



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](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> ?                                | <b>\$ 1,000</b> Individual / <b>\$2,000</b> Family network<br><b>\$2,000</b> Individual / <b>\$4,000</b> Family out-of-network   | 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 <a href="#">network</a> and <a href="#">out-of-network deductibles</a> accumulate separately.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, for example certain preventive services, COVID-19 expenses, diagnostic tests, and office visits   | 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. See a list of preventive services at <a href="https://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> ? | <b>\$3,500</b> Individual / <b>\$7,000</b> Family network<br><b>\$7,000</b> Individual / <b>\$14,000</b> Family out-of-network   | 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 <a href="#">network</a> and <a href="#">out-of-network 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> .  |

Questions: Call 1-844-812-9207 or visit [www.anthem.com](http://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](http://www.cpg.org/uniform-glossary) or call 1-800-480-9967 to request a copy.

\*\* See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and 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<br>(You will pay the least) | Out-of-Network Provider<br>(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                             | 50% coinsurance                                    | **   |
|  | <a href="#">Specialist</a> visit                       | \$45 copay/visit                             | 50% coinsurance                                    |  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge.                                   | 50% coinsurance                                    | 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="https://www.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                              | 50% coinsurance                                    | <a href="#">Deductible</a> does not apply. **  |
|  | Imaging (CT/PET scans, MRIs)                           | 20% coinsurance                              | 50% coinsurance                                    | <a href="#">Deductible</a> does not apply. **  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 20% coinsurance                              | 50% coinsurance                                    | None.  |
|  | Physician/surgeon fees                                 | 20% coinsurance                              | 50% coinsurance                                    | None.  |
| If you need immediate medical attention                                | <a href="#">Emergency room care</a>                    | \$250 copay/visit                            | \$250 copay/visit                                  | The \$250 <a href="#">copay</a> will be waived if you are admitted to the hospital as an inpatient within 24 hours. <a href="#">Deductible</a> does not apply. **  |
|  | <a href="#">Emergency medical transportation</a>       | 20% coinsurance                              | 20% coinsurance                                    | <a href="#">Deductible</a> does not apply. **  |
|  | <a href="#">Urgent care</a>                            | \$50 copay                                   | \$50 copay   | **   |
| If you have a hospital stay  | Facility fee (e.g., hospital room)                     | 20% coinsurance                              | 50% coinsurance                                    | Prior authorization is required. **  |
|  | Physician/surgeon fees                                 | 20% coinsurance                              | 50% coinsurance                                    |  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.cpg.org](http://www.cpg.org).

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| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(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                        | 20% coinsurance                              | 50% coinsurance                                    |   |
|  | Colleague Group                           | 30% coinsurance                              | 30% coinsurance                                    | The <a href="#">plan</a> 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                                    | <a href="#">Copay</a> applies only to the visit to confirm pregnancy. In-network <a href="#">deductible</a> does not apply.   |
|  | Childbirth/delivery professional services | 20% coinsurance                              | 50% coinsurance                                    | Well-newborn care is covered. Newborn must be enrolled in the Plan within 30 days of birth.   |
|  | Childbirth/delivery facility services     |  |  |   |
| If you need help recovering or have other special health needs             | <a href="#">Home health care</a>          | 20% coinsurance                              | 50% coinsurance                                    | Limited to 210 visits per plan year. Prior authorization is required.   |
|  | <a href="#">Rehabilitation services</a>   | \$30 PCP/\$45 specialist copay               | 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. |
|  | <a href="#">Habilitation services</a>     | \$30 PCP/\$45 specialist copay               | 50% coinsurance                                    |   |
|  | <a href="#">Skilled nursing care</a>      | 20% coinsurance                              | 50% coinsurance                                    | Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.  |
|  | <a href="#">Durable medical equipment</a> | 20% coinsurance                              | 50% coinsurance                                    | In-network <a href="#">Deductible</a> does not apply.   |
|  | <a href="#">Hospice services</a>          | 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.                                       |   |

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| 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 |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> | 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. See “Important Questions” regarding the Plan’s out-of-pocket limit on page 1.<br><br>For a complete list of non-essential specialty medications, see <a href="http://SaveonSP.com/cpg">SaveonSP.com/cpg</a> . |
|   | 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   |   |
|   | <a href="#">Specialty drugs</a> | Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. Certain specialty drugs are considered non-essential health benefits and <a href="#">copayments</a> may be set to the maximum of above or any available manufacturer-funded <a href="#">copay</a> assistance. |               |                           |               |   |

**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   | • 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   |
| • Hearing aids         | • Infertility treatment | • Non-emergency care when traveling outside the U.S. <sup>1</sup> |
| • Private-duty nursing |                         |   |

<sup>1</sup> 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.

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**COVID-19 Evaluation, Testing, and Treatment, and Telehealth Services:** The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. Additionally, 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. 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>2</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 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.*—————

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<sup>2</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>\$12,731</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$20           |
| Coinsurance                       | \$2,480        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,500</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>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,160        |
| Coinsurance                       | \$372          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$1,588</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>\$1,925</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$125        |
| Copayments                        | \$255        |
| Coinsurance                       | \$172        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$552</b> |