




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](http://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](http://www.cpg.org/uniform-glossary) or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<u>Network</u> : \$1,000 Individual / \$2,000 Family <u>Out-of-Network</u> : \$2,000 Individual / \$4,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family deductible. The network and out-of-network <a href="#">deductibles</a> accumulate separately.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, for example, network preventive care, emergency room care, urgent care, and certain telehealth services.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .**
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<u>Network</u> : \$3,500 Individual / \$7,000 Family <u>Out-of-Network</u> : \$7,000 Individual / \$14,000 Family	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 <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. The network and out-of-network <a href="#">out-of-pocket limits</a> accumulate separately.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Contributions, ( <a href="#">premiums</a> ), <a href="#">balance-billing</a> charges, penalties, <a href="#">copays</a> for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this <a href="#">plan</a> 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.anthem.com">www.anthem.com</a> or call (844) 812-9207 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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 a <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.cpg.org](http://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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	<a href="#">Specialist</a> visit	\$45 copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. See a list of preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	Physician/surgeon fees	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay/visit <a href="#">Deductible</a> does not apply	\$250 copay/visit <a href="#">Deductible</a> does not apply	The \$250 <a href="#">copay</a> will be waived if you are admitted to the hospital as an inpatient within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None.

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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)	
	<a href="#">Urgent care</a>	\$50 copay/visit <a href="#">Deductible</a> does not apply	\$50 copay/visit plus any <a href="#">balance billing</a> <a href="#">Deductible</a> does not apply	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Prior authorization is required.
	Physician/surgeon fees	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> <a href="#">Deductible</a> does not apply	None.
	Inpatient services	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Prior authorization is required.
If you are pregnant	Office visits	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	<a href="#">Copay</a> applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Well-newborn care is covered. Newborn must be enrolled in the <a href="#">plan</a> within 30 days of birth.
	Childbirth/delivery facility services	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Limited to 210 visits per plan year. Prior authorization is required.
	<a href="#">Rehabilitation services</a>	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	<a href="#">Habilitation services</a>	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	

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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)			
	<a href="#">Skilled nursing care</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.		
	<a href="#">Durable medical equipment</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.		
	<a href="#">Hospice services</a>	No charge.	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Prior authorization is required.		
<b>If your child needs dental or eye care</b>	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		
<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.express-scripts.com">www.express-scripts.com</a>		Retail	Home Delivery	Retail	Home Delivery	<a href="#">Deductible</a> does not apply.
	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. <sup>1</sup> See "Important Questions" regarding the Plan's out-of-pocket limit on page 1.
	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	
	<a href="#">Specialty drugs</a>	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max	Up to \$90	Up to \$225	No charge for contraceptives.  For a complete list of non-essential specialty medications, see <a href="http://SaveonSP.com/cpg">SaveonSP.com/cpg</a> .

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• 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

<sup>1</sup> 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](http://www.cpg.org).

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

**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.<sup>2</sup>
- 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 Quantum Health's telehealth platform, Teladoc. The Medical Trust will also allow claims for virtual visits with [network](#) and [out-of-network providers](#) who do not use Teladoc through Quantum Health, 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 requirements<sup>3</sup>. 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, kwijijigo holne' (800) 480-9967.

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

<sup>2</sup> 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.

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

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## 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](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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>
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In this example, Peg would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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>
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In this example, Joe would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

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>
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In this example, Mia would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,670</b>

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