CHURCH PENSION GROUP

Serving the Episcopal Church and its People

Healthcare Benefit Information

for

The Episcopal Diocese of Los Angeles

2019

EPISCOPAL CHURCH
MEDICAL TRUST

Table of Contents

Vendor Contacts, Websites & Network Access Directions

Cigna Medical & Dental (800) 244-6224

1. Go to **www.cigna.com**
2. Click on FIND A DOCTOR. Then select the orange box that reads, "For plans offered through work or school".
3. Choose the provider type you are looking for: doctor, dentist, or hospital/pharmacy/facility
4. Enter the geographic location you wish to search
5. Select one of the plans offered by your employer during Open Enrollment
6. Enter a provider name, specialty, or other search term. Click **Search** to see your results.

<u>If searching for medical providers:</u>

a. For CDHP or OAP/OAP-IN plans, choose "Open Access Plus, OA Plus, Choice Fund OA Plus"

<u>If searching for dental providers:</u>

a. Select dentist instead of provider. Choose *Cigna Dental PPO or EPO*
b. For Network, choose either Cigna DPPO Advantage or Cigna DPPO

Cigna Behavioral Health (866) 395-7794
(Behavioral Health and EAP)

1. Go to **www.cignabehavioral.com**
2. Click on FIND A THERAPIST OR PSYCHIATRIST
3. Log in (on left) to review your EAP benefits. "Episcopal" is the Employer ID
4. Fill in the fields for seeking a provider under *either* Behavioral Health or EAP
5. Click SEARCH

Anthem Blue Cross and Blue Shield (844) 812-9207

1. Go to **www.anthem.com**
2. Under **Menu**, Click on **Find a Doctor**
3. Login with your username or search as a guest.
4. Enter your search criteria
5. Under **Select a plan/network**, select National PPO (BlueCard PPO)
6. Click **Search and Continue**
7. Choose the type of provider you are looking for and click **Search**

Kaiser Permanente

Colorado	(877) 883-6698
Georgia:	(866) 800-1486
Mid-Atlantic States:	(877) 740-4117

Kaiser Permanente (continued)

Northwest:	(866) 800-3402
Northern California:	(800) 663-1771
Southern California:	(800) 533-1833

1. Go to **www.kp.org**
2. If searching as a guest, click on **Doctors and Locations**. Select your region and click SEARCH
3. Select the criteria for your search

EyeMed Vision Care (866) 723-0513

1. Go to **www.eyemedvisioncare.com**
2. Click on *Find a Provider.* Enter your zip code. Under Choose Network*, select Insight,* and click GET RESULTS

Express Scripts (Pharmacy Benefit) (800) 841-3361

1. Go to **www.express-scripts.com** and follow the steps to register. Then log on to price medications, view Express Scripts' formulary list (preferred drugs), locate a participating pharmacy, etc.
2. Express Scripts has special representatives to assist you with any Open Enrollment questions. Call (800) 841-3361 and select option #1

Health Advocate (866) 695-8622

1. Go to www.healthadvocate.com
2. Click on Member Login
3. Enter "Episcopal" in the log-in box and click SUBMIT to view your benefits

Amplifon Hearing Health Care **(866) 349-9055**

www.amplifonusa.com

Click on "Find a Provider"
Enter zip code and hit enter

UnitedHealthcare Global Assistance (800) 527-0218 (from US, Canada, Puerto Rico, Virgin Islands, Bermuda

https://members.uhcglobal.com

Medical Trust Client Services Call Center

Active and Retired Members (800) 480-9967 (8:30AM – 8:00PM ET)

EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Medical Deductible	$0 per person $0 per family	$500 per person $1,000 per family	$500 per person $1,000 per family	$1,000 per person $2,000 per family	$1,000 per person $2,000 per family	$2,000 per person $4,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$2,000 per person $4,000 per family	$4,000 per person $8,,000 per family	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$5,000 per person $10,000 per family	$10,000 per person $20,000 per family
Preventive Care								
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services								
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance	$30 copay	50% coinsurance
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance	$45 copay	50% coinsurance
Hospital Services								
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
Ambulance Services	$0 copay	$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS BlueCard PPO 100		Anthem BCBS BlueCard PPO 90		Anthem BCBS BlueCard PPO 80		Anthem BCBS BlueCard PPO 70	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Mental Health/Substance Abuse								
Outpatient Services	$30 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	$30 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	$30 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	$30 copay Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem
Inpatient Services	$250 copay Services are provided through Cigna Behavioral Health, not through Anthem	50% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	10% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	50% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	20% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	50% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	30% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem	50% coinsurance Services are provided through Cigna Behavioral Health, not through Anthem
Other Medical Services								
Durable Medical Equipment	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Home Health Care	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Therapy	$30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$30 copay PCP/$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing / Acute Rehabilitation Facility	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay

EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA		Kaiser EPO High	Kaiser EPO 80	Kaiser CDHP 20/HSA
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network Only	Network Only	Network Only
Annual Medical Deductible	$1,400 per person $2,800 per family (deductible is non-embedded)	$2,800 per person $5,600 per family (deductible is non-embedded)	$2,700 per person $5,450 per family	$3,000 per person $6,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family	$0 per person $0 per family	$500 per person $1,000 per family	$2,700 per person $5,450 per family
Annual Out-of-Pocket Limit	$2,400 per person $4,800 per family (out-of-pocket limit is non-embedded)	$4,800 per person $9,600 per family (out-of-pocket limit is non-embedded)	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$6,000 per person $12,000 per family	$10,000 per person $20,000 per family	$1,750 per person $3,500 per family	$3,500 per person $7,000 per family	$4,200 per person $8,450 per family
Preventive Care									
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	60% coinsurance	$0 copay (Frequency and age limits for those age 24 months and older are managed by the KP provider. Well-child check-ups are limited to those less than 24 months old.)	$0 copay (Frequency and age limits for those age 24 months and older are managed by the KP provider. Well-child check-ups are limited to those less than 24 months old.)	$0 copay (Frequency and age limits for those age 24 months and older are managed by the KP provider. Well-child check-ups are limited to those less than 24 months old.)
Physician Services									
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$25 copay	$25 copay	20% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$50 copay	20% coinsurance	20% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$25 copay	$35 copay	20% coinsurance
Hospital Services									
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$100 per day copay to maximum of $600	20% coinsurance	20% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$100 copay	20% coinsurance	20% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	$100 copay	20% coinsurance	20% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	$0 copay	20% coinsurance	20% coinsurance

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA		Kaiser EPO High	Kaiser EPO 80	Kaiser CDHP 20/HSA
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network	Network Only	Network Only	Network Only
Mental Health/Substance Abuse									
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$25 copay per visit for individual visit; $12 for group visit	$25 copay per visit for individual visit; $12 for group visit	20% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$100 per day copay to maximum of $600	20% coinsurance	20% coinsurance
Other Medical Services									
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$0 copay	20% coinsurance	20% coinsurance
Home Health Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$0 copay	$0 copay	$0 copay
Outpatient Therapy	15% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	20% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	45% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	60% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	$25 copay (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	20% coinsurance
Skilled Nursing / Acute Rehabilitation Facility	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance	$0 copay	20% coinsurance	20% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance	$50 copay	$50 copay	20% coinsurance

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Prescription Drug Benefits

	Premium		CDHP-15/HSA	CDHP-20/HSA	CDHP-40/HSA
	Retail	Home Delivery	Retail and Home Delivery	Retail and Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	None	None	$1,400 per person $2,800 per family (combined with medical deductible) (non-embedded deductible)	$2,700 per person $5,450 per family (combined with medical deductible)	$3,500 per person $7,000 per family (combined with medical deductible)
Tier 1: Generic	Up to a $5 copay	Up to a $12 copay	You pay 15% after deductible	You pay 15% after deductible	You pay 15% after deductible
Tier 2: Preferred Brand Name	Up to a $30 copay	Up to a $75 copay	You pay 25% after deductible	You pay 25% after deductible	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	Up to a $60 copay	Up to a $150 copay	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply (retail) or 90-day supply (mail order)

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Prescription Drug Benefits

Kaiser Health Plans

EPO High		CDHP-20/HSA	EPO 80	
Retail	**Home Delivery**	**Retail and Home Delivery**	**Retail**	**Home Delivery**
None	None	$2,700 per person $5,450 per family (combined with medical deductible)	None	None
Up to a $10 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply	You pay 15% after deductible	Up to a $10 copay	Up to a $10 copay for a 30-day supply or $20 for up to a 90-day supply
Up to a $25 copay	Up to a $25 copay for a 30-day supply or $50 for up to a 90-day supply	You pay 25% after deductible	Up to a $30 copay	Up to a $30 copay for a 30-day supply or $60 for up to a 90-day supply
Not Applicable	Not Applicable	You pay 50% after deductible	Not Applicable	Not Applicable
Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)	Up to a 30-day supply	Up to a 90-day supply

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Vision Benefits		
	EyeMed	
	Network	Out-of-Network
Eye Examinations	$0 copay	Plan pays up to $30 for ophthalmologists or optometrists
Lenses (eligible once every calendar year)	$10 copay	Plan pays up to: $32 for single vision $46 for bifocal $57 for trifocal
Lens Options		
Standard Progressive (add-on to bifocal)	Up to $75 copay	Play pays up to $46
UV Coating	up to $15 copay	You are responsible for the cost of any lens options that you elect from out-of-network providers.
Tint (solid and Gradient)	up to $15 copay	
Standard Scratch Resistance	up to $15 copay	
Standard Polycarbonate	$0 copay	
Standard Anti-Reflective Coating	up to $45 copay	
Disposable	20% off retail price	
Frames (eligible once every calendar year)	$150 allowance, 20% off balance over $150	Plan pays up to $47
Contact Lenses (eligible once every calendar year)		
Conventional	$150 allowance, 15% off balance over $150	Plan pays up to $100
Disposable	$150 allowance, then you pay balance over $150	Plan pays up to $100

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

EPISCOPAL CHURCH MEDICAL TRUST

Dental Benefits			
	Cigna Dental		
	Dental & Orthodontia PPO Plan	Basic Dental PPO Plan	Preventive Dental PPO Plan
Annual DPPO & Out-of-Network Deductible (No deductible for DPPO Advantage providers)	$25 per person $75 per family	$50 per person $150 per family	None
Preventive & Diagnostic Services (e.g., oral exams, cleanings, x-rays, emergency care to relieve pain)	You pay $0 (not subject to annual deductible)	You pay $0 (not subject to annual deductible)	You pay $0 (includes sealants to age 14 in addition to all other preventive and emergency care)
Basic Restorative Care	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	You pay 15% Includes fillings, root canal therapy, periodontal scaling and root planing, denture adjustments and repairs, extractions	You pay 20% Includes only fillings, denture adjustments and repairs, root canal therapy
Major Restorative Services	You pay 15% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anesthetics, and bridges	You pay 50% Includes crowns, dentures, oral surgery, osseous surgery, dental implants, night guards, anestheetics, and bridges	You pay 99% Includes crowns, dentures, oral surgery, osseous surgery, and bridges
Orthodontia	You pay 50% ($1,500 individual lifetime limit)	Not covered	You pay 99%
Annual Benefit Maximum	$2,000	$2,000	$1,500

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.

The Plans described in this document (collectively, the Plans) are sponsored and administered by the Church Pension Group Services Corporation (CPGSC), also known as The Episcopal Church Medical Trust (the Medical Trust). The Plans that are self-funded are funded by The Episcopal Church Clergy and Employees' Benefit Trust (ECCEBT), which is a voluntary employees' beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code.

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should not be viewed as a contract, an offer of coverage, a confirmation of eligibility, or investment, tax, medical or other advice. In the event of a conflict between this document and the official Plan documents (summary of benefits and coverage, Plan Document Handbook), the official Plan documents will govern. The Church Pension Fund and CPGSC (collectively, CPG), retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, for any reason and, unless required by law, without notice.

The Plans are church plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States, and not all Plans are available on both a self-funded and fully insured basis. The Plans do not cover all healthcare expenses, and Plan participants should read the official Plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations and procedures.

All benefits under the Plans are subject to applicable laws, regulations and policies.

Except for the Preventive Dental PPO Plan, all such benefits are subject to coordination of benefits. The Plans are subrogated to all of the rights of a Plan participant against any party liable for such participant's illness or injury, to the extent of the reasonable value of the benefits provided to such participant under the Plans. The Plans may assert this right independently of a Plan participant, and such participant is obligated to cooperate with the Medical Trust in order to protect the Plans' subrogation rights.

CPG does not provide any healthcare services and therefore cannot guarantee any results or outcomes. Healthcare providers and vendors are independent contractors in private practice and are neither employees nor agents of CPG. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

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?	**$ 0**/Individual/**$0** Family network **$500** Individual/**$1,000** 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?	No.	
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**, $2,000** individual / **$4,000** family; for out-of-network providers **$4,000** individual / **$8,000** 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, 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.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge.	50% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay	50% coinsurance	None.
	Physician/surgeon fees	No charge.	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	No charge.	No charge.	None.
	Urgent care	$50 copay	$50 copay	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay	50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	No charge.	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. Benefits provided through Cigna Behavioral Health	Outpatient services	$30 copay/visit	30% coinsurance	None. Benefits are provided through Cigna Behavioral Health. Prior authorization is required for inpatient services. For more information, visit **www.mycigna.com** or call (866) 395-7794
	Inpatient services	$250 copay	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.
	Childbirth/delivery professional services	$250 copay	50% coinsurance	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	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.
	Habilitation services	$30 PCP/$45 specialist	50% coinsurance	
	Skilled nursing care	No charge.	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior Authorization is required.
	Durable medical equipment	No charge.	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.
	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

[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 or Cigna Behavioral Health.

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, Express Scripts, or Cigna Behavioral Health 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	**$0**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**0%**

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	**$12,991**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**0%**

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	**$7,955**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$555**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$45**
Hospital (facility) *[cost sharing]*	**$250**
Other *[cost sharing]*	**0%**

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	$0
Copayments	$285
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$285**

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

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,	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, 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	

* 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. Benefits provided through Cigna Behavioral Health	Outpatient services	$30 copay/visit	30% coinsurance	None. Benefits are provided through Cigna Behavioral Health. Prior authorization is required for inpatient services. For more information, visit **www.mycigna.com** or call (866) 395-7794
	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.
	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

[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 or Cigna Behavioral Health.

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, Express Scripts, or Cigna Behavioral Health 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.

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?	**$ 1,000** Individual / **$2,000** Family network **$2,000** Individual / **$4,000** 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,	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?	**$3,500** Individual / **$7,000** Family network **$7,000** Individual / **$14,000** Family out-of-network	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, 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.
	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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None. **Deductible** does not apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None. **Deductible** 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	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. **Deductible** does not apply.
	Emergency medical transportation	20% coinsurance	20% 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)	20% coinsurance	50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	20% 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. Benefits provided through Cigna Behavioral Health	Outpatient services	$30 copay/visit	30% coinsurance	None. Benefits are provided through Cigna Behavioral Health. Prior authorization is required for inpatient services. For more information, visit **www.mycigna.com** or call (866) 395-7794
	Inpatient services	20% 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	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	Home health care	20% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$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.
	Habilitation services	$30 PCP/$45 specialist copay	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance	50% coinsurance	None. In-network **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.	

* 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

[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 or Cigna Behavioral Health.

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, Express Scripts, or Cigna Behavioral Health 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** **$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)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$20
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,160
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,588**

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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$125
Copayments	$255
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$552**

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

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?	**$ 3,500**/Individual or **$7,000** Family network **$7,000** Individual or **$14,000** 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	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**, $5,000** individual / **$10,000** family; for out-of-network providers **$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, 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.
	Specialist visit	$45 copay/visit	50% coinsurance	None.
	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. **Deductible** does not apply for services provided in-network.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None. **Deductible** does not apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None. **Deductible** does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	30% 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	30% coinsurance	30% coinsurance	None. **Deductible** does not apply.
	Urgent care	$50 copay/visit	$50 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	30% 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. Benefits provided through Cigna Behavioral Health	Outpatient services	$30 copay/visit	30% coinsurance	None. Benefits are provided through Cigna Behavioral Health. Prior authorization is required for inpatient services. For more information, visit **www.mycigna.com** or call (866) 395-7794
	Inpatient services	30% 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	30% coinsurance	50% coinsurance	Well-newborn care is covered but is not subject to the $100 per day **copay**. 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	Home health care	30% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$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.
	Habilitation services	$30 PCP/$45 specialist copay	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	None. In-network **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.	

* 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

[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 either Express Scripts or Cigna Behavioral Health.

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, Express Scripts, or Cigna Behavioral Health 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** **$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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,676
Copayments	$30
Coinsurance	$3,324
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,090**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,160
Coinsurance	$558
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,774**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$122
Copayments	$255
Coinsurance	$258
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$634**

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

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?	**$ 1,400**/Individual or **$2,800** Family network **$2,800** Individual or **$5,600** 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 policy, the overall family **deductible** must be met before the **plan** begins to pay. The network and out-of-network **deductibles** accumulate separately.
Are there services covered before you meet your deductible?	Yes, preventive care	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.	
What is the out-of-pocket limit for this plan?	For network providers, **$2,400** individual / **$4,800** family; for out-of-network providers **$4,800** individual / **$9,600** 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**, the overall family **out-of-pocket limit** must be met. The network and out-of-network **out-of-pocket limits** accumulate separately.
What is not included in the out-of-pocket limit?	**Premiums** (contributions), **balance-billing** charges, penalties, 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**.

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	15% coinsurance	40% coinsurance	None.
	Specialist visit	15% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge.	40% 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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	15% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	None.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None.
	Urgent care	15% coinsurance	15% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	40% coinsurance	Prior authorization is required.
	Physician/surgeon fees	15% coinsurance	40% 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	15% coinsurance	40% coinsurance	Prior authorization required for inpatient services.
	Inpatient services	15% coinsurance	40% 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	15% coinsurance	40% coinsurance	None.
	Childbirth/delivery professional services	15% coinsurance	40% 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	Home health care	15% coinsurance	40% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	15% coinsurance	40% 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.
	Habilitation services	15% coinsurance	40% coinsurance	
	Skilled nursing care	15% coinsurance	40% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	15% coinsurance	40% coinsurance	None.
	Hospice services	No charge.	40% coinsurance	
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
		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	15% (after deductible)		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. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	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

[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.

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

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** $1,400
- **Specialist** *[cost sharing]* 15%
- **Hospital (facility)** *[cost sharing]* 15%
- **Other** *[cost sharing]* 15%

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	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$1,895
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,355**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $1,400
- **Specialist** *[cost sharing]* 15%
- **Hospital (facility)** *[cost sharing]* 15%
- **Other** *[cost sharing]* 15%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$1,436
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,891**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $1,400
- **Specialist** *[cost sharing]* 15%
- **Hospital (facility)** *[cost sharing]* 15%
- **Other** *[cost sharing]* 15%

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	$1,400
Copayments	$0
Coinsurance	$289
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,689**

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

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?	**$ 2,700**/Individual or **$5,450** Family network **$3,000** Individual or **$6,000** 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	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.	
What is the out-of-pocket limit for this plan?	For network providers, **$4,200** individual / **$8,450** family; for out-of-network providers **$7,000** individual / **$13,000** 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?	**Premiums** (contributions), **balance-billing** charges, penalties, 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	20% coinsurance	45% coinsurance	None.
	Specialist visit	20% coinsurance	45% coinsurance	
	Preventive care/screening/ immunization	No charge.	45% 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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	45% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	45% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance	Prior authorization is required.
	Physician/surgeon fees	20% coinsurance	45% 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	20% coinsurance	45% coinsurance	Prior authorization required for inpatient services.
	Inpatient services	20% coinsurance	45% 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	20% coinsurance	45% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	45% 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	Home health care	20% coinsurance	45% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	20% coinsurance	45% 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.
	Habilitation services	20% coinsurance	45% coinsurance	
	Skilled nursing care	20% coinsurance	45% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	20% coinsurance	45% coinsurance	None.
	Hospice services	No charge.	45% coinsurance	
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
		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	15% (after deductible)		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. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	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

[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** $2,700
- **Specialist** *[cost sharing]* 20%
- **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)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$2,525
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,285**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2,700
- **Specialist** *[cost sharing]* 20%
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$1,582
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,337**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2,700
- **Specialist** *[cost sharing]* 20%
- **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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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

What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2019– 12/31/2019
Coverage for: All tiers – Plan type: PPO

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?	$ 3,500/Individual or $7,000 Family network $7,000 Individual or $14,000 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	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.	
What is the out-of-pocket limit for this plan?	For network providers, $6,000 individual / $12,000 family; for out-of-network providers $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?	Premiums (contributions), balance-billing charges, penalties, 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	40% coinsurance	60% coinsurance	None.
	Specialist visit	40% coinsurance	60% coinsurance	
	Preventive care/screening/ immunization	No charge.	60% 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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	60% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	60% coinsurance	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	60% coinsurance	None.
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None.
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None.
	Urgent care	40% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	60% coinsurance	Prior authorization is required.
	Physician/surgeon fees	40% coinsurance	60% 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	40% coinsurance	60% coinsurance	Prior authorization required for inpatient services.
	Inpatient services	40% coinsurance	60% 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	40% coinsurance	60% coinsurance	None.
	Childbirth/delivery professional services	40% coinsurance	60% 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	Home health care	40% coinsurance	60% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	40% coinsurance	60% 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.
	Habilitation services	40% coinsurance	60% coinsurance	
	Skilled nursing care	40% coinsurance	60% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.
	Durable medical equipment	40% coinsurance	60% coinsurance	None.
	Hospice services	No charge.	60% coinsurance	
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
		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	15% (after deductible)		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. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% (after deductible)		
	Non-preferred brand drugs	50% (after deductible)		
	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

[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.

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

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]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$12,739

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$5,045
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$8,605

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]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$2,167
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$5,723

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$1,155
Copayments	$0
Coinsurance	$770
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,925

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

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?	**$ 0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	
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**, $1,750** individual / **$3,500** 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.
What is not included in the out-of-pocket limit?	Contributions **(Premiums**, **balance-billing** charges, penalties, 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.kp.org or call (866) 213-3062 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?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt**.** 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	$25 copay/visit	Not covered.	None.
	Specialist visit	$25 copay/visit	Not covered.	
	Preventive care/screening/ immunization	No charge.	Not covered.	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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	$50 copay	Not covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	
	Emergency medical transportation	$0 copay	$0 copay	None.
	Urgent care	$50 copay/visit	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per day to maximum of $600	Not covered.	Prior authorization is required.
	Physician/surgeon fees			

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	$25 copay/day individual / $12 copay/day group	Not covered.	None.
	Inpatient services	$100 copay per day to maximum of $600	Not covered.	Prior authorization is required.
	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	$25 copay	Not covered.	**Copay** applies only to the visit to confirm pregnancy.
	Childbirth/delivery professional services	$100 copay per day to maximum of $600	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	$25 copay/visit	Not covered.	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.
	Habilitation services	$25 copay/visit	Not covered.	
	Skilled nursing care	No charge.	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	No charge.	Not covered.	None.
	Hospice services	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Additional 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
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	$10 copay	$10 for up to a 30-day supply, $20 for up to a 90-day supply	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy.
	Preferred brand drugs	$25 copay	$25 for up to a 30-day supply, $50 for up to a 90-day supply	
	Specialty drugs	$25 copay	$25 for up to a 30-day supply, $50 for up to a 90-day supply	

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
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss program

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
- 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 COBRA requirements[1]. 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.

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

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 Kaiser Permanente.

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.

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

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	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**$25**

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	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,350**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**$25**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,685
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,740**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist *[cost sharing]*	**$25**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**$25**

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	$0
Copayments	$325
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$325**

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

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	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.
Are there services covered before you meet your deductible?	Yes, preventive care, durable medical equipment	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?	**$3,500** individual / **$7,000** 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.
What is not included in the out-of-pocket limit?	Contributions **(Premiums**, **balance-billing** charges, penalties, 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.kp.org or call (866) 213-3062 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?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt**.** 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	$25 copay/visit	Not covered.	None.
	Specialist visit	$35 copay/visit	Not covered.	
	Preventive care/screening/ immunization	No charge.	Not covered.	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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	$50 copay/visit	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required.
	Physician/surgeon fees			

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	$25 copay/day individual / $12 copay/day group	Not covered.	There is 20% coinsurance for partial hospitalization for which prior authorization is required.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
	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	$25 copay/PCP / $35 copay specialist	Not covered.	**Copay** applies only to the visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	$25 copay/visit	Not covered.	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.
	Habilitation services	$25 copay/visit	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered.	None.
	Hospice services	No charge.	Not covered.	None.
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
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	$10 copay	$10 for up to a 30-day supply, $20 for up to a 90-day supply	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy.
	Preferred brand drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-day supply	
	Specialty drugs	$30 copay	$30 for up to a 30-day supply, $60 for up to a 90-day supply	

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
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss program

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
- Private-duty nursing

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

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[1]. 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 Kaiser Permanente.

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.

[1] 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]*	**$35**
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)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,651**

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]*	**$35**
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$970
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,898**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$500**
Specialist *[cost sharing]*	**$35**
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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$205
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$877**

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

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?	**$ 2,700**/Individual or **$5,450** 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.
Are there services covered before you meet your deductible?	Yes, preventive care	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.	
What is the out-of-pocket limit for this plan?	**$4,200** individual / **$8,450** 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.
What is not included in the out-of-pocket limit?	Contributions **(Premiums)**, **balance-billing** charges, penalties, 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.kp.org or call (866) 213-3062 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?	Yes.	The Plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Questions: Call 1-866-213-3062 or visit http://my.kp.org/ecmt. 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	20% coinsurance	Not covered.	None.
	Specialist visit	20% coinsurance	Not covered.	
	Preventive care/screening/ immunization	No charge.	Not covered.	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. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered.	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	Not covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required.
	Physician/surgeon fees			

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	20% coinsurance	Not covered.	None.
	Inpatient services	20% coinsurance	Not covered.	Prior authorization is required.
If you are pregnant	Office visits	No charge.	Not covered.	None. **Deductible** does not apply to pre-natal and first post-partum visit.
	Childbirth/delivery professional services	20% coinsurance	Not covered.	Well-newborn care is covered.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge.	Not covered.	Includes nurse visits (2 hours), aide visits (4 hours), therapy visits, and supplies. Limited to 210 visits per plan year.
	Rehabilitation services	20% coinsurance	Not covered.	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.
	Habilitation services	20% coinsurance	Not covered.	
	Skilled nursing care	20% coinsurance	Not covered.	Limited to 60 days per plan year, combined with acute rehabilitation.
	Durable medical equipment	20% coinsurance	Not covered.	None.
	Hospice services	No charge.	Not covered.	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	Additional 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
		Retail	Mail Order	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org.	Generic drugs	15% coinsurance		You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using the mail order pharmacy. Your prescription deductible and out-of-pocket limit is combined with your medical deductible and out-of-pocket limit.
	Preferred brand drugs	25% coinsurance		
	Specialty drugs	25% coinsurance		

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
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss program

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
- 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 COBRA requirements[1]. 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 Kaiser Permanente.

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

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.

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

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** $2,700
- **Specialist** *[cost sharing]* *20%*
- **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)*

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$2,525
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,605**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $2,700
- **Specialist** *[cost sharing]* *20%*
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$950
Copayments	$1,135
Coinsurance	$465
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,605**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $2,700
- **Specialist** *[cost sharing]* *20%*
- **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)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$275
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

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

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2019 (DD25: Dental & Orthodontia)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: II, III and IX expenses	$2,000	$2,000	$2,000
Calendar Year Deductible Individual Family	 $0 $0	 $25 $75	 $25 $75
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Oral Surgery: major Osseous Surgery	85% No Deductible	85% After Deductible	85% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $1,500	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	85% No Deductible	85% After Deductible	85% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.

Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program. Those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: *Benefit frequency limitations are based on date of service.*	
Oral Evaluations	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2019 (DD50: Basic Dental)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: II, III and IX expenses	$2,000	$2,000	$2,000
Calendar Year Deductible Individual Family	 $0 $0	 $50 $150	 $50 $150
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	100% No Deductible	100% No Deductible
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	85% No Deductible	85% After Deductible	85% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Anesthesia: general and IV sedation Oral Surgery: major Osseous Surgery	50% No Deductible	50% After Deductible	50% After Deductible
Class IX: Implants	50% No Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Carryover Provision	Dental Expenses incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.
Pretreatment Review	Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.

Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program. Those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations: *Benefit frequency limitations are based on date of service.*	
Oral Evaluations	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;	
Prosthodontics: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Orthodontics: orthodontic treatment;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

BSD

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2019 (DDPV: Preventive Dental)

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class II, III, and IV expenses	$1,500		$1,500	
Calendar Year Deductible Individual Family	$0 $0		$0 $0	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments	80% No Deductible	20% No Deductible	80% No Deductible	80% No Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures Oral Surgery: major	1% No Deductible	99% No Deductible	1% No Deductible	99% No Deductible

Class IV: Orthodontia Coverage for Employee and All Dependents	1% No Deductible	99% No Deductible	1% No Deductible	99% No Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations	3 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	3 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	2 per calendar year for children under age 19
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

Procedures and services not included in the list of covered dental expenses;

Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars; Periodontics: bite registrations; splinting;
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;
Implants: implants or implant related services
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs
Charges in excess of the Maximum Reimbursable Charge

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

BSD

Episcopal Church Medical Trust

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$0 Co-pay	Up to $30
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $150 allowance; 20% off balance over $150	Up to $47
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $32
Bifocal	$10 Co-pay	Up to $46
Trifocal	$10 Co-pay	Up to $57
Standard Progressive Lens	$75 Co-pay	Up to $46
Premium Progressive Lens△	$95 Co-pay - $120 Co-pay	
Tier 1	$95 Co-pay	Up to $46
Tier 2	$105 Co-pay	Up to $46
Tier 3	$120 Co-pay	Up to $46
Tier 4	$75 Co-pay, 20% off charge less $120 Allowance	Up to $46
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$0	Up to $28
Standard Polycarbonate - Kids under 19	$0	Up to $28
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating△	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Co-pay; $150 allowance; 15% off balance over $150	Up to $100
Disposable	$0 Co-pay; $150 allowance; plus balance over $150	Up to $100
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

△Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

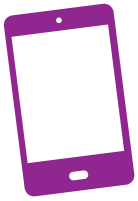
Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	**$0 Co-pay**	Up to $30
Frames (Once every 12 months)	**$0 Co-pay; $150 allowance; 20% off balance over $150**	Up to $47
Single Vision Lenses (Once every 12 months) Or **Contacts** (Once every 12 months)	**$10 Co-pay** / **$0 Co-pay; $150 allowance; plus balance over $150**	Up to $32 / Up to $100

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

87% SAVINGS with us*

With EyeMed	Without Insurance**
Exam $0 Co-pay	Exam $106
Frame $163 **-$150 allowance** **$13** **-$2.60 (20% discount off balance)** **$10.40**	Frame $163
Lens $10 Co-pay **$15 UV treatment add-on** **+$15 Scratch coating add-on** **$40**	Lens $78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total $50.40	Total $395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Optical | Sears Optical | JCPenney optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.