




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 contribution or 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 <u>deductible</u>? | \$ 500 /Individual or \$1,000 Family network \$1,000 Individual or \$2,000 Family out-of-network | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible. The network and out-of-network <u>deductibles</u> accumulate separately. |
| Are there services covered before you meet your <u>deductible</u>? | Yes, preventive care, inpatient care, maternity care, | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For network providers, \$2,500 individual / \$5,000 family; for out-of-network providers \$5,000 individual / \$10,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. The network and out-of-network <u>out-of-pocket limits</u> accumulate separately. |
| What is not included in the <u>out-of-pocket limit</u>? | Contributions, (<u>Premiums</u>), <u>balance-billing</u> charges, penalties, and healthcare this <u>plan</u> doesn't cover | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.anthem.com or call (844) 812-9207 for a list of <u>network providers</u> . | This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

Questions: Call 1-844-812-9207 or visit www.anthem.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call 1-800-480-9967 to request a copy.

 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 | 50% coinsurance | None. . In-network deductible does not apply. |
| | Specialist visit | \$45 copay/visit | 50% coinsurance | |
| | Preventive care/screening/immunization | No charge. | 50% coinsurance | Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics. In-network Deductible does not apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | 10% coinsurance | 50% coinsurance | None. Deductible does not apply. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 50% coinsurance | None. Deductible does not apply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 50% coinsurance | None. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | None. |
| If you need immediate medical attention | Emergency room care | \$250 copay/visit | \$250 copay/visit | The \$250 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None. Deductible does not apply. |
| | Urgent care | \$50 copay | \$50 copay | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 50% coinsurance | Prior authorization is required. |
| | Physician/surgeon fees | 10% coinsurance | 50% coinsurance | |

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

| 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 need mental health, behavioral health, or substance abuse services. | Outpatient services | \$30 copay/visit | 30% coinsurance | Prior authorization is required for inpatient services. |
| | Inpatient services | 10% coinsurance | 50% coinsurance | |
| | Colleague Group | 30% coinsurance | 30% coinsurance | The plan will reimburse 70% up to a maximum reimbursable fee of \$40. The member is responsible for all costs above that amount. |
| If you are pregnant | Office visits | \$30 copay | 50% coinsurance | Copay applies only to the visit to confirm pregnancy. In-network Deductible does not apply. |
| | Childbirth/delivery professional services | 10% coinsurance | 50% coinsurance | Well-newborn care is covered. Newborn must be enrolled in Plan within 30 days of birth. |
| | Childbirth/delivery facility services | | | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% coinsurance | 50% coinsurance | Limited to 210 visits per plan year. Prior authorization is required. |
| | <u>Rehabilitation services</u> | \$30 PCP/\$45 specialist | 50% coinsurance | Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies. In-network Deductible does not apply. |
| | <u>Habilitation services</u> | \$30 PCP/\$45 specialist | 50% coinsurance | |
| | <u>Skilled nursing care</u> | 10% coinsurance | 50% coinsurance | Limited to 60 days per plan year, combined with acute rehabilitation. Prior Authorization is required. |
| | <u>Durable medical equipment</u> | 10% coinsurance | 50% coinsurance | None. Deductible does not apply. |
| | <u>Hospice services</u> | No charge. | 50% coinsurance | 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. | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|--|---------------------------|--|---------------|---------------------------|---------------|---|
| | | Standard Prescription Plan | | Premium Prescription Plan | | |
| | | Retail | Home Delivery | Retail | Home Delivery | |
| 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 | Up to \$10 | Up to \$25 | Up to \$5 | Up to \$12 | 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. |
| | Preferred brand drugs | Up to \$40 | Up to \$100 | Up to \$30 | Up to \$75 | |
| | Non-preferred brand drugs | Up to \$80 | Up to \$200 | Up to \$60 | Up to \$150 | |
| | Specialty drugs | Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. | | | | |

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) | • Hearing aids |
| • Long-term care | • Routine eye care (Adult) | • 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.)

| | | |
|-------------------------|---|------------------------|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Infertility treatment | • Non-emergency care when traveling outside the U.S. ¹ | • Private-duty nursing |

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

¹ Coverage for non-emergency care when traveling outside the U.S. applies only to services available through Anthem Blue Cross and Blue Shield. Non-emergency care outside the U.S. is not available through Express Scripts.

COBRA requirements². 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 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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 **\$500**
- Specialist [cost sharing] **\$45**
- Hospital (facility) [cost sharing] **10%**
- Other [cost sharing] **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 | \$13,219 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$100 |
| Coinsurance | \$1,240 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,900 |

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$500**
- Specialist [cost sharing] **\$45**
- Hospital (facility) [cost sharing] **10%**
- Other [cost sharing] **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 | \$7,399 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,160 |
| Coinsurance | \$186 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$1,401 |

Mia's Simple Fracture

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

- The plan's overall deductible **\$500**
- Specialist [cost sharing] **\$45**
- Hospital (facility) [cost sharing] **10%**
- Other [cost sharing] **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 | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$129 |
| Copayments | \$255 |
| Coinsurance | \$86 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$470 |