CHURCH PENSION GROUP
Serving the Episcopal Church and its People

Episcopal Diocese of Los Angeles

Healthcare Benefits Information

2021

Church Pension Group
Integrated Benefits Account Management Services

EPISCOPAL CHURCH MEDICAL TRUST

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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 Deductible (CDHPs have a combined medical & Rx 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
Behavioral Health								
Outpatient Services	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance	$30 copay	30% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
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 (210 visits per calendar year, combined network and out-of-network)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)	$30 copay PCP/$45 copay specialist (includes speech, physical, and occupational)	50% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$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

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EPISCOPAL CHURCH MEDICAL TRUST

Plan	Anthem BCBS CDHP 15/HSA		Anthem BCBS CDHP 20/HSA		Anthem BCBS CDHP 40/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Deductible (CDHPs have a combined medical & Rx 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)	$2,800 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
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
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Behavioral Health						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	15% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)	45% coinsurance (includes speech, physical, and occupational)	40% coinsurance (includes speech, physical, and occupational)	60% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

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EPISCOPAL CHURCH MEDICAL TRUST

Plan	Kaiser EPO High	Kaiser EPO 80	Kaiser CDHP 20/HSA
	Network Only	Network Only	Network Only
Annual Deductible (CDHPs have a combined medical & Rx deductible)	$0 per person $0 per family	$500 per person $1,000 per family	$2,800 per person $5,450 per family
Annual Out-of-Pocket Limit	$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	$0 copay	$0 copay
Physician Services			
Office Visit	$25 copay	$25 copay	20% coinsurance
Diagnostic Services (outpatient)	$50 copay	20% coinsurance	20% coinsurance
Specialist Care	$25 copay	$35 copay	20% coinsurance
Hospital Services			
Inpatient Services (including inpatient maternity services)	$100 per day copay to maximum of $600	20% coinsurance	20% coinsurance
Outpatient Surgery	$100 copay	20% coinsurance	20% coinsurance
Emergency Room Care	$100 copay	20% coinsurance	20% coinsurance
Ambulance Services	$0 copay	20% coinsurance	20% coinsurance
Behavioral Health			
Outpatient Services	$25 copay per visit for individual visit	$25 copay per visit for individual visit	20% coinsurance
Inpatient Services	$100 per day copay to maximum of $600	20% coinsurance	20% coinsurance
Other Medical Services			
Durable Medical Equipment	$0 copay	20% coinsurance	20% coinsurance
Home Health Care (210 visits per calendar year, combined network and out-of-network)	$0 copay	$0 copay	$0 copay
Outpatient Therapy (60 visits per calendar year per each type of therapy, combined network and out-of-network)	$25 copay (includes speech, physical, and occupational)	$25 copay (includes speech, physical, and occupational)	20% coinsurance (includes speech, physical, and occupational)
Skilled Nursing / Acute Rehabilitation Facility (60 days per calendar year, combined network and out-of-network)	$0 copay	20% coinsurance	20% coinsurance
Urgent Care Services	$50 copay	$50 copay	20% coinsurance

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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)	$2,800 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)

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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	$2,800 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

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Dental Benefits						
	CIGNA DENTAL					
	Preventive Dental PPO Plan		**Basic Dental PPO Plan**		**Dental & Orthodontia PPO Plan**	
	DPPO Advantage	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*	*DPPO Advantage*	*DPPO and Out-of-Network*
Deductible	$0 per person $0 per family	$0 per person 0 per family	$0 per person $0 per family	$50 per person $150 per family	$0 per person $0 per family	$25 per person $75 per family
Annual Benefit Limit	$1,500		$2,000		$2,000	
Preventive and 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 (not subject to annual deductible)	
Basic Restorative Services (Includes fillings, root canal therapy, and denture adjustments and repairs)	You pay 20% coinsurance		You pay 15% coinsurance	You pay 15% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Major Restorative Services (Includes crowns, dentures, oral surgery, osseous surgery, and bridges)	You pay 99% coinsurance		You pay 50% coinsurance	You pay 50% coinsurance after deductible	You pay 15% coinsurance	You pay 15% coinsurance after deductible
Orthodontia Services	You pay 99% coinsurance		Not covered. You pay 100%.		You pay 50% coinsurance up to individual lifetime benefit limit of $1,500	You pay 50% coinsurance up to individual lifetime benefit limit of $1,500 after deductible

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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.

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, copays for certain specialty pharmacy drugs considered non-essential health benefits, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

** See Page 5 for important information about evaluation, testing, and treatment of COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
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	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing, and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$30 copay/visit	30% coinsurance	Prior authorization is required for inpatient services.
	Inpatient services	$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.
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.
	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.

** See Page 5 for important information about evaluation, testing, and treatment of COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information *
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	Up to $40	Up to $100	Up to $30	Up to $75	
	Non-preferred brand drugs	Up to $80	Up to $200	Up to $60	Up to $150	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. Certain specialty drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance.				

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[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 services outside the U.S. are not available through Express Scripts.

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

** See Page 5 for important information about evaluation, testing, and telehealth services.

COVID-19 Evaluation, Testing, and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[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:
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[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.
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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, for example certain preventive services, COVID-19 expenses, diagnostic tests, and office visits	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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, copays for certain specialty pharmacy drugs considered non-essential health benefits, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (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	In-network deductible does not apply.**
	Specialist visit	$45 copay/visit	50% coinsurance	**
	Preventive care/screening/ immunization	No charge.	50% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	Deductible does not apply. **
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	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	Deductible does not apply. **
	Urgent care	$50 copay	$50 copay	**
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.
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$30 copay/visit	30% coinsurance	Prior authorization is required for inpatient services.
	Inpatient services	10% coinsurance	50% coinsurance	
	Colleague Group	30% coinsurance	30% coinsurance	The plan will reimburse 70% up to a maximum reimbursable fee of $40. The member is responsible for all costs above that amount. Benefits are provided through Cigna Behavioral Health.
If you are pregnant	Office visits	$30 copay	50% coinsurance	Copay applies only to the visit to confirm pregnancy. In-network deductible does not apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	Well-newborn care is covered. Newborn must be enrolled in Plan within 30 days of birth.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 210 visits per plan year. Prior authorization is required.
	Rehabilitation services	$30 PCP/$45 specialist	50% coinsurance	Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies. In-network Deductible does not apply.
	Habilitation services	$30 PCP/$45 specialist	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per plan year, combined with acute rehabilitation. Prior Authorization is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	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.
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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	Up to $40	Up to $100	Up to $30	Up to $75	
	Non-preferred brand drugs	Up to $80	Up to $200	Up to $60	Up to $150	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. Certain specialty drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance.				

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[1]
• Private-duty nursing		

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COVID-19 Evaluation, Testing, and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[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.

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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.

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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, for example certain preventive services, COVID-19 expenses, diagnostic tests, and office visits	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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, copays for certain specialty pharmacy drugs considered non-essential health benefits, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (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	**
	Specialist visit	$45 copay/visit	50% coinsurance	
	Preventive care/screening/ immunization	No charge.	50% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Deductible does not apply. **
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	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	Deductible does not apply. **
	Urgent care	$50 copay	$50 copay	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization is required. **
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$30 copay/visit	30% coinsurance	Prior authorization is required for inpatient services.
	Inpatient services	20% coinsurance	50% coinsurance	
	Colleague Group	30% coinsurance	30% coinsurance	The 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	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.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. See "Important Questions" regarding the Plan's out-of-pocket limit on page 1. For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	Up to $40	Up to $100	Up to $30	Up to $75	
	Non-preferred brand drugs	Up to $80	Up to $200	Up to $60	Up to $150	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. Certain specialty drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance.				

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[1]
• Private-duty nursing		

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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.

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[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	$3,500

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, for example certain preventive services, COVID-19 expenses, office visits, and diagnostic tests	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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, copays for certain specialty pharmacy drugs considered non-essential health benefits, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (844) 812-9207 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (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	**
	Specialist visit	$45 copay/visit	50% coinsurance	**
	Preventive care/screening/ Immunization	No charge.	50% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	**Deductible** does not apply.**
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	**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	**Deductible** does not apply.**
	Urgent care	$50 copay/visit	$50 copay/visit	**
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	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services.	Outpatient services	$30 copay/visit	30% coinsurance	Prior authorization is required for inpatient services.
	Inpatient services	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	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.
** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information*
		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Home Delivery	Retail	Home Delivery	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Up to $10	Up to $25	Up to $5	Up to $12	You may get up to a 30-day supply when using a retail pharmacy, and up to a 90-day supply when using home delivery. See "Important Questions" regarding the Plan's out-of-pocket limit on page 1.** For a complete list of non-essential specialty medications, see SaveonSP.com/cpg.
	Preferred brand drugs	Up to $40	Up to $100	Up to $30	Up to $75	
	Non-preferred brand drugs	Up to $80	Up to $200	Up to $60	Up to $150	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug. Certain specialty drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance.				

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[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.

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

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

COVID-19 Evaluation, Testing, and Treatment, and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. Additionally, the Medical Trust will allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[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， ☒☒打☒个号☒ (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.

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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	$5,000

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.
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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, for example certain preventive services and COVID-19 expenses	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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.

** See Page 5 for important information about evaluation, testing, and treatment of COVID-19, and telehealth services.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (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	**
	Specialist visit	15% coinsurance	40% coinsurance	**
	Preventive care/screening/ immunization	No charge.	40% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	**
	Imaging (CT/PET scans, MRIs)	15% coinsurance	40% coinsurance	**
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	**
	Emergency medical transportation	15% coinsurance	15% coinsurance	**
	Urgent care	15% coinsurance	15% coinsurance	**
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.	

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)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	Non-emergency care when traveling outside the U.S.[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.

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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， ☒☒打☒个号☒ (800) 480-9967.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 480-9967.

[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 $1,400
- 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	$2,400

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	$2,400

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?	$ 2,800/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, for example certain preventive services and COVID-19 expenses	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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	**
	Specialist visit	20% coinsurance	45% coinsurance	**
	Preventive care/screening/ immunization	No charge.	45% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	45% coinsurance	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance	**
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	**
	Emergency medical transportation	20% coinsurance	20% coinsurance	**
	Urgent care	20% coinsurance	20% coinsurance	**
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	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

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)	• Long-term care
• Routine eye care (Adult)	• Routine foot care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Non-emergency care when traveling outside the U.S.[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.

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[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， ☒☒打☒个号☒ (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.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

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	$4,260

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	$4,255

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.

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, for example certain preventive services and COVID-19 expenses	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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	**
	Specialist visit	40% coinsurance	60% coinsurance	**
	Preventive care/screening/ immunization	No charge.	60% coinsurance	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	60% coinsurance	**
	Imaging (CT/PET scans, MRIs)	40% coinsurance	60% coinsurance	**
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	**
	Emergency medical transportation	40% coinsurance	40% coinsurance	**
	Urgent care	40% coinsurance	40% coinsurance	**
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	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	

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

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

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)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.[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.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services received through vendor platforms. The Medical Trust will also allow claims for virtual visits with network and out-of-network providers who do not use a telehealth platform offered by Anthem. Standard deductibles, copays, and coinsurance will apply.

Your Rights to Continue Coverage: The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[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， ☒☒打☒个号☒ (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]* 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	$6,060

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.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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.	**
	Specialist visit	$25 copay/visit	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	Not covered.	**
	Imaging (CT/PET scans, MRIs)	$50 copay	Not covered.	**
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	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	$50 copay/visit	Not covered.	**
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			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing

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

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

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， ☒☒打☒个号☒ (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	$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, for example certain preventive services, COVID-19 expenses, and office visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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.	**
	Specialist visit	$35 copay/visit	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	**
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	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	$50 copay/visit	Not covered.	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required. **
	Physician/surgeon fees			

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

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing

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

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

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，☒☒打☒个号☒ (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?	$ 2,800/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, for example certain preventive services and COVID-19 expenses	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. See a list of preventive services at healthcare.gov/coverage/preventive-care-benefits.**
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.

** See Page 5 for important information about evaluation, testing, and treatment for COVID-19, and telehealth services.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (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.	**
	Specialist visit	20% coinsurance	Not covered.	**
	Preventive care/screening/ immunization	No charge.	Not covered.	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. See a list of preventive services at healthcare.gov/coverage/ preventive-care-benefits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered.	**
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered.	**
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	If provided through the 911 emergency response system, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital. **
	Urgent care	20% coinsurance	Not covered.	**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered.	Prior authorization is required. **
	Physician/surgeon fees			

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information *
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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)	• Long-term care
• Non-emergency care when traveling outside the U.S.	• Routine eye care	• Routine foot care
• Weight loss programs		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids	• Infertility treatment	• Private-duty nursing

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

** See Page 5 for important information about the evaluation, testing, and treatment of COVID-19 and telehealth services.

COVID-19 Evaluation, Testing, and Treatment and Telehealth Services: The Medical Trust will waive all copays, deductibles, and coinsurance for its members for healthcare services relating to the evaluation and testing for COVID-19. In addition, the Medical Trust will waive all copays, deductibles, and in-network coinsurance for its active members for healthcare services relating to the treatment of COVID-19. The Medical Trust will also waive all copays, deductibles, and coinsurance for all telehealth services with a Kaiser provider.

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， ☒☒打☒个号☒ (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	$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	$4,260

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%*

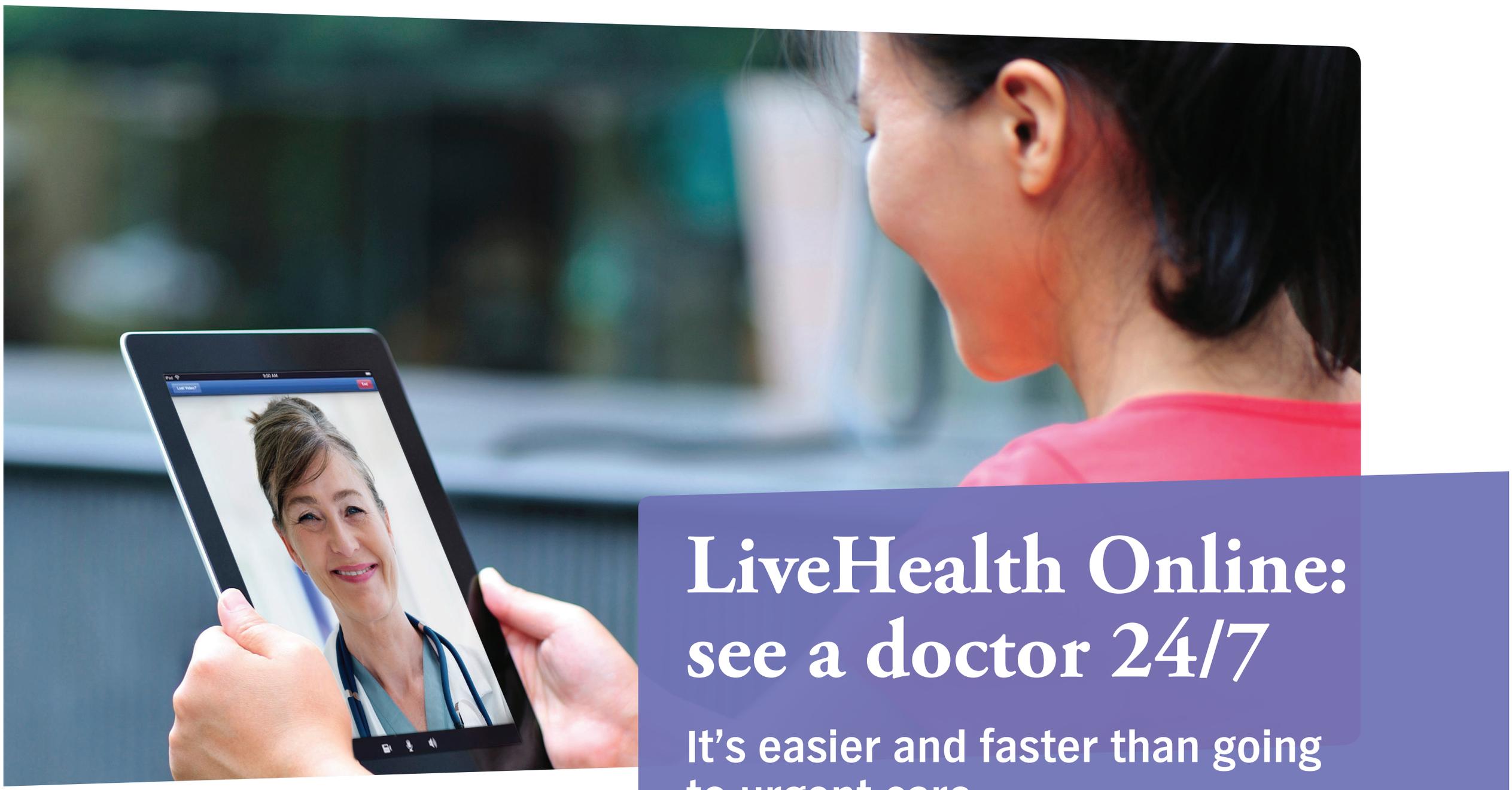
This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

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.



LiveHealth Online: see a doctor 24/7

It's easier and faster than going to urgent care

Sign up for LiveHealth Online today!
It's quick and easy to sign up — just go to **livehealthonline.com** or download the mobile app.

Download on the App Store
apple.com

ANDROID APP ON Google play
play.google.com/store

The next time you or someone in your family needs to see a doctor, use LiveHealth Online. See a doctor with a smartphone or tablet using our free app, or a computer with a webcam.[1]

With LiveHealth Online, you get:

- Immediate, 24/7 access to board-certified doctors.
- Secure and private video chats with your choice of doctor.
- Prescriptions that can be sent to your pharmacy, if needed.[2]

The cost of a LiveHealth Online visit is $49 or less depending on your health plan.

Anthem BlueCross BlueShield

LiveHealth ONLINE

1 LiveHealth Online is offered in most states and is expected to grow more in the near future. Visit the home page at livehealthonline.com to see the latest map showing where service is available.

2 As legally permitted in certain states.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc.; HMO plans administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Anthem BlueCross BlueShield

LiveHealth® ONLINE

Frequently asked questions

What is LiveHealth Online®?

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving and no waiting at an urgent care center.

Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! It's faster, easier and more convenient than a visit to an urgent care center.

Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online is not meant to replace your primary care physician. However, it is a convenient option for care if your physician is not available, or if you need care for common problems like a cold or the flu. LiveHealth Online connects you with a board-certified doctor in just a couple of minutes. Plus, you can get a LiveHealth Online visit summary from the *MyHealth* tab to print, email or fax to your primary doctor.

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

When is LiveHealth Online available?

Doctors are available on LiveHealth Online 24/7, 365 days a year.

How do I access the LiveHealth Online mobile app?

You can download the LiveHealth Online mobile app for free on your mobile device by visiting the App Store℠ or Google Play™.

Do doctors have access to my health information?

LiveHealth Online doctors can only access your health information and review previous treatment recommendations and information from prior LiveHealth Online visits.

If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future LiveHealth Online visits.

How does LiveHealth Online work?

When you need to see a doctor, simply go to **livehealthonline.com** or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Best of all, LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit.

Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule.

Once connected, you can talk and interact with the doctor as if you were in a private exam room.

How long does a LiveHealth Online session with a doctor usually last?

A typical LiveHealth Online session lasts about 10 minutes.

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How much does it cost to use LiveHealth Online?

LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit. To find out how much your visit will cost, enter your member ID on LiveHealth Online and the cost will be shown before you visit with a doctor.

Your family and friends also can use LiveHealth Online by paying the full cost of the visit, $49.

Will I be charged more if I use LiveHealth Online on weekends, holidays or at night?

No. The cost is the same.

How do I pay for a LiveHealth Online session?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Please keep in mind that charges for prescriptions aren't included in the cost of your doctor's visit.

Can I get online care from a doctor if I'm traveling or in another state?

As long as you are located in a state where LiveHealth Online is available, you can get online care. To determine if online visits with a doctor are available in your state, please visit **livehealthonline.com** and view the state map at the bottom of the home page.

Why do some states offer prescriptions after my visit and other states don't?

Some state laws require a face-to-face visit before allowing prescriptions. Every state is different and these laws change often. Please visit **livehealthonline.com** regularly to see if online visits with a doctor are available in your state. Please note that doctors using LiveHealth Online are not able to prescribe controlled substances or lifestyle drugs.

Do I have what I need to access doctors through LiveHealth Online?

To find out how to use LiveHealth Online on your computer or mobile device, go to **livehealthonline.com** and select the **About** tab. Then scroll down to the *More Information* section on the left side of the page.

Who do I get in touch with if I still have questions?

You can email, customersupport@livehealthonline.com or call toll free at 1-855-603-7985.

If you send us an email, please be sure to include:

- Your name
- Your email
- A phone number where you can be reached

Anthem BlueCross BlueShield

LiveHealth ONLINE

EPISCOPAL CHURCH MEDICAL TRUST

2020-2021 Consumer-Directed Health Plan/Health Savings Account Fact Sheet for Members

Your Consumer-Directed Health Plan

A Consumer-Directed Health Plan (CDHP),[1] coupled with an interest-bearing Health Savings Account (HSA), is a health plan that works a little differently from what you might be accustomed to.

Understanding how a CDHP/HSA functions will help you get the most from your benefits. This fact sheet provides CDHP/HSA basics, including how to get started after you enroll and how to use your CDHP/HSA benefits actively. The Episcopal Church Medical Trust (Medical Trust) offers seven CDHPs: three through Anthem Blue Cross and Blue Shield (Anthem BCBS), three through Cigna, and one through Kaiser Permanente (Kaiser). See details below about the plans.

CDHP Overview

A CDHP is designed to have a high deductible, a requirement that allows you to set up an HSA. This annual deductible applies to most covered medical, behavioral, and pharmacy benefits. It does not apply to most preventive care services. That means you pay 100% of your medical, behavioral, and prescription drug expenses until you have met your annual deductible. **Most preventive services are covered at 100% with no cost-sharing when using network providers.**

Once you have met the annual deductible, the plan shares expenses with you. You will then pay coinsurance for eligible services, but the total amount you pay will be limited to the annual out-of-pocket limit, which is the combined total of your annual deductible and annual coinsurance ceiling.

HSA Overview

A qualified CDHP—such as those offered through the Medical Trust from Anthem BCBS, Cigna, and Kaiser—allows employees to open an HSA, provided the HSA eligibility requirements are otherwise met. (See next section.)

With an HSA, you may choose to fund expenses out-of-pocket and let the tax-favored funds grow in your HSA for future healthcare expenses, or you may use them as needed. You, your employer, and/or others have the option of contributing to the account. Contributions are tax-free up to federal annual limits.

You should also understand these basic aspects of how an HSA works:

- Accounts are owned by the employee.
- Accounts are portable from employer to employer.
- Unused funds roll over from year to year.
- HSA funds can earn interest.
- Funds in the HSA may be invested (once any applicable minimum threshold is met).
- Withdrawals from the HSA are not subject to federal income tax when they are used to pay for qualified medical expenses.

[1] *Consumer-Directed Health Plan/Health Savings Account (CDHP/HSA) is used throughout to refer to the Anthem BCBS, Cigna, and Kaiser HDHPs, where they are alike. Any differences in the plans will be clearly noted within the text.*

HSA Eligibility

To open an HSA, you must be enrolled in a qualifying CDHP. Generally, you are not permitted to be covered by other, disqualifying types of health plans, with these exceptions: AFLAC-type coverage, separate dental and vision coverage, and disability coverage. Disqualifying health coverage includes Medicare, TRICARE, non-CDHP coverage under a plan of your spouse's or domestic partner's employer, or healthcare flexible spending account (FSA) coverage. However, you are permitted coverage under a limited-purpose flexible spending account (LPFSA) or limited-purpose health reimbursement account (HRA). LPFSAs and limited-purpose HRAs are designed to work with HSAs. Contact your employer to see if an LPFSA or limited-purpose HRA is offered.

Also note that you may not be claimed as a dependent on another individual's tax return.

CDHP Basics

Preventive Care Services

Certain preventive care services are covered at 100% in-network. This means that you do not need to meet the deductible before the plan pays for recommended routine visits such as adult physicals, well-child visits, and OB/GYN annual exams. Depending on factors such as age and family history, other preventive care services may also be fully covered.

Annual Deductible (medical and pharmacy)

Your deductible is an integrated medical and pharmacy deductible. This means both your medical and pharmacy expenses count toward your deductible. It is important to keep in mind that your network and out-of-network deductibles accumulate separately.

Coinsurance

Once you meet your annual deductible,[2] you will pay coinsurance for eligible services. Coinsurance is a percentage of the allowed expense that you must pay. (The Medical Trust's CDHPs differ from other employer-provided plans, which often use copayments in addition to or instead of coinsurance.) The percentage you pay is lower when you use network providers than when using out-of-network providers.

After you pay your coinsurance, the plan pays the remainder of the bill for eligible services from network providers. For out-of-network provider services, you are responsible for coinsurance and any charges above the allowed amount, making out-of-network providers more costly than network providers in most cases.
Note: The Kaiser CDHP covers network services only.

CDHP Annual Out-of-Pocket Limit

Your plan sets a limit on the amount you will have to pay out-of-pocket for services each year. This is your "out-of-pocket limit" and is equal to the combined total of your annual coinsurance maximum and annual deductible.

After you reach the out-of-pocket limit,[3] the plan will pay 100% of eligible charges for the remainder of the plan year.

It is important to note that your network and out-of-network out-of-pocket limits accumulate separately.

Network = Savings

You will usually pay less for services from network providers than you will from out-of-network providers, for two reasons. First, your network coinsurance is lower than your out-of-network coinsurance. Second, network providers can bill you based only on a certain amount, the "allowed amount."

The allowed amount is what our plan vendors—Anthem BCBS, Kaiser, and Cigna—have negotiated with service providers on behalf of the Medical Trust. These discounted rates for medical services from network providers can save you lots of money.

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[2] *Members enrolled in a CDHP-15 with covered dependents must meet the family deductible before the plan pays for any covered member.*
[3] *Members enrolled in a CDHP-15 with covered dependents must reach the family out-of-pocket limit before the plan begins to pay 100% of covered services for any covered member.*

Using Network Providers

Remember, going to a network provider should make things easier for you overall and may have significant cost-saving advantages.

1. Provide your health plan membership information when you call to make the appointment.
2. If you see a network provider, you are not required to make payment at the time of service.[4] Your network provider will code the visit and bill it to your plan.
3. If you choose to pay out-of-pocket at the time of service, be sure that the service and your related payment are run through the vendor claims system so that any network discount will apply and your payment will be credited toward your network deductible.
4. Anthem BCBS, Cigna, or Kaiser will send you an Explanation of Benefits (EOB) informing you of the cost share you will pay for the services based on the negotiated rates and plan coverage.
5. You may make payment by using your HSA debit card5, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.
6. Many preventive care services are paid at 100% when you use a network provider; all other services are subject to the annual deductible and, if applicable, coinsurance.

Using Out-of-Network Providers

It is important to note that if you see an out-of-network provider, you may be required to make payment at the time of service. **Note:** The Kaiser CDHP covers network services only.

1. Provide your health plan membership information when you call to make the appointment.
2. You may make payment by using your HSA debit card[5,] or you can use another bank card and either reimburse yourself with funds from your HSA[4] or let your health savings remain in the HSA for future use.
3. Be sure that the service and your related payment are run through the vendor claims system by reviewing your Explanation of Benefits so that your payment will be credited toward your out-of-network deductible and coinsurance maximum as applicable.

Prescription Benefits

Prescriptions must be paid for at the time of service at a retail pharmacy or through a mail-order pharmacy.

1. Provide the pharmacy with your Express Scripts card to ensure purchases are applied toward your annual deductible and coinsurance maximum, as applicable.
2. You will be paying the negotiated rate. (Coinsurance amounts begin once you have met your annual deductible.)
3. You may make payment by using your HSA[5] debit card, or you can use another bank card and either reimburse yourself with funds from your HSA or let your health savings remain in the HSA for future use.

Using Your HSA Contributions

Making regular contributions to your Health Savings Account is a simple and convenient way to build up your HSA balance, creating tax-favored savings for future qualified medical expenses.

Keep Your Receipts
The IRS requires that you keep records to show that HSA distributions were used to pay for or reimburse qualified medical expenses that had not been previously paid or reimbursed from another source.

Note that you may cover dependents under a CDHP even if they are not your federal tax code

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[4] We encourage you to wait for your Explanation of Benefits from Anthem BCBS, Cigna, or Kaiser before making payment to ensure that the negotiated rate for service is applied.

[5] Note that some banks have fees associated with reimbursing yourself through your debit card. Check with your financial institution about any such fees.

dependents for HSA purposes. For example, your 25-year-old child may not be a tax dependent, but he or she would still be eligible for coverage from the CDHP. Because your child is not a tax dependent, however, she or he will not be eligible to have expenses reimbursed from the HSA even though the child is covered under the CDHP.

If you do not use all of your HSA funds in one calendar year, the remaining money rolls over for use in future years. If you change plans or retire, the HSA is still yours and can be used for qualified medical expenses.

Tax-Free Advantage

You pay absolutely no federal taxes on any contributions (up to applicable limits), interest earned, or investment profits in your HSA. If you make a contribution to your HSA with money on which you have already been taxed, you can take a corresponding deduction on your federal income tax return, again, up to applicable limits. In addition, you are not subject to federal income tax when you withdraw money to pay for qualified medical expenses.

However, if you withdraw money for reasons other than to pay for qualified medical expenses, you will pay taxes and an IRS-determined penalty (currently 20%) on the amount of the withdrawal. The penalty does not apply if you are 65-plus years of age, or disabled, or if you have died and your HSA is being used by your spouse who is 65-plus years of age. (Spouses who are under 65 must then use the money for eligible expenses or pay a penalty.) If you have died and your beneficiary is someone other than your spouse, then the HSA ceases to be an HSA and the money in the account is fully taxable to the beneficiary.

HSA Funding Options

HealthEquity – Members who enroll in any CDHP through the Medical Trust will automatically have an HSA set up by HealthEquity, who will also send them a welcome kit. If the member uses HealthEquity as the HSA vendor, there are no setup fees for the HSA and maintenance fees are waived for the subscribing member only. If a subscribing member's employment is terminated or the member is no longer enrolled in a CDHP through the Medical Trust, she or he will be responsible for all fees.

HealthEquity also offers other advantages, including access to web-based tools that can assist you in tracking and monitoring your HSA activity.

Local bank chosen by your employer – In some cases, your employer may choose to use an institution other than HealthEquity for HSA funding. If so, you will receive information from your employer concerning the HSA funding process.

Financial institution of your choice – Members who do not wish to use HealthEquity as their HSA vendor can choose, after consulting with their employer, to establish an HSA with any appropriate institution (e.g., those qualified to administer IRAs), but they will be responsible for all fees.

If you do so, however, please keep in mind that you may not be able to direct to that financial institution contributions by your employer (if any) or tax-advantaged salary reduction contributions. Please check with your employer and the institution. Consequently, you may lose valuable employer contributions and the ability to make contributions through convenient payroll deduction. (You will still be able to make after-tax contributions up to the applicable contribution limit and claim a corresponding deduction on your federal income tax return.)

If you establish an HSA with HealthEquity (to receive employer contributions and your pre-tax contributions), you may then transfer any funds to an HSA with another bank.

Annual HSA Employer and Employee Combined Contribution Limits

2020	2021
Individual $3,550	Individual $3,600
Family $7,100	Family $7,200

If you are age 55 or older, you may make additional catch-up contributions of up to $1,000 for 2020 and 2021.

Timing of HSA Contributions

Contributions to an HSA cannot occur until after the first of the month in which the CDHP becomes effective, and your HSA has been opened. What that means is if your plan becomes effective on January 1, contributions cannot be made until after that date. If you have medical expenses on January 1 before your account is funded, you can pay out-of-pocket and reimburse yourself from your HSA once the funds are deposited. No reimbursement is permitted for expenses incurred before you open your HSA. So, for example, if you delay and do not complete the requisite paperwork to open the account until February 1, expenses incurred in January cannot be reimbursed.

Employer HSA Contributions

Each employer (diocese, parish, school, or other Episcopal organization) establishes its HSA contribution policy in line with IRS requirements.

Your employer's HSA contribution policy will define the amount of funds, if any, your employer will contribute to your HSA, the frequency with which these contributions will be made (bi-weekly, monthly, quarterly, or annually), and who will be eligible for such contributions.

Your employer is responsible for communicating its contribution policy to you.

Employee HSA Contributions

Once opened, you may begin contributing funds into your HSA. To contribute, you can make pre-tax contributions through automatic payroll deductions (if available) or through an after-tax contribution that you mail in. You can then take a corresponding deduction on your taxes at the end of the tax year. You must make HSA contributions for a given calendar year by the tax filing deadline for that year (generally the following April 15, but in some years the date may differ due to the calendar).

Be mindful that your own contributions and any funding you will receive from your employer do not exceed the annual limits for HSA contributions.

Qualified Medical Expenses

Qualified medical expenses include, but are not limited to, deductibles and coinsurance, prescription drugs, mental health and substance use disorder treatment, as well as dental and vision services. HSA distributions can be used for qualified medical expenses for you, your spouse, and your federal tax code dependents. A list of qualified medical expenses can be found on the IRS website.

Funds in the HSA are yours to determine how best to use. You may use them right away to cover deductibles and coinsurance amounts, or you may choose to use your own money and pay out-of-pocket, and reserve the funds in your HSA as your tax-favored health savings for future expenses.

Managing HSA Funds

If, for instance, in March you have $1,000 in your HSA and a $1,500 medical bill, you can use the $1,000 in the HSA and pay the additional $500 from your own funds. Throughout the year, the IRS allows you to reimburse yourself the remaining $500 from the HSA, as contributions are made into the account. You are responsible for keeping documentation to prove that the HSA funds being reimbursed were used for qualified medical expenses.

Tax Information

Your HSA custodian will provide the following forms to both you and the IRS annually:

Form 5498-SA – This form details HSA contributions made by you and your employer for the year.

Form 1099-SA – This form reports all HSA distributions made during the year.

Your employer must report to you on your Form W-2, in box 12 with code W, all employer HSA contributions as well as any HSA amounts contributed by you (from your paycheck) on a pre-tax basis through an Internal

Revenue Code section 125 cafeteria plan. You will be responsible for completing Form 8889, which details HSA contributions, when you file your Form 1040. Also, please note that any additional amounts contributed to your HSA must be reported on Form 8889 and may be eligible to be claimed as a tax deduction, which could lower your taxable income.

Domestic Partners and Same-Gender Spouses

If your group allows domestic partners to be covered as dependents on your health plan, then your domestic partner can be enrolled in the CDHP. However, the IRS does not permit an employee's HSA funds to be used to cover the healthcare expenses of domestic partners, unless the domestic partner otherwise qualifies as your federal tax code dependent.

The domestic partner can open his or her own HSA, which your employer may or may not choose to fund. Note, however, that an employer contribution to an HSA of a non-employee domestic partner would be included in the employee's taxable income.

Same-gender couples who are legally married can use the account in the same way as different-gender married couples.

Additional Benefits

CDHP members have access to the Medical Trust's value-added benefits, such as vision care through EyeMed, the Cigna Employee Assistance Program (EAP) , Health Advocate, Amplifon Hearing Health Care discounts, and UnitedHealthcare Global Travel Assistance. For more information about these value-added benefits, please visit our website at *cpg.org*.

Members may use their HSA funds, if available, to cover any applicable coinsurance amounts under these benefits.

U.S. Treasury Department HSA Information

The HSA section of the IRS website has links to informational brochures, up-to-date regulations, FAQs, IRS forms, and publications, including these:

Publication 502 – A list of qualified medical expenses

Publication 969 – A detailed explanation of HSAs and how the IRS treats them

Questions?

For assistance with HSA procedures and account questions, members using HealthEquity can reach its Member Services team 24/7 at (866) 346-5800 or email *memberservices@healthequity.com*. Otherwise, please contact our Client Services team at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET, or email *mtcustserv@cpg.org*.

10/19

INVESTING YOUR HSA

Convenient investment options

MAXIMIZE *your* earning POTENTIAL

HealthEquity®

MAXIMIZE YOUR TAX-FREE[1] EARNING POTENTIAL

Just like a traditional savings account, your HSA earns interest which is not taxed. This makes your HSA an effective component of your retirement strategy. Once your account meets a certain threshold, you can invest in mutual funds to maximize your HSA earning potential.

Options to fit your needs

A wide range of investment and savings options are offered, designed to suit your individual needs and financial goals:

Cash account[2]

HealthEquity's standard, low-interest, cash account. This is the default option when opening an HSA.

Yield Plus

Yield Plus[3] allows you to increase earning potential with minimal risk. Interest rates vary based on your HSA balance, but are higher than federally-insured interest rates. Funds invested in Yield Plus are not federally-insured, but remain liquid in your HSA for spending or investing as desired.

Varying risk mutual funds[4]

A diverse lineup of of high-quality, low-cost mutual funds' are selected by HealthEquity Advisors, LLC, an SEC-registered investment adviser and wholly owned subsidiary of HealthEquity. Investor Choice (details on page 5, fees may apply) allows members to choose the strategy that best fits their needs.

The investment spectrum provides an option for every member, regardless of age, HSA balance, or investment experience. HealthEquity meets you where you are most comfortable, and provides the educational support you need to understand how you can grow your HSA investments and make it easy to enroll and manage your investments.

Requirements to invest

There is no minimum balance to participate in our cash account, or to enroll in Yield Plus. In order to invest in mutual funds, your HSA cash balance must meet a minimum threshold. Contact HealthEquity member services at 866.346.5800 or visit the Investments section of your HealthEquity member portal to confirm your plan's threshold.

[1] HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2] Health savings account (HSA) cash balances are held at FDIC-insured or NCUA-insured institutions and are eligible for federal deposit insurance, subject to applicable requirements and limitations.

[3] Yield Plus is a non-federally insured group funded annuity agreement. Current interest rates, terms and conditions are available on the member portal.

[4] Investments available to HSA holders are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HealthEquity, Inc. does not provide financial advice. HealthEquity Advisors, LLC™, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered investment adviser, does provide web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). HealthEquity Advisors, LLC also selects the mutual funds offered to HSA holders through the HealthEquity, Inc. platform. Registration does not imply endorsement by any state or agency and does not imply a level of skill, education, or training. HSA holders making investments should review the applicable fund's prospectus. Investment options and thresholds may vary and are subject to change. Consult your advisor or the IRS with any questions regarding investments or on filing your tax return.

Advice

Advice is dependent upon your personal risk profile. You are able to edit your risk profile settings at any time and Advisor will adjust your advice based upon your changes.

Take the guesswork out of investing with Advisor™ (Powered by: HealthEquity ADVISORS, LLC)

HealthEquity is one of the first HSA administrators to provide access to individualized, web-based investment advisory services. Advisor is a web-based automated investment advisor tool offered by HealthEquity Advisors, LLC and is accessible through the HealthEquity member portal. With Advisor you receive professional web-based investment guidance and access to convenient online tools designed to help you maximize your earning potential best suited for your investment experience. When you sign up for Advisor, you complete a simple personal risk profile that identifies your risk preferences and retirement goals. Based on this profile, Advisor provides guidance and management on:

- How much cash to keep in your HSA.
- How much to invest.
- How to optimally diversify amongst the available mutual funds to manage risk and maximize growth potential.

3 options for investing

HealthEquity offers members options when it comes to investing in mutual funds. Members can choose to receive investment advice through Advisor and select either AutoPilot or GPS for a single price. If members prefer to manage funds on their own, they can choose the self-driven option.

	ADVISOR™ powered by: HealthEquity ADVISORS, LLC		
	AutoPilot	GPS	Self-driven
Advice type	Full service	Guidance	None
Implementation and timing	Automatic	Member	None
Advised portfolio rebalancing	Automatic	Member	None
Advised fund rotation	Automatic	Member	None
Advised category rotation	Automatic	Member	None
Portfolio alerts	Yes	Yes	No
Weekly performance summary	Yes	Yes	No
Monthly investment advisory fees	.05% ($15 monthly fee cap)		None
Monthly investment administration fees	.03% ($10 monthly fee cap)*		

*The monthly investment administration fee is charged by HealthEquity, Inc.

All investment related fees are calculated based on the average daily investment balance. Services fees are charged to your HSA cash account on the same day each month corresponding to your subscription date, and appear on your monthly statement. If your balance is not sufficient to pay the fees, billing will postpone until more money arrives. Multiple months of unpaid Advisor fees may result in suspended access until an HSA contribution is made. Advisor will not sell investments to settle any unpaid fees, though you can initiate the sale of funds in "Edit Profile" by changing the cash setting to the amount you want available in your HSA cash balance.

Investments are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HealthEquity Advisors, LLC™, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered investment adviser, provides web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). Registration does not imply endorsement by any state or agency and does not imply a level of skill, education, or training. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

INVESTOR CHOICE FUND OFFERINGS

HealthEquity offers access to the Investor Choice fund lineup of low cost mutual funds with a monthly investing administration fee. Investor Choice is a lineup of mutual funds which provides flexibility for members to reflect their investment philosophies and strategies. Other than the monthly investment administration fee and the respective mutual fund expense ratio there are no trading costs, commissions or fund minimums.

Fund name/symbol	Category
PASSIVELY MANAGED FUNDS	
Vanguard Emerging Mkts Stock Idx I (VEMIX)	Emerging
Vanguard Extended Market Idx Instlplus (VEMPX)	Mid Cap US Stocks
Vanguard Growth Index I (VIGIX)	Large Cap US Stocks
Vanguard Inflation-Protected Secs I (VIPIX)	TIPS
Vanguard Institutional Index Instl Pl (VIIIX)	Large Cap US Stocks
Vanguard Materials Index Adm (VMIAX)	Natural Res
Vanguard Reit Index I (VGSNX)	Real Estate
Vanguard Small Cap Index Adm (VSMAX)	Small Cap US Stocks
Vanguard Total Bond Market Idx Instlpls (VBMPX)	Agg Bonds
Vanguard Total Intl Stock Idx Instlpls (VTPSX)	Int'l Stocks
Vanguard Short-Term Bond Index Adm (VBIRX)	Agg Bonds
Vanguard Total Intl Bd Idx Admiral (VTABX)	Foreign Bonds

Mutual Funds have operating expense ratios, which are disclosed in each Fund's Prospectus. Expense ratios are fees charged by the mutual fund and are not controlled or influenced by HealthEquity or HealthEquity Advisors, LLC. Before making any investment, review the fund's prospectus. Investment options and thresholds may vary and are subject to change.

Fund name/symbol	Category
PASSIVELY MANAGED FUNDS (CONT)	
Vanguard Value Index Adm (VVIAX)	Large Cap US Stocks
Vanguard Mid-Cap Value Index Adm (VMVAX)	Mid Cap US Stocks
Vanguard Small-Cap Value Index Adm (VSIAX)	Small Cap US Stocks
Vanguard Shrt-Term Infl-Prot Sec Idx Adm (VTAPX)	TIPS
ACTIVELY MANAGED FUNDS	
Vanguard Wellesley Income Admiral (VWIAX)	Other
TARGET DATE FUNDS	
Vanguard Target Retirement 2020 Inv (VTWNX)	Target Date
Vanguard Target Retirement 2030 Inv (VTHRX)	Target Date
Vanguard Target Retirement 2040 Inv (VFORX)	Target Date
Vanguard Target Retirement 2050 Inv (VFIFX)	Target Date
Vanguard Target Retirement 2060 Inv (VTTSX)	Target Date
Vanguard Target Retirement Income Inv (VTINX)	Target Date

Mutual Funds have operating expense ratios, which are disclosed in each Fund's Prospectus. Expense ratios are fees charged by the mutual fund and are not controlled or influenced by HealthEquity or HealthEquity Advisors, LLC. Before making any investment, review the fund's prospectus. Investment options and thresholds may vary and are subject to change.

HealthEquity

Helpful support for our members is available every hour of every day

Our team of specialists based in Salt Lake City are available 24 hours a day, providing you with insight to help you optimize your HSA. They can answer any questions you may have.

866.346.5800

GET STARTED TODAY!

1 Access investments through the member portal

Log in to your account at www.myHealthEquity.com and access the investment desktop by selecting “Investments” from the “My Account” tab.

2 Select your preferred investment method

Advisor: Investment advice by our subsidiary, HealthEquity Advisors, LLC through AutoPilot or GPS for a single price. (investment advisory fees apply)

Self-driven: Directed by you, no advice

3 If you select Self-driven

Review the fund line-up and accept the terms and conditions, proceed to specify the amount you desire to hold in reserve and allocate funds by percentage to specific funds. Upon completion, simply select the 'Submit trade' button.

4 Optimize your investments

Select from two optional investment features:

Automatic investing: Maximize earning potential by electing to automatically invest any balance above the pre-determined reserve amount.

Automatic portfolio rebalancing: Maintain your desired level of asset allocation automatically so that it is consistent with your desired risk preference.

Learn more:

HealthEquity.com/InvestmentGuide

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life changing decisions.

Investments available to HSA holders are subject to risk, including the possible loss of the principal invested and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. HealthEquity, Inc. does not provide financial advice. HealthEquity Advisors, LLC™, a wholly owned subsidiary of HealthEquity, Inc. and an SEC-registered investment adviser, does provide web-based investment advice to HSA holders that subscribe for its services (minimum thresholds and additional fees apply). HealthEquity Advisors, LLC also selects the mutual funds offered to HSA holders through the HealthEquity, Inc. platform. Registration does not imply endorsement by any state or agency and does not imply a level of skill, education, or training. HSA holders making investments should review the applicable fund’s prospectus. Investment options and thresholds may vary and are subject to change. Consult your advisor or the IRS with any questions regarding investments or on filing your tax return.

HealthEquity Inc. charges an annual investment platform administration and recordkeeping fee of 0.36%. It is charged on a monthly basis (0.03% per month) against the average daily invested balance in the Investor Choice Funds. Investors should add the mutual fund annual expense ratio to the investment administration fee to determine the total annual cost for investing in the Investor Choice Funds, plus any investment advisory fees to which they subscribe.

HealthEquity®

15 West Scenic Pointe Drive
Draper, UT 84020
info@healthequity.com | www.HealthEquity.com

Investing_Your_HSA_Dec_ 2019

Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2020 (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
01/01/2020 (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.	

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Cigna Dental Benefit Summary
Episcopal Church Medical Trust
01/01/2020 (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	20% 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 Osseous Surgery	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.

AH2015 BLM2015

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.

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

CPG Vendor Information

Employee Assistance Program (EAP)

(866) 395-7794

24 hours a day, 7 days a week or register at

www.mycigna.com

Employer ID: episcopal

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What do you need help with? Try your Employee Assistance Program.

It's there to help you. Call toll-free: (866) 395-7794

Or register at *www.mycigna.com* and enter your Employer ID: *episcopal*

100 Reasons to call the Employee Assistance Program

1. To access 10 free counseling sessions
2. For questions about my mental health
3. For a free 60 minute consultation for identity theft
4. For a free 30 minute legal consultation
5. I need help finding a kennel for my pet.
6. To get information about managing stress
7. I'm moving, and I need information about my new town.
8. I need to find a daycare facility for my child.
9. My grandparents are visiting, and I need to find some rentable medical equipment.
10. My daughter has allergies, and I need to find stores that carry wheat-free foods.
11. My veterinarian retired and I need to find a new one.
12. I need information about dealing with a moody teenager.
13. I think I got ripped off by a telemarketer. What can I do?
14. I think I am being harassed at work.
15. I need renter's insurance, and I don't know who to call.
16. How do I know if someone is abusing drugs? What do I look for?
17. How to find a drug treatment center
18. How to do an intervention for someone on drugs
19. How to find an Al-anon meeting
20. I need information about adoption.
21. I would like information about providing foster care.
22. I'm retiring, and I would like to find some support groups in my area.
23. My son was arrested for driving while intoxicated. How can I help him?
51. I would like to start a book club. Can you give me ideas for how to do it?
52. How do I put together a budget? I've never done it before.
53. Will my living will and other papers be legal if I move to a different state?
54. I think my neighbor's child is being abused. What can I do?
55. I need a veterinarian oncologist. Can you help me find one?
56. I need more social outlets. What is available in my area?
57. I need assistance updating my resume. Can you help?
58. How can I judge if a children's daycare facility is safe and well-staffed?
59. School is back in session and I want to help my kids start the year with good homework habits.
60. What are some kid-friendly activities in my area?
61. My mother has Alzheimer's, and I need to know of any local resources.
62. Can you provide some questions I can use when interviewing a pediatrician?
63. My friend asked me to be the executor of her estate. What does that mean?
64. How do I report a stolen credit card?
65. Where can I find a health aide to help my mother in her home?
66. Do you have a list of activities to do with Alzheimer's patients?
67. How do I find a music therapist who works with kids?
68. Due to seizures, my adult son can't drive. How can I find rides for him?
69. How can I find a reputable audiologist?
70. Do I need travel insurance when I take a vacation, and what does it cover?
71. I'm taking a trip with my family, and I need information about traveling with kids.
72. Where can I find tools to help my child feel safe when flying alone?
73. Where can I find vacation ideas for my parents who are senior citizens?

23. My son was arrested for driving while intoxicated. How can I help him?
24. Our daughter is looking to hire a nanny. What should she ask during interviews?
25. I was diagnosed with high blood pressure and I need to decrease the salt in my diet. Can you help?
26. We're thinking of selling our house. How do we choose a realtor?
27. I need some tips for talking to my son about respecting his dates.
28. I need a support group for my sister who just found out that her daughter is gay.
29. I need help finding elder care for my mother who lives on the West Coast.
30. Are there any yoga classes in my area?
31. Where can I find information on healthy eating?
32. How do I help my son look for colleges?
33. How do I find a therapeutic boarding school for my daughter?
34. My child is being deployed for combat, and I need help to deal with this.
35. Where can I find a place that can test my son for ADHD?
36. I need information about finding a chiropractor.
37. I need help to stop smoking.
38. I think my child has an eating disorder.
39. Where can I find an assisted living facility for my grandmother?
40. How do I know if a nursing home is reputable?
41. Where can I find help for my son who is deaf?
42. My mother is having problems with her sight. Where can I find help?
43. Can you help me find a grief counselor?
44. Do you have information about autism?
45. I need to find a college that will work with kids who have learning disabilities.
46. How can I find assistance to help with college tuition?
47. I've started riding my bike again. Can you help me find bike paths in my area?
48. I lost my wallet. How can I protect myself?
49. I think my son-in-law is abusive. What are some signs I should look for?
50. My oldest daughter just lost her job. How can I be supportive?
73. Where can I find vacation ideas for my parents who are senior citizens?
74. Should I get pet insurance?
75. Can you provide me with a list of farmers' markets in my area?
76. I'm doing some home repairs. How can I find reliable contractors?
77. Where do I report someone who did not complete a job he was doing for me?
78. I lost my job and I need help to find another one.
79. I'm going through a divorce, and I need some support services for my children.
80. I think my child is chatting with inappropriate people online. I need help.
81. How can I block my computer from sites I don't want my kids to access?
82. Are there guidelines for protecting kids from internet sites?
83. My daughter's teacher is dying. How can I talk to my child about this?
84. I need to find an accountant who can handle clergy taxes.
85. I need to find a therapist for my daughter while she is away at college.
86. Our dog died. How can I help my son handle his grief?
87. I need to find a summer camp for my child.
88. What should I ask about when helping my parents choose a retirement facility?
89. My daughter dresses only in black. Should I be worried?
90. Where can I find a dog sitter?
91. I am going to be traveling for an extended period. How do I protect my home?
92. I feel like I'm in a rut. Am I depressed?
93. How can I help my son interact with his autistic cousin?
94. My dad is in hospice. How can I talk with him about his funeral?
95. Where can I find information about finding a funeral director and discussing available funeral-planning options?
96. We bought a home with a swimming pool. How can we make it child-safe?
97. Where can I donate all my parents furnishings? They're too good to throw away.
98. I'm pregnant. How do I find a midwife?
99. I am looking for an Episcopal retirement community. Can you help me?
100. Can you tell me where there are AA meetings in a town I will be visiting?

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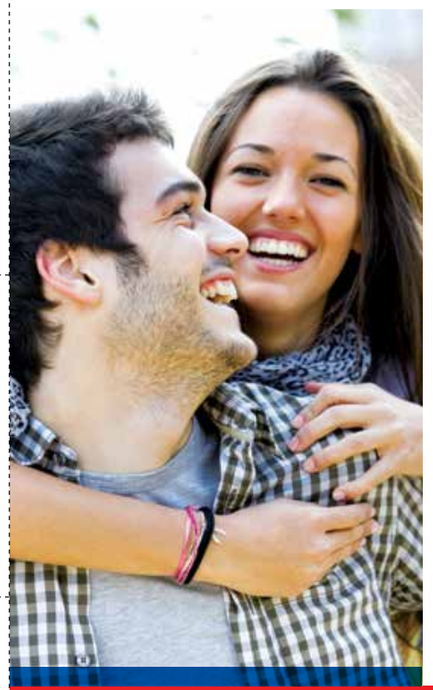

Real People, **Real Stories**

Insurance-related issues

Gina's husband needed surgery for a life-threatening condition. The paperwork approving the procedure got "lost in the system." Health Advocate tracked down and coordinated the paperwork between the doctor, insurance plan and hospital, and convinced the insurance company to permit a prompt operation.

We can help.

Call us today! 24/7 support **866.695.8622**

Visit us online at: HealthAdvocate.com/members

We're here when you need us most

Your Health Advocate benefit can be accessed 24/7. Normal business hours are Monday - Friday, from 8 am to 12 am (midnight), Eastern Time. Staff is available for assistance after hours and on weekends.

There is no cost to use our service

Your employer or plan sponsor offers your Health Advocate benefit at no cost to you.

We're not an insurance company

West's Health Advocate Solutions is not affiliated with any insurance or third party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Your privacy is protected

Our staff carefully follows protocols and complies with all government privacy standards. Your medical and personal information is kept strictly confidential.

Welcome

to Your New Health Advocate Benefit

Health Advocate is a service provided at no cost to you, courtesy of your employer or plan sponsor. It can help you and your eligible family members resolve healthcare and insurance-related issues—all through a single, toll-free number.

We look forward to serving you!

HealthAdvocate Solutions™ west®

Introducing Health Advocacy

This helpful guide provides an overview of Health Advocate and its many services. If you have questions or need assistance, **simply call the toll-free number for prompt support.**

We are here to help you

During your first call, you will be assigned a Personal Health Advocate who will begin helping you right away.

Personal Health Advocates are typically registered nurses, supported by medical directors and benefits and claims specialists. They'll help cut through the red tape and assist with complex conditions, find specialists, address eldercare issues, clarify insurance coverage, work on claim denials, help negotiate fees for non-covered services **and get to the heart of your issue.**

Who is covered?

Health Advocacy is available to eligible employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

How We Can Help

Don't know where to turn?
We point the way.

- **Find the right doctors,** dentists, specialists and other providers
- **Schedule appointments;** arrange for treatments and tests
- **Answer questions** about test results, treatments and medications

Confused by health insurance?
We cut through the red tape.

- **Clarify benefits;** uncover billing errors
- **Get to the bottom of coverage denials**
- **Get appropriate approvals** for covered services

Want to save on healthcare costs?
We help find solutions.

- **Find options** for non-covered services
- **Negotiate payment arrangements** with providers
- **Provide information** about generic drug options

Need eldercare services?
We're there for you.

- **Find in-home care,** adult day care, assisted living and long-term care
- **Clarify Medicare,** Medicare Supplement plans and Medicaid
- **Research transportation** to appointments

24/7 support
866.695.8622
Visit us online at:
HealthAdvocate.com/members

Help Is Only a Phone Call Away

- Clarify benefits
- Find the right doctors
- Untangle insurance claims
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Custom hearing solutions - we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

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Risk-free 60-day trial - 100% money-back guarantee.

Hearing aid low price guarantee - if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

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1. Call Amplifon at (877) 609-0755 and we'll find a provider near you.
2. We'll explain the Amplifon process and help you schedule an appointment.
3. We'll send information to you and the provider, ensuring your discount is activated.

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Discount Card

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your discount, call (877) 609-0755 today!

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$50 off one hearing aid* -or- $125 off two hearing aids*

Call (877) 609-0755 today!

ACT NOW!

*Savings on top of our already discounted pricing. Please bring this offer with you to your appointment.

MEDICAL & SECURITY ASSISTANCE AND EVACUATION
ACCESS PROGRAM DESCRIPTION

A comprehensive program providing 24/7 emergency medical and travel assistance services when You are outside Your Home Country or 100 or more miles away from Your primary residence in Your Home Country. The program also provides emergency security assistance services when you are outside of Your Home Country. Expatriates are eligible for medical services while in Your Host Country, while traveling outside of Your Home Country, or while traveling within Your Home Country 100 or more miles away from Your primary residence. Expatriates are eligible for security services while in Your Host Country or when traveling outside of Your Home Country.

How To Use UnitedHealthcare Global Assistance Services

24 hours a day, 7 days a week, 365 days a year

If You have a medical, personal safety or travel problem, simply call Us for assistance. Our toll-free and collect-call telephone numbers are printed on Your ID card. Either call the toll-free number of the country You are in, call the Emergency Response Center collect, or email the Emergency Response Center at:

Baltimore, MD, USA +1-410-453-6330
Assistance@uhcglobal.com

A multilingual assistance coordinator will ask for Your name, Your company or group name, the group ID number shown on Your card, and a description of Your situation. We will immediately begin assisting You. A full listing of services follows.

If the condition is a medical emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

In the event of an emergency security situation, You should immediately get to a safe location and then contact the Emergency Response Center. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Your program provides You with Medical Assistance Services, Medical Evacuation and Repatriation Services, Travel Assistance Services, Security and Political Evacuation Assistance Services, and Worldwide Destination Intelligence as described below. These services are subject to certain Conditions and Limitations also described below.

UnitedHealthcare Global
8501 LaSalle Road, Suite 200
Baltimore, MD USA 21286
www.uhcglobal.com

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: We will provide referrals to help You locate appropriate treatment and quality care.

Monitoring of Treatment: Our case managers will continually monitor Your case. In addition, Our Physician Advisors provide Us consultative and advisory services, including review and analysis of the quality of medical care You are receiving.

Facilitation of Hospital Payment: Upon securing payment or a guarantee to reimburse, We will either wire or guarantee funds needed for hospital admittance costs. You are ultimately responsible for the payment of the cost of medical care and treatment, including hospital expenses or wiring fees.

Transfer of Insurance Information to Medical Providers: We will relay insurance benefit information to help prevent delays or denials of medical care. We will also assist with hospital admission and discharge planning.

Transfer of Medical Records: Upon Your consent, We will assist with the transfer of medical information and records to You or the treating physician.

Medication and Vaccine Transfers: In the event medication or vaccines are not available locally, or a prescription medication is lost or stolen, We will make commercially reasonable efforts to coordinate their transfer to You upon the prescribing physician's authorization, if it is legally permissible. You will be responsible for the cost of the medication or vaccine and any delivery costs.

Updates to Family, Employer, and Home Physician: With Your approval, We will provide periodic case updates to appropriate individuals You designate in order to keep them informed.

Hotel Arrangements: We will assist You with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care. You are responsible for costs of lodging and incidental expenses..

Replacement of Corrective Lenses and Medical Devices: We will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel. You will be responsible for the cost of the item and any delivery costs.

MEDICAL EVACUATION & REPATRIATION SERVICES

The following services are available if the Participant suffers an Injury or a sudden and unexpected Illness:

Emergency Medical Evacuation: If You sustain an Injury or Illness that, in the opinion of UnitedHealthcare Global and the treating health care provider, requires urgent medical attention and adequate medical treatment is not available at Your initial medical facility, We will arrange for a medically supervised evacuation to the nearest medical facility We determine to be capable of providing appropriate medical treatment. Your medical condition and situation must be such that, in the professional opinion of the health care provider and UnitedHealthcare Global, You require immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. All such arrangements must be coordinated and approved in advance by Us.

Dispatch of Doctors/Specialists: In an emergency where We determine that You cannot adequately be assessed by telephone for possible evacuation from Your initial medical facility, or You cannot be moved and local treatment is unavailable, We will arrange to send an appropriate medical practitioner to You when We deem it appropriate for medical management of a case. You are responsible for the payment of the cost of transportation, medical care, and treatment.

Medical Repatriation: Following stabilization of Your condition and discharge from the hospital, We will coordinate transportation to Your Home Country or Host Country if We determine that You should return for continuing medical care. Medical escorts and mobile medical equipment will be arranged if UnitedHealthcare Global determines either is warranted during the transportation. We will also arrange for a change to Your existing return travel arrangements if the change is required as a direct result of Your medical condition or treatment. All travel

arrangements will be as necessitated by Your medical condition as determined by Your treating physician and UnitedHealthcare Global. All such arrangements must be coordinated and approved in advance by Us.

Transportation After Stabilization: When Medical Repatriation is not required following stabilization of Your condition and discharge from the hospital, We will coordinate transportation to Your point of origin, Your Home Country, or your Host Country. All such arrangements must be coordinated and approved by Us in advance.

Transportation to Join a Hospitalized Participant: If You are traveling alone and are or will be hospitalized due to an Illness or Injury, We will coordinate round-trip airfare for a person of Your choice to join You. We will also assist with the arrangement of their hotel stay during Your hospitalization. Costs of travel, lodging, meals, and incidental expenses are the responsibility of the traveler.

Return of Minor Children: If Your minor child(ren) age 18 or under are present but left unattended as a result of Your Injury or Illness, We will coordinate airfare to send them back to Your Home Country. We will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required and as determined by Us.

Repatriation of Mortal Remains: In the event of Your death, We will assist in obtaining the necessary clearances for Your cremation or the return of Your mortal remains. We will coordinate the preparation and transportation of Your mortal remains to Your Home Country or place of primary residence, as well as obtain the number of certified death certificates required by the Host Country and Home Country to release and receive the remains.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: We will assist You in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: We will make new reservations for airlines, hotels, and other travel services in the event of an Illness or Injury or Emergency Security Situation.

Transfer of Funds: We will provide You with an emergency cash advance subject to Us first securing funds from You or Your family. You are responsible for any fees for the wiring of these funds.

Legal Referrals: Should You require legal assistance, We will direct You to an attorney.

Language Services: Our multilingual case managers are available to provide immediate interpretation assistance in a variety of languages in an emergency; otherwise We will provide You with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter will be subject to an additional fee.

Message Transmittals: You may send and receive emergency messages toll-free, 24-hours a day, through Our Emergency Response Center.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, You can contact the Emergency Response Center to have a pre-trip destination report sent to You. This report draws upon Our intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. Our global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

SECURITY AND POLITICAL EVACUATION ASSISTANCE SERVICES

Transportation To Departure Point: As part of a Security or Political Evacuation, We will coordinate the arrangement of Your ground transportation to the designated international airport or other safe departure point.

Security Evacuation: In the event of an Emergency Security Situation, We will, to the extent commercially reasonable, arrange for Your evacuation from an international airport or other safe departure point We designate to the nearest safe haven. Evacuation must be requested within 5 days (120 hours) from the time the order to evacuate is issued by the recognized government of the Home Country or Host Country. If evacuation becomes impractical due to hostile or dangerous conditions, We will maintain contact with You and advise You until evacuation becomes viable or the Emergency Security Situation has passed.

Political Evacuation: In the event the officials of Your Home Country issue a written order that You depart Your Host Country for non-medical reasons, or if You are expelled or declared "persona non grata" on the written authority of Your Host Country, We will, to the extent commercially reasonable, arrange for Your evacuation from an international airport or other safe departure point to the nearest safe haven. Evacuation must be requested within 5 days (120 hours) from the time of ordered departure notice given by the recognized government of Your Home Country or Host Country.

Transportation After Security or Political Evacuation: Following a Security or Political Evacuation and when safety allows, We will coordinate for one-way airfare to return You to either Your Host Country or Your Home Country.

PROGRAM DEFINITIONS

The following definitions apply:

"Emergency Security Situation" means a civil and/or military uprising, insurrection, war, revolution, or other violent disturbance in a Host Country, which results in either Your Home Country or Host Country ordering immediate evacuation. Emergency Security Situation does not include Natural Disasters.

"Enrollment Period" means the period of time for which You are validly enrolled for a UnitedHealthcare Global program and for which We have received the appropriate enrollment fee.

"Expatriate" means individual traveler whose trips exceed 90 consecutive days or whose travel exceeds 180 days in a 12-month period.

"UnitedHealthcare Global Physician Advisors" means physicians, retained by UnitedHealthcare Global to provide Us with consultative and advisory services, including the review and analysis of the quality of medical care You are receiving.

"Home Country" means the country as shown on Your passport or the country where You have Your primary residence.

"Host Country" means a country or territory You are visiting or in which You are living which is not Your Home Country.

"Illness" means a sudden and unexpected sickness that manifests itself during Your Enrollment Period.

"Injury" means an identifiable accidental injury caused by a sudden, unexpected, unusual, specific event that occurs during Your Enrollment Period.

"Natural Disaster" means an event occurring directly from natural cause, including but not limited to, earthquake, flood, storm (wind, rain, snow, sleet, hail, lightning, dust or sand), tsunami, volcanic eruption, wildfire or other similar event that results in severe and widespread damage such that the area of damage is declared a disaster area by the government of the Home or Host Country AND the participant's location is Uninhabitable.

"Participant" means a person validly enrolled for a UnitedHealthcare Global program and for whom We have received the appropriate enrollment fee.

"Uninhabitable" means the Participant's Host Country location is deemed unfit for residence, as determined by Our security personnel in accordance with Home Country and Host Country authorities, due to lack of habitable shelter, food, heat, and/or potable water AND no suitable supplemental housing is available within 100 miles of the disaster site.

"We," "Us," and "Our" means UnitedHealthcare Global.

"You" and "Your" means the Participant.

CONDITIONS AND LIMITATIONS

The services described are available to You only during Your Enrollment Period. Medical services are available to You only when You are outside Your Home Country or 100 or more miles away from Your permanent residence in Your Home Country. Security services are available to You only when You are outside of Your Home Country. Expatriates are eligible for Medical services while in Your Host Country, while traveling outside of Your Home Country, or while traveling within Your Home Country 100 or more miles away from Your primary residence. Expatriates are eligible for Security services while in Your Host Country or when traveling outside of Your Home Country.

We reserve the right to determine, at Our sole discretion, the need for a security evacuation and the means, method, timing, and destination of that evacuation. Our security personnel will consult with relevant governments, security analysts, and the sponsor of Your UnitedHealthcare Global program. At a minimum, Our program will adhere to any announcement made by Your Home or Host Country ordering the departure of personnel. You will be responsible for all transportation and living expenses while at the safe haven. The decision to travel is the sole responsibility of the traveler.

We are not responsible for the availability, timing, quality, results of, or failure to provide any medical, security, legal or other care or service caused by conditions beyond Our control. This includes Your failure to obtain care or service or where the rendering of such care or service is prohibited by U.S. law, local laws, or regulatory agencies.

Your legal representative shall have the right to act for You and on Your behalf if You are incapacitated or deceased.

We shall not be responsible for providing any assistance services for a situation arising from:

1. Your traveling against the advice of a physician or traveling for the purpose of obtaining medical treatment.
2. Taking part in military or police service operations.
3. The commission of, or attempt to commit, an unlawful act.
4. Failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
5. Political and Security Evacuations from Your Home Country.
6. Political and Security Evacuations when the Emergency Security Situation precedes Your arrival in the Host Country, or when the evacuation notice issued by the recognized government of Your Home Country or Host Country has been posted for a period of more than 5 days (120 hours).
7. Security or Political Evacuation assistance directly or indirectly related to a Natural Disaster
8. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.

REIMBURSEMENT TO UNITEDHEALTHCARE GLOBAL AND RIGHTS OF SUBROGATION

You or a responsible party on Your behalf shall either pay the cost of medical care and treatment, including hospital expenses directly or shall reimburse Us upon demand for all such costs and expenses which may be imposed upon Us by health care providers for the cost of medical care and treatment, including hospital expenses, or related assistance services either authorized by You or deemed to be advisable and necessary by Us under urgent medical circumstances, to the extent that such expenses are not Our responsibility. Such reimbursement shall be without regard to the specific terms, conditions, or limitations of any insurance policies or benefits available to You.

We shall be fully and completely subrogated to Your rights against parties who may be liable for the payment of, or a contribution toward the payment of, the costs and expenses of assistance services provided by Us or medical care and treatment, including hospital expenses, in the event that We pay or contribute to the payment of them. You must assign to Us any and all rights of recovery under any such insurance plans, including any occupational benefit plan, health insurance, or other insurance plan or public assistance program, up to the sum of any payments by Us.

UnitedHealthcare Global

Benefit Highlights Sheet

Short-Term Disability Income Insurance	STD Coverage - 13 Weeks 60% Employer Paid
Who gets it?	Active employees working a minimum of 20 hours per week, excluding seasonal and temp workers.
How much STD coverage can I get?	- 60% of base pay, not to exceed $1,500 per week.
Waiting / Elimination Period Illness:	- 14 days.
Waiting / Elimination Period Accident:	- 14 days.
Who pays for it?	Your employer pays for your STD Income Insurance coverage.

Short-Term Disability Income Insurance

What is Short-Term Disability Income Insurance?	Short-Term Disability Income Insurance, or STD, replaces a portion of your paycheck if you can't work due to an illness or injury that occurs off the job (non-occupational). It also pays a benefit for the birth of a child.
What is my STD Income Insurance coverage amount?	Your STD plan pays a benefit to replace a portion of your pre-disability weekly income equal to 60% of your base pay, not to exceed $1,500 per week. Your benefits may be reduced by other sources of income and disability earnings.
When would benefits begin if I were disabled?	There is a fourteen (14) day Elimination or Waiting period for your coverage to begin if you are disabled due to an illness or injury or due to the birth of a child. You must be under the care of a physician and no benefit is payable during the Elimination or Waiting period.
What is the definition of disability?	You are disabled when we determine that: • you are unable to perform one or more of the material and substantial duties of your own occupation due solely to your illness or injury • you are under the regular care of a physician • you have a 20% or more loss in your covered weekly earnings due to that illness or injury.
How long could I receive payments?	Your maximum benefit period is eleven (11) weeks after you have satisfied the Elimination or Waiting period.
Are there any exclusions or limitations?	Disability plans have conditions, exclusions, offsets, and limitations. You must be actively-at-work for at least one day for your coverage to begin. Below is some important information, but review your plan documents for a complete listing of all that apply. No benefit will be paid for disabilities caused by or related to: • an on-the-job injury or illness for which workers' compensation benefits are paid, or may be paid if duly claimed • intentionally self-inflicted injuries or attempted suicide • active participation in a riot or an act of insurrection, rebellion or civil commotion • war, declared or undeclared, or any act of war • participation in an illegal activity or illegal act • commission of a crime for which you have been convicted, or attempting to commit a criminal act • intoxication, including driving a motor vehicle while intoxicated • serving on full-time active duty in any armed forces • influence of a controlled substance, unless administered by a physician, or taken according to a physician's instructions, and within clinical guidelines • illness or injury for which a benefit is payable under the Jones Act for which a Jones Act claim has been or will be filed • injury sustained as a result of doing any work for pay or profit for another employer.

Additional Information

When does coverage begin?	Any choices made during annual enrollment will become effective January 1, 2020. If you are newly hired or newly eligible, your coverage becomes effective on the first of the month coinciding with or following your date of hire or eligibility.
Are there any other benefits with the plan?	Your plan includes valuable resources for you and your loved ones when you need it most, with the support of master's level licensed social workers for disabled or terminally ill members. Care Managers are available toll-free at 800-206-8826. Everest Funeral Concierge services provide online and at-need planning and price negotiation assistance available 24/7. Everest includes a free online Will Prep tool to help in the preparation of Wills, Power of Attorney documents, Health Care Directives, and more. Visit everestfuneral.com and use code ZURICH100 to register free of charge. Advisors are also available toll-free at 800-913-8318.

Please note, benefits, and provisions are specific to your group policy.
Please consult your certificate for information regarding your specific coverage.

Online Portal	https://mybenefits.zurichna.com	Customer Care Center	1-800-206-8826 8 AM – 8 PM EST, Mon-Fri

Benefit Harbor Insurance Services
199 Scott Swamp Road | Farmington, CT 06032

Benefit Harbor Insurance Services, LLC, is the exclusive independent agent and administrator of Zurich American Life Insurance Company and Zurich American Life Insurance Company of New York representing group life products, group disability products, and absence management services. Benefit Harbor Insurance Services, LLC conducts its administration business in the state of California under the name Benefit Harbor Administrators (CA LIC# 0L76891).

Zurich American Life Insurance Company of New York
Zurich American Life Insurance Company
7045 College Boulevard, Overland Park, Kansas 66211-1523

In New York, the terms and conditions for the Group Short-Term Disability Income Insurance policy are set forth in policy form number 1000-ZAGP-DS-NY-01. The policies are issued by Zurich American Life Insurance Company of New York, a New York domestic life insurance company, located at its registered home address of 150 Greenwich Street, Four World Trade Center, 54th Floor, New York, NY 10007-2366.

In all states other than New York, the terms and conditions for the Group Short-Term Disability Insurance Policy are set forth in policy form number 1000-ZAGP-01-01 or applicable state variation. The policies are issued by Zurich American Life Insurance Company, an Illinois domestic life insurance company, located at its registered home address of 1299 Zurich Way, Schaumburg, IL 60196.

The policies are subject to the laws of the state where they are issued. This material is a summary of the product features only. Please read the policy carefully for details. Certain coverages may not be available in all states and policy provisions may vary by state.

BENEFIT HARBOR INSURANCE SERVICES

ZURICH

Benefit Highlights Sheet

Long-Term Disability Income Insurance	LTD Coverage - 90 days 60% Employer Paid
Who gets it?	Active employees working a minimum of 20 hours per week, excluding seasonal and temp workers.
How much LTD Income Insurance coverage can I get?	- 60% of your pre-disability monthly income, not to exceed $7,500 per month.
Waiting / Elimination Period:	- 90 days.
Who pays for it?	Your employer pays for your LTD Income Insurance coverage.

Long-Term Disability Income Insurance

What is Long-Term Disability Income Insurance?	Long-Term Disability Income Insurance, or LTD, replaces a portion of your paycheck if you can't work due to a longer-lasting illness or injury.
What is my LTD Insurance coverage amount?	Your LTD plan pays a benefit to replace 60% of your pre-disability monthly income, not to exceed $7,500 per month.
When would benefits begin if I were disabled?	The Elimination or Waiting period for benefits to begin is ninety (90) days.
What is the definition of disability?	You are disabled when we determine that: • You are unable to perform the material and substantial duties of your regular occupation due solely to your illness or injury • You have a 20% or more loss in your covered monthly earnings due to that same illness or injury • you are under the regular care of a physician; and After monthly payments have been payable for 24 months, you are still considered disabled when we determine that due to the same illness or injury: • You are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
Are there any exclusions or limitations?	Disability plans have conditions, exclusions, offsets, and limitations. You must be actively-at-work for at least one day for your coverage to begin. Here is some important information but review your plan documents for a complete listing of all that apply. Your plan does not cover any disabilities caused by, contributed to by, or resulting directly or indirectly from: • an on-the-job injury or illness for which workers' compensation benefits are paid, or may be paid if duly claimed • a pre-existing condition • intentionally self-inflicted injuries or attempted suicide • active participation in a riot or an act of insurrection, rebellion or civil commotion • war, declared or undeclared, or any act of war • the revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or illness otherwise covered by the Policy • participation in an illegal activity or illegal act or to which a contributing cause was your being engaged in an illegal occupation • commission of a crime for which you have been convicted, this includes but is not limited to local, state, country, provincial or federal law, or the disability results from commission of, or attempting to commit a criminal act • intoxication, including driving a motor vehicle while intoxicated. ("intoxicated" means your blood alcohol or drug level meets or exceeds the level at which intoxication would be presumed under the law of the state, country, or jurisdiction in which the event, activity or accident occurred; or • influence of a controlled substance, unless administered by a physician, or taken according to a physician's instructions, and within clinical guidelines.

Additional Information

When does coverage begin?	Any choices made during annual enrollment will become effective January 1, 2020. If you are newly hired or newly eligible, your coverage becomes effective on the first of the month coinciding with or following your date of hire or eligibility.
Are there any other benefits with the plan?	Your plan includes valuable resources for you and your loved ones when you need it most, with the support of master's level licensed social workers for disabled or terminally ill members. Care Managers are available toll-free at 800-206-8826. Everest Funeral Concierge services provide online and at-need planning and price negotiation assistance available 24/7. Everest includes a free online Will Prep tool to help in the preparation of Wills, Power of Attorney documents, Health Care Directives, and more. Visit everestfuneral.com and use code ZURICH100 to register free of charge. Advisors are also available toll-free at 800-913-8318.

Please note, benefits, and provisions are specific to your group policy.
Please consult your certificate for information regarding your specific coverage.

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Zurich American Life Insurance Company of New York
Zurich American Life Insurance Company
7045 College Boulevard, Overland Park, Kansas 66211-1523

In New York, the terms and conditions for the Long Term Disability Income Insurance policy are set forth in policy form number 1000-ZAGP-DS-NY-01. The policies are issued by Zurich American Life Insurance Company of New York, a New York domestic life insurance company, located at its registered home address of 150 Greenwich Street, Four World Trade Center, 54th Floor, New York, NY 10007-2366.

In all states other than New York, the terms and conditions for the Group Long Term Disability Insurance Policy are set forth in policy form number 1000-ZAGP-01-01 or applicable state variation. The policies are issued by Zurich American Life Insurance Company, an Illinois domestic life insurance company, located at its registered home address of 1299 Zurich Way, Schaumburg, IL 60196.

The policies are subject to the laws of the state where they are issued. This material is a summary of the product features only. Please read the policy carefully for details. Certain coverages may not be available in all states and policy provisions may vary by state.

2020 - CPG – 90 days – 60% - ER PD - LTD

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days* of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

* Please refer to the HIPAA Notice of Special Enrollment Rights for information on an extension of time to request coverage as a result of the COVID-19 pandemic.

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

HIPAA Notice of Special Enrollment Rights

This notice informs you of your right to enroll in a group health plan sponsored by The Episcopal Church Medical Trust (a "Medical Trust Plan") under the special enrollment provisions of the Health Insurance Portability and Accountability Act (HIPAA).

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a Medical Trust Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Also, if you or any of your dependents loses eligibility for coverage under Medicaid or the Children's Health Insurance Plan (CHIP) or if you or any of your dependents becomes eligible for premium assistance under Medicaid or CHIP, you may be able to enroll yourself and your dependents in a Medical Trust Plan. However, you must request enrollment within 60 days after this change.

To request special enrollment or obtain more information, contact The Episcopal Church Medical Trust at the following address and phone number:

The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(800) 480-9967

You may also review the applicable Medical Trust Plan Document Handbook available at ***www.cpg.org/mtdocs***.

EPISCOPAL CHURCH MEDICAL TRUST

Joint Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Church Pension Group Services Corporation, doing business as The Episcopal Church Medical Trust (Medical Trust), is the plan sponsor of certain group health plans (each a Plan and together the Plans) that are subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations enacted thereunder (HIPAA).

HIPAA places certain restrictions on the use and disclosure of Protected Health Information (PHI) and requires the Medical Trust to provide this Joint Notice of Privacy Practices (the "Notice") to you. PHI is your individually identifiable health information that is created, received, transmitted or maintained by the Plans or its business associates, regardless of the form of the information. It does not include employment records held by your employer in its role as an employer. This Notice describes how your PHI may be used and disclosed by the Plans and by employees of the Medical Trust that are responsible for internal administration of the Plans. It also describes your rights regarding the use and disclosure of such PHI and how you can gain access to it.

What This Notice Applies To

This Notice applies only to health benefits offered under the Plans. The health benefits offered under the Plans include, but may not be limited to, medical benefits, prescription drug benefits, dental benefits, the health care flexible spending account, and any health care or medical services offered under the employee assistance program benefit. This Notice does not apply to benefits offered under the Plans that are not health benefits. Some of the Plans provide benefits through the purchase of insurance. If you are enrolled in an insured Plan, you will also receive a separate notice from that Plan, which applies to your rights under that Plan.

Duties and Obligations of the Plans

The privacy of your PHI is protected by HIPAA. The Plans are required by law to:

- Maintain the privacy of your PHI
- Provide you with a notice of the Plans' legal duties and privacy practices with respect to your PHI
- Abide by the terms of the Notice currently in effect

When the Plans May Use and Disclose Your PHI

The following categories describe the ways the Plans are required to use and disclose your PHI without obtaining your written authorization:

Disclosures to You. The Plans will disclose your PHI to you or your personal representative within the legally specified period following a request.

Government Audit. The Plans will make your PHI available to the U.S. Department of Health and Human Services when it requests information relating to the privacy of PHI.

As Required By Law. The Plans will disclose your PHI when required to do so by federal, state or local law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

The following categories describe the ways that the Plans *may* use and disclose your PHI **without obtaining your written authorization**:

- **Treatment.** The Plans may disclose your PHI to your providers for treatment, including the provision of care or the management of that care. For example, the Plans might disclose PHI to assist in diagnosing a medical condition or for pre-certification activities.
- **Payment.** The Plans may use and disclose your PHI to pay benefits. For example, the Plans might use

or disclose PHI when processing payments, sending explanations of benefits (EOBs) to you, reviewing the medical necessity of services rendered, conducting claims appeals and coordinating the payment of benefits between multiple medical plans.

- **Health Care Operations.** The Plans may use and disclose your PHI for Plan operational purposes. For example, the Plans may use or disclose PHI for quality assessment and claim audits.
- **Public Health Risks.** The Plans may disclose your PHI for certain required public health activities (such as reporting disease outbreaks) or to prevent serious harm to you or other potential victims where abuse, neglect or domestic violence is involved.
- **National Security and Intelligence Activities.** The Plans may disclose your PHI for specialized government functions (such as national security and intelligence activities).
- **Health Oversight Activities.** The Plans may disclose your PHI to health oversight agencies for activities authorized by law (such as audits, inspections, investigations and licensure).
- **Lawsuits and Disputes.** The Plans may disclose your PHI in the course of any judicial or administrative proceeding in response to a court's or administrative tribunal's order, subpoena, discovery request or other lawful process.
- **Law Enforcement.** The Plans may disclose your PHI for a law enforcement purpose to a law enforcement official, if certain legal conditions are met (such as providing limited information to locate a missing person).
- **Research.** The Plans may disclose your PHI for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **To Avert a Serious Threat to Health or Safety.** The Plans may disclose your PHI to avert a serious threat to the health or safety of you or any other person.
- **Workers' Compensation.** The Plans may disclose your PHI to the extent necessary to comply with laws and regulations related to workers' compensation or similar programs.
- **Coroners, Medical Examiners and Funeral Directors.** The Plans may disclose your PHI to coroners, medical examiners or funeral directors for purposes of identifying a decedent, determining a cause of death or carrying out their respective duties with respect to a decedent.
- **Organ and Tissue Donation.** If you are an organ donor, the Plans may release your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, the Plans may release your PHI as required by military command authorities.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plans may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Business Associates.** The Plans may contract with other businesses for certain plan administrative services. The Plans may release your PHI to one or more of their business associates for plan administration if the business associate agrees in writing to protect the privacy of your information.
- **Plan Sponsor.** ECMT, as sponsor of the Plans, will have access to your PHI for plan administration purposes. Unless you authorize the Plans otherwise in writing (or your individual identifying data is deleted from the information), your PHI will be available only to the individuals who need this information to conduct these plan administration activities, but this release of your PHI will be limited to the minimum disclosure required, unless otherwise permitted or required by law.

The following categories describe the ways that the Plans *may* use and disclose your PHI **upon obtaining your written authorization**:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Uses and disclosures that constitute a sale of PHI.

Any other use or disclosure of your PHI not identified in this section will be made only with your written authorization.

Authorizing Release of Your PHI

To authorize release of your PHI, you must complete a medical information authorization form. An authorization form is available at ***www.cpg.org*** or by calling (800) 480-9967. You have the right to limit the type of information that you authorize the Plans to disclose and the persons to whom it should be disclosed. You may revoke your written authorization at any time. The revocation will be followed to the extent action on the authorization has not yet been taken.

Interaction with State Privacy Laws

If the state in which you reside provides more stringent privacy protections than HIPAA, the more stringent state law will still apply to protect your rights. If you have a question about your rights under any particular federal or state law, please contact the Church Pension Group Privacy Officer. Contact information is included at the end of this Notice.

Fundraising

The Plans may contact you to support their fundraising activities. You have the right to opt out of receiving such communications.

Underwriting

The Plans are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Your Rights With Respect to Your PHI

You have the following rights regarding PHI the Plans maintain about you:

Right to Request Restrictions. You have the right to request that the Plans restrict their uses and disclosures of your PHI. You will be required to provide specific information as to the disclosures that you wish to restrict and the reasons for your request. The Plans are not required to agree to a requested restriction, but may in certain circumstances. To request a restriction, please write to the Church Pension Group Privacy Officer and provide specific information as to the disclosures that you wish to restrict and the reasons for your request.

Right to Request Confidential Communications. You have the right to request that the Plans' confidential communications of your PHI be sent to another location or by alternative means. For example, you may ask that all EOBs be sent to your office rather than your home address. The Plans are not required to accommodate your request unless your request is reasonable and you state that the ordinary communication process could endanger you. To request confidential communications, please submit a written request to the Church Pension Group Privacy Officer.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the PHI held by the Plans. However, access to psychotherapy notes, information compiled in reasonable anticipation of or for use in legal proceedings, and under certain other, relatively unusual circumstances, may be denied. Your request should be made in writing to the Church Pension Group Privacy Officer. A reasonable fee may be imposed for copying and mailing the requested information. You may contact the Medical Trust Plan Administration at ***astill@cpg.org*** for a full explanation of ECMT's fee structure.

Right to Amend. You have the right to request that the Plans amend your PHI or record if you believe the information is incorrect or incomplete. To request an amendment, you must submit a written request to the Medical Trust Plan Administration at **astill@cpg.org**. Your request must list the specific PHI you want amended and explain why it is incorrect or incomplete and be signed by you or your authorized representative. All amendment requests will be considered carefully. However, your request may be denied if the PHI or record that is subject to the request:

Is not part of the medical information kept by or for the Plans;

- Was not created by or on behalf of the Plans or its third party administrators, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you are permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to receive information about when your PHI has been disclosed to others. Certain exceptions apply to this rule. For example, a Plan does not need to account for disclosures made to you or with your written authorization, or for disclosures that occurred more than six

years before your request. To request an accounting of disclosures, you must submit your request in writing to the Medical Trust-Plan Administration at ***astill@cpg.org*** and indicate in what form you want the accounting (*e.g.,* paper or electronic). Your request must state a time period of no longer than six years and may not include dates before your coverage became effective. The Medical Trust Plan Administrator will then notify you of any additional information required for the accounting request. A Plan will provide you with the date on which a disclosure was made, the name of the person or entity to whom PHI was disclosed, a description of the PHI that was disclosed, the reason for the disclosure and certain other information. If you request this accounting more than once in a 12-month period, you may be charged a reasonable, cost-based fee for responding to these additional requests. You may contact Medical Trust Plan Administration at ***astill@cpg.org*** for a full explanation of the Medical Trust's fee structure.

Breach Notification. You have the right to receive a notification from the Plans if there is a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You are entitled to get a paper copy of this Notice at any time, even if you have agreed to receive it electronically. To obtain a paper copy of this Notice, please contact the Church Pension Group Privacy Officer.

If You Are a Person in the European Union, the Following Provisions Will Also Be Applicable to You:
For the purposes of the General Data Protection Regulation 2016/679 (the "GDPR"), the Data Controller is Church Pension Group Services Corporation registered in the State of Delaware in the United States with a registered address at 19 East 34th Street, New York, NY 10016.

You can request further information from our Privacy Officer at Privacy@cpg.org.

In addition to your rights with respect to your PHI addressed above, you may have additional or overlapping rights under the GDPR. GDPR rights regarding your PHI include the following:

- You may access and export a copy of PHI;
- You may request deletion of, and update to PHI;
- You have the right to be informed about any automated decision-making of PHI including the significance and consequences of such processing for you;
- You may also object to or restrict the Plans' use of PHI. For example, you can object at any time to the Plans' use of PHI for direct marketing purposes.
- Where you believe that the Plans have not complied with its obligations under this Privacy Policy or the applicable law, you have the right to make a complaint to an EU Data Protection Authority;
- If the Plans' obtained your consent to use your PHI, you may withdraw that consent at any time.

Data Retention
We only retain PHI collected for a limited time period as long as we need it to fulfill the purposes for which have initially collected it, unless otherwise required by law.

Data Transfers
We maintain servers in United States and Canada and your information may be processed on servers located in the United States and Canada. Data protection laws vary among countries, with some providing more protection than others. Regardless of where your information is processed, we apply the same protections described in this policy.

If You Believe Your Privacy Rights Have Been Violated

If you believe your privacy rights have been violated by any Plan, you may file a complaint with the Church Pension Group Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be filed in writing. You will not be retaliated against for filing a complaint.

To contact the Church Pension Group Privacy Officer:

Privacy Officer
The Church Pension Group
19 East 34th Street
New York, NY 10016
(212) 592-8365
privacy@cpg.org

To contact the Secretary of the U.S. Department of Health and Human Services:
U.S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 | (877) 696-6775 (toll-free)
www.hhs.gov/contactus.html

Effective Date

This Notice is effective as of August 29, 2018.

Changes

Each Plan sponsored by the Medical Trust reserves the right to change the terms of this Notice and information practices and to make the new provisions effective for all PHI it maintains, including any PHI it currently maintains as well as PHI it receives or holds in the future, as permitted by applicable law. Any material amendment to the terms of this Notice and these information practices will be provided to you via mail or electronically with your prior written consent.

EPISCOPAL CHURCH MEDICAL TRUST

Notice of Nondiscrimination

Church Pension Group Services Corporation ("CPGSC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CPGSC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. CPGSC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print materials
- Provides free language services to people whose primary language is not English, such as information written in other languages

If you need these services, contact Adriene Clarke, Civil Rights Coordinator.

If you believe that CPGSC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can obtain a copy of the grievance procedures or file a grievance with: Adriene Clarke, Civil Rights Coordinator, Church Pension Group, 19 East 34th Street, New York, NY 10016, Phone: 212-592-6299, Fax: 212-592-9487, Email: aclarke@cpg.org. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Adriene Clarke, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697(TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-480-9967.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-480-9967.

ملحوظة: إذا كنت تتحدث اللغة اذكر، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل
1-800-480-9967.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-480-9967.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-480-9967.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-480-9967.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-480-9967.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-480-9967.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-480-9967.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-480-9967.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-480-9967.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-480-9967.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-480-9967.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-480-9967.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-480-9967 تماس بگیرید.

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Acts of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthetics; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator or The Episcopal Church Medical Trust at (800) 480-9967.