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 deductible?	$ 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 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, preventive care, inpatient care, maternity care, certain non-essential specialty pharmacy drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	For network providers, $2,500 individual / $5,000 family; for out-of-network providers $5,000 individual / $10,000 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, 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.

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	

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. Benefits are provided through Cigna Behavioral Health.
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	Home health care	10% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$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.
	Habilitation services	$30 PCP/$45 specialist	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior Authorization is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	None. Deductible does not apply.
	Hospice services	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.	

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. See "Important Questions" regarding the Plan's out-of-pocket limit. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	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. Certain specialty drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay 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)	• 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

[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.

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[2]. 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, kwiijigo 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:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$1,240
What isn't covered	
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:

Cost Sharing	
Deductibles	$0
Copayments	$1,160
Coinsurance	$186
What isn't covered	
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:

Cost Sharing	
Deductibles	$129
Copayments	$255
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$470

The plan would be responsible for the other costs of these EXAMPLE covered services.