preventive services at 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 ? | <u>Network:</u> \$5,000 Individual / \$10,000 Family <u>Out-of-Network:</u> \$10,000 Individual / \$20,000 Family | 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. The network and out-of-network out-of-pocket limits accumulate separately. |
| What is not included in the out-of-pocket limit ? | Contributions, (premiums), balance-billing charges, penalties, copays for certain specialty pharmacy drugs considered non-essential health benefits 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.anthem.com or call (844) 812-9207 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.cpg.org.

**See Page 5 for important information about telehealth services.

 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 | \$30 copay/visit Deductible does not apply | 50% coinsurance plus any balance billing | None. |
| | Specialist visit | \$45 copay/visit Deductible does not apply | 50% coinsurance plus any balance billing | None. |
| | Preventive care/screening/immunization | No charge. | 50% coinsurance plus any balance billing | 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. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits . |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance Office Visits, Independent Labs, Outpatient: Deductible does not apply | 50% coinsurance plus any balance billing | Outpatient refers to Outpatient Institutional and Outpatient Professional charges and does not include High Diagnostic Imaging (e.g., MRI/MRA) |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance Office Visits, Independent Labs, Outpatient: Deductible does not apply | 50% coinsurance plus any balance billing | Outpatient refers to Outpatient Institutional and Outpatient Professional charges and does not include High Diagnostic Imaging (e.g., MRI/MRA) |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance plus any balance billing | None. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance plus any balance billing | None. |
| If you need immediate medical attention | Emergency room care | \$250 copay/visit Deductible does not apply | \$250 copay/visit Deductible does not apply | The \$250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours. |

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**See Page 5 for important information about telehealth services.

| 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) | |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None. |
| | Urgent care | \$50 copay/visit Deductible does not apply | \$50 copay/visit plus any balance billing Deductible does not apply | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance plus any balance billing | Prior authorization is required. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance plus any balance billing | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 PCP / \$45 specialist copay/visit Deductible does not apply | 30% coinsurance plus any balance billing Deductible does not apply | None. |
| | Inpatient services | 30% coinsurance Deductible does not apply | 50% coinsurance plus any balance billing | Prior authorization is required. |
| If you are pregnant | Office visits | \$30 PCP / \$45 specialist copay/visit Deductible does not apply | 50% coinsurance plus any balance billing | Copay applies only to the initial visit to confirm pregnancy. |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance plus any balance billing | Well-newborn care is covered. Newborn must be enrolled in the plan within 30 days of birth. |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance plus any balance billing | |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 50% coinsurance plus any balance billing | Limited to 210 visits per plan year. Prior authorization is required. |
| | Rehabilitation services | \$30 PCP / \$45 specialist | 50% coinsurance plus | Benefits include speech/hearing, physical, |

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**See Page 5 for important information about telehealth services.

| 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) | | | |
| | | copay/visit Deductible does not apply | any balance billing | and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies. | | |
| | Habilitation services | \$30 PCP / \$45 specialist copay/visit Deductible does not apply | 50% coinsurance plus any balance billing | | | |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance plus any balance billing | Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required. | | |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance plus any balance billing | None. | | |
| | Hospice services | No charge. | 50% coinsurance plus any balance billing | Prior authorization is required. | | |
| If your child needs dental or eye care | Children’s eye exam | Not covered. | Not covered. | Vision benefits are available through EyeMed Vision Care | | |
| | Children’s glasses | Not covered. | Not covered. | | | |
| | Children’s dental check-up | Not covered. | Not covered. | | | |
| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information* |
| | | Standard Prescription Plan | | Premium Prescription Plan | | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com | Generic drugs | Retail | Home Delivery | Retail | Home Delivery | Deductible does not apply. You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. ¹ See “Important Questions” regarding the Plan’s out-of-pocket limit on page 1. No charge for contraceptives. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg . |
| | | Up to \$10 | Up to \$25 | Up to \$5 | Up to \$12 | |
| | Preferred brand drugs | 25%; up to \$40 min / \$80 max | 25%; up to \$100 min / \$200 max | Up to \$35 | Up to \$87 | |
| | Non-preferred brand drugs | 40%; up to \$80 min / \$160 max | 40%; up to \$200 min / \$400 max | Up to \$70 | Up to \$175 | |
| | Specialty drugs | 40%; up to \$100 min / \$200 max | 40%; up to \$250 min / \$500 max | Up to \$90 | Up to \$225 | |

¹ The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at www.cpg.org.

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**See Page 5 for important information about telehealth services.

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](#).)

- | | | |
|----------------------------|--|------------------------|
| • Cosmetic surgery | • Dental care (Adult) | • Long-term care |
| • Routine eye care (Adult) | • Routine foot care (unless related to diabetes or certain other conditions) | • Weight loss programs |

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

- | | | |
|---|---|---|
| • Acupuncture (limit 20 visits per year) | • Bariatric surgery (if Medically Necessary) | • Chiropractic care (limit 20 visits per year) |
| • Hearing aids (limit \$3,000 every three years) | • Infertility treatment (\$50,000 lifetime maximum) | • Non-emergency care when traveling outside the U.S. ² |
| • Private duty nursing (only through home healthcare benefit) | | |

Telehealth Services: The Medical Trust will waive all [copays](#), [deductibles](#), and [coinsurance](#) for all telehealth services received through its third-party administrators' telehealth platforms. The Medical Trust will also allow claims for virtual visits with [network](#) and [out-of-network providers](#) who do not use a telehealth platform offered by Anthem Blue Cross and Blue Shield, but standard [deductibles](#), [copays](#), and [coinsurance](#) will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements³. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

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 Anthem Blue Cross and Blue Shield or Express Scripts, as appropriate.

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 (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 480-9967.

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

² Coverage for non-emergency care when traveling outside the U.S. applies only to services available through the medical benefit administered by Anthem Blue Cross and Blue Shield. Non-emergency services outside the U.S. are not available through the prescription drug benefit administered by Express Scripts.

³ Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

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**See Page 5 for important information about telehealth services.

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 [cost sharing] | \$45 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 30% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,500 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,060 |

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 [cost sharing] | \$45 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 30% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$500 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,120 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,500 |
| ■ Specialist [cost sharing] | \$45 |
| ■ Hospital (facility) [cost sharing] | 30% |
| ■ Other [cost sharing] | 30% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,200 |
| Copayments | \$600 |
| Coinsurance | \$30 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,830 |

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