




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 [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.cpg.org/mtdocs](http://www.cpg.org/mtdocs) or call (800) 480-9967. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.cpg.org/uniform-glossary](http://www.cpg.org/uniform-glossary) or call (800) 480-9967 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<u>Network</u> : \$1,000 Individual / \$2,000 Family <u>Out-of-Network</u> : \$2,000 Individual / \$4,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family deductible. The network and out-of-network <a href="#">deductibles</a> accumulate separately.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, for example, network preventive care, emergency room care, urgent care, and certain telehealth services.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .**
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<u>Network</u> : \$3,500 Individual / \$7,000 Family <u>Out-of-Network</u> : \$7,000 Individual / \$14,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. The network and out-of-network <a href="#">out-of-pocket limits</a> accumulate separately.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Contributions, ( <a href="#">premiums</a> ), <a href="#">balance-billing</a> charges, penalties, <a href="#">copays</a> for certain specialty pharmacy drugs considered non-essential health benefits and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.mycigna.com">www.mycigna.com</a> or call (800) 244-6224 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

\*\*See Page 5 for important information about 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	<a href="#">Specialist</a> visit	\$45 copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. See a list of preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
	Physician/surgeon fees	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 copay/visit <a href="#">Deductible</a> does not apply	\$250 copay/visit <a href="#">Deductible</a> does not apply	The \$250 <a href="#">copay</a> will be waived if you are admitted to the hospital as an inpatient within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None.
	<a href="#">Urgent care</a>	\$50 copay/visit	\$50 copay/visit plus any	None.

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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)	
		<a href="#">Deductible</a> does not apply	<a href="#">balance billing</a> <a href="#">Deductible</a> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Prior authorization is required.
	Physician/surgeon fees	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	30% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a> <a href="#">Deductible</a> does not apply	None.
	Inpatient services	20% coinsurance <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Prior authorization is required.
If you are pregnant	Office visits	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	<a href="#">Copay</a> applies only to the initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Well-newborn care is covered. Newborn must be enrolled in the <a href="#">plan</a> within 30 days of birth
	Childbirth/delivery facility services	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Limited to 210 visits per plan year. Prior authorization is required.
	<a href="#">Rehabilitation services</a>	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	Benefits include speech/hearing, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.
	<a href="#">Habilitation services</a>	\$30 PCP / \$45 specialist copay/visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	
	<a href="#">Skilled nursing care</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus	Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization

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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)			
			any <a href="#">balance billing</a>	is required.		
	<a href="#">Durable medical equipment</a>	20% coinsurance	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	None.		
	<a href="#">Hospice services</a>	No charge.	50% <a href="#">coinsurance</a> plus any <a href="#">balance billing</a>	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		
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>		Retail	Home Delivery	Retail	Home Delivery	<a href="#">Deductible</a> does not apply.  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. <sup>1</sup> See "Important Questions" regarding the Plan's out-of-pocket limit on page 1.  No charge for contraceptives.  For a complete list of non-essential specialty medications, see <a href="http://SaveonSP.com/cpg">SaveonSP.com/cpg</a> .
	Generic drugs	Up to \$10	Up to \$25	Up to \$5	Up to \$12	
	Preferred brand drugs	25%; up to \$40 min / \$80 max	25%; up to \$100 min / \$200 max	Up to \$35	Up to \$87	
	Non-preferred brand drugs	40%; up to \$80 min / \$160 max	40%; up to \$200 min / \$400 max	Up to \$70	Up to \$175	
	<a href="#">Specialty drugs</a>	40%; up to \$100 min / \$200 max	40%; up to \$250 min / \$500 max	Up to \$90	Up to \$225	

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Cosmetic surgery	• Dental care (Adult)	• Long-term care
• Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult)	• Routine foot care (unless related to diabetes or certain other conditions)
• Weight loss programs		

<sup>1</sup> The prescription drug plan maintains a retail refill limit policy. The retail refill limit requires that you use home delivery if you are prescribed a maintenance medication. In some circumstances, you may not be required to use home delivery. See the plan document at [www.cpg.org](http://www.cpg.org).

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\*\* See Page 5 for important information about telehealth services.

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

- |  |   |   |
|--|---|---|
| • Acupuncture (limit 20 visits per year)         | • Bariatric surgery (if Medically Necessary)        | • Chiropractic care (limit 20 visits per year)                |
| • Hearing aids (limit \$3,000 every three years) | • Infertility treatment (\$50,000 lifetime maximum) | • Private duty nursing (only through home healthcare benefit) |

**Telehealth Services:** The Medical Trust will waive all [copays](#), [deductibles](#), and [coinsurance](#) for all telehealth services received through Quantum Health's telehealth platform, Teladoc. The Medical Trust will also allow claims for virtual visits with [network](#) and [out-of-network providers](#) who do not use Teladoc through Quantum Health, but standard [deductibles](#), [copays](#), and [coinsurance](#) will apply.

**Your Rights to Continue Coverage:** The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as COBRA) for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements<sup>2</sup>. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how 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 Cigna or Express Scripts, as appropriate.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al (800) 480-9967.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 480-9967.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(800) 480-9967.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 480-9967.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

<sup>2</sup> Under Section 4980B(d) of the Code and Treasury Regulation Section 54.4980 B-2, Q. and A. No. 4.

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$800
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$45
- Hospital (facility) [\[cost sharing\]](#) 20%
- Other [\[cost sharing\]](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$70
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,670</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.