This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cpg.org or by calling 1-800-480-9967.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,700** Individual/**$5,450** Family network **$3,000** Individual/**$6,000** Family out-of-network Deductible does not apply to preventive care received in network and emergency care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. Prescription drug benefits are through Express Scripts.
Is there an out–of–pocket limit on my expenses?	Yes, **$4,200** Individual/**$8,450** Family Network **$7,000** Individual/**$13,000** Family out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Contributions (premiums), balance-billed charges, health care this plan doesn't cover, and penalties.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.empireblue.com/medicaltrust or call 1-800-352-3152.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $30) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	45% coinsurance	None
	Specialist visit	20% coinsurance	45% coinsurance	None
	Other practitioner office visit	20% coinsurance for chiropractor services and acupuncture	45% coinsurance for chiropractor, 20% coinsurance for acupuncture	Limited to 20 visits per year for chiropractor services, 12 visits per year for acupuncture
	Preventive care/screening/immunization	No charge	45%	Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance	None
	Physician/surgeon fees			None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-network Provider	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Hospital admission must be certified within 24 hours.
	Emergency medical transportation	20% coinsurance	45% coinsurance	None
	Urgent care	20% coinsurance	45% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance	Prior authorization is required..
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs.	Mental/Behavioral health outpatient services	20% coinsurance	45% coinsurance	None
	Substance use disorder outpatient services	20% coinsurance	45% coinsurance	None
	Mental/Behavioral health inpatient services	20% coinsurance	45% coinsurance	Admissions must be precertified.
	Substance use disorder inpatient services	20% coinsurance	45% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Out-of-network Provider	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	45% coinsurance	
	Delivery and all inpatient services	20% coinsurance	45% coinsurance	Prior authorization is required.
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. Precertification 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 (facility)	20% coinsurance	45% coinsurance	Limited to 60 days per Plan year.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice service	20% coinsurance	45% coinsurance	Limited to one episode per lifetime. Precertification is required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Vision benefits are available through EyeMed Vision Care.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Common Medical Event	Services You May Need	Your Cost		Limitations & Exceptions
		Retail	Mail Order	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at 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 the mail order pharmacy. Your prescription deductible is combined with your medical deductible. **Prescription drug benefits are through Express Scripts.**
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-term care
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the United States*
- Private duty nursing

** Applies only to services covered by Anthem Blue Cross and Blue Shield. Coverage for non-emergency care and services outside of the United States is not available through Express Scripts.*

Your Deductible

This plan has an embedded deductible. This means that once each member of your family has met the individual deductible, this plan will cover his or her medical expenses minus the appropriate cost share. The individual deductible is also credited toward the family deductible.

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 1-800-480-9967 for more information.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Anthem Blue Cross and Blue Shield at 1-844-812-9207.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-480-9967
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-480-9967
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-480-9967
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-480-9967

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

[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:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,190
- **Patient pays** $3,350

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,700
Copays	$0
Coinsurance	$500
Limits or exclusions	$150
Total	**$3,350**

These numbers assume the patient has given notice of her pregnancy to the Plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information please contact Anthem Blue Cross and Blue Shield at 1-844-812-9207.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,180
- **Patient pays** $3,220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,700
Copays	$
Coinsurance	$440
Limits or exclusions	$80
Total	**$3,220**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.