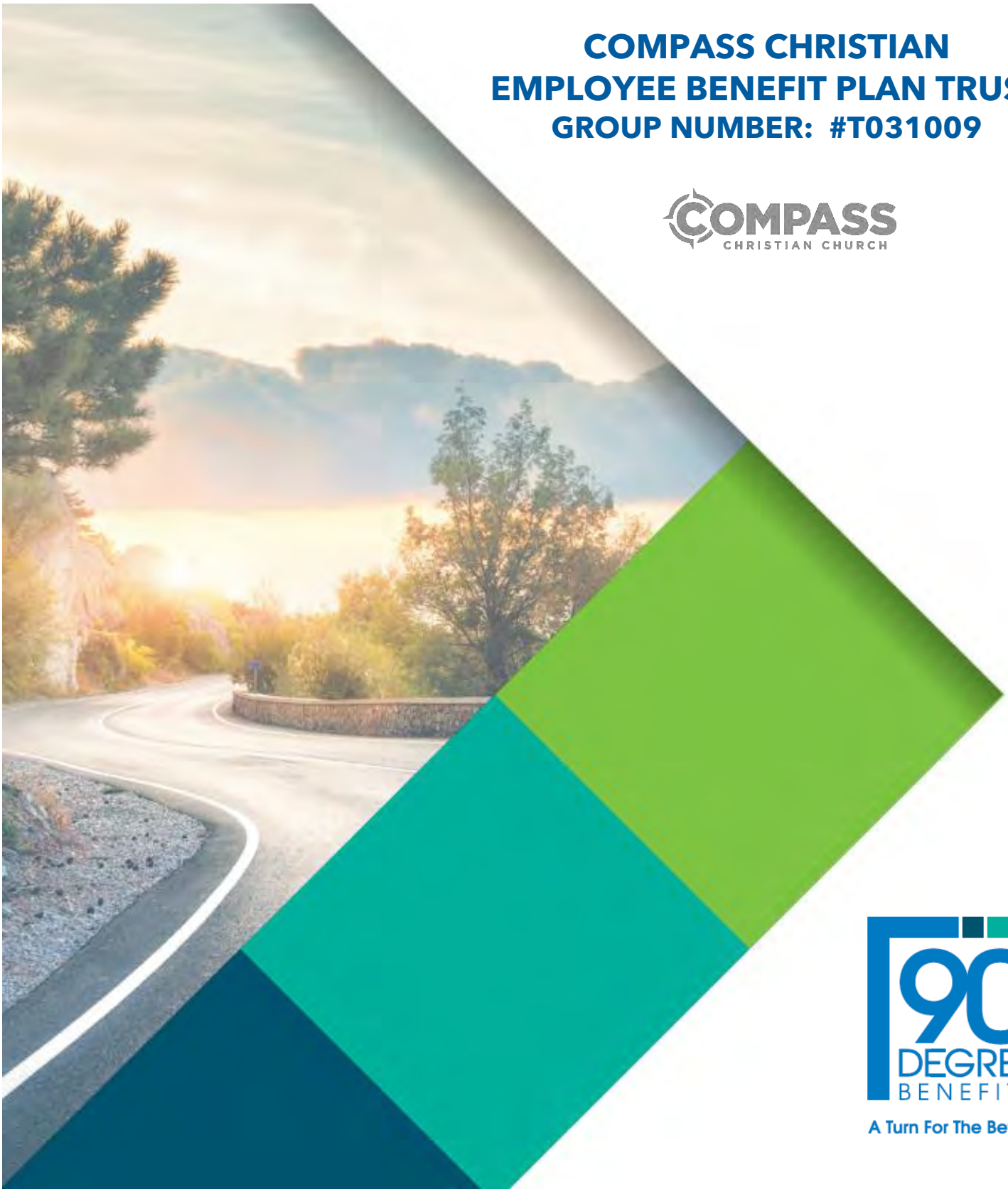


COMPASS CHRISTIAN EMPLOYEE BENEFIT PLAN TRUST

GROUP NUMBER: #T031009

COMPASS CHRISTIAN CHURCH

90 DEGREE BENEFITS

A Turn For The Better

2022 EMPLOYEE BENEFIT GUIDE

INSIDE THIS BENEFIT GUIDE

TABLE OF CONTENTS

HOW YOUR PLAN WORKS

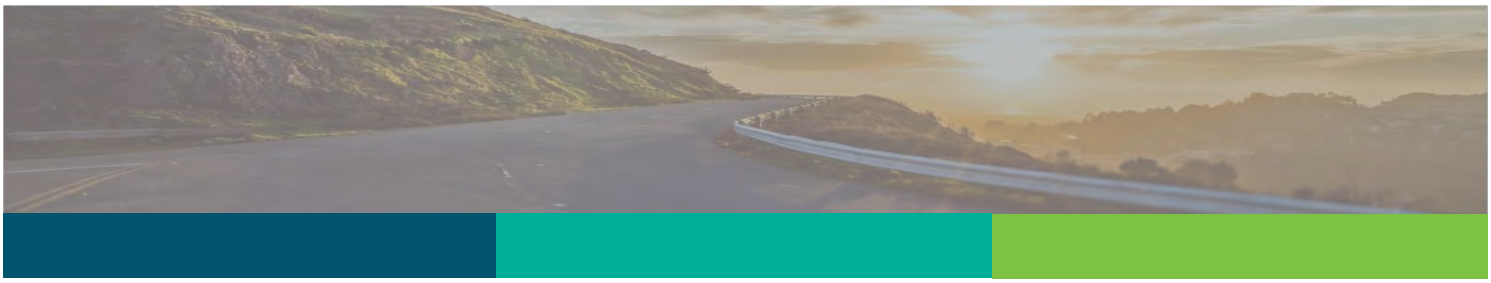
CIGNA PPO NETWORK - Our plan has contracted with Cigna PPO Choice Fund Network. Utilizing the network offers our plan and its participants the contractual right to assign your benefit payments directly to the provider, significant discounts, provider credentialing and access to a nationwide list of physicians that handle medical conditions both inside and outside your geographic area. To find out who is in the network, visit Cigna at www.mycigna.com or by calling (833) 382-7878.

BALANCE BILLING – When utilizing providers that are not in the PPO Network, our plan has determined a reference amount for the plan reimbursement. The difference between the reference amount our Plan allows and a greater amount a provider might charge is known as "Balance Billing". You are financially responsible for balance bills. To avoid balance billing, you must discuss or negotiate your out-of-network provider's fees in advance and ensure that they do not exceed the amount allowed by the Plan.

MEDICAL HELPLINE ADVOCATE - Entrust provides access to Patient Advocacy Service Specialists which will attempt to negotiate with a Provider or Facility in advance of services. If the services would be allowed as a payable claim under the terms of the Plan Document and Summary Plan Description (SPD) and the provider will agree in advance to the defined Allowable Amount, the Plan may agree to waive the Plan Participant's Deductible for the facility portion of the bill. You must refer to your Plan Document and Summary Plan Description for details regarding how your plan will consider "Direct Contract Negotiations".

PRIOR AUTHORIZATION REVIEW - Your Plan contains a Pre-authorization/Utilization Review requirement. Prior to any inpatient hospital admission or outpatient facility procedure, you must contact Medical Helpline Advocate. The Medical Helpline Advocate will monitor the confinement and make recommendations to keep the charges realistic or assist in negotiating a cash price. Since procedures are scheduled in advance, this call must be made at least five (5) business days in advance of services being rendered or within two (2) days after an emergency event. The employee, a family member, or your service provider is responsible for notifying Medical Helpline at 833-382-7875. Prior-authorization is not required for Inpatient maternity confinements within the minimum stay requirements.

ENFORMED+ For claims, eligibility, and accumulators, or just to view your ID card, download the Enformed+ App.
Register a member account at: www.enformed.com



90 DEGREE BENEFITS
A Turn For The Better

Corporate Office: 22322 Grand Corner Drive #200 Katy, Texas 77494 - (281) 368 – 7878
Corpus Christi Office: 210 S. Carancahua Suite 301, Corpus Christi, Texas 78401

ELIGIBILITY

FULL-TIME EMPLOYEES that work at least 30 hours per week are eligible for coverage on the 1st of the month following or coinciding with date of hire or Full-Time Status.

IMPORTANT STEPS FOR YOUR ENROLLMENT PROCESS: You must complete your enrollment within 31 days of your eligibility date, otherwise you will not be able to enroll in the Compass Christian Employee Benefit Plan Trust (EBPT) until the next annual open enrollment unless you have a qualifying life event.

ELIGIBLE DEPENDENTS

- Legal spouse
- Any child of an eligible employee up to age 26
- Any child under legal guardianship of the eligible employee up to age 26
- Step-children of eligible employee up to age 26
- Dependent child(ren) required to be covered through a Qualified Medical Support Order
- Any child meeting the criteria above who is over the age 26 and legally incapacitated
- All employees must either accept or waive coverage

LIFE EVENTS

- Birth or adoption of a child
- Marriage or divorce
- Death of spouse and/or dependents
- Dependent's loss of eligibility
- Gain/loss of health care coverage of spouse due to employment changes
- Taking an unpaid leave of absence
- You or your spouse become eligible or ineligible for Medicare benefits
- Other such event Plan Administrator determines to be permitted under I.R.S. Section 125 or other applicable guidelines issued by the I.R.S.
- Gain/loss of eligibility for Medicaid/CHIP (60 days to enroll/cancel coverage rather than 31 for all other life events)

Change to your benefit election must be consistent with the change in family status (i.e., birth of child allows the Plan to add a newborn but does not allow you to drop your current coverage). Newborn children of an eligible employee will not be covered from the moment of birth unless enrollment for the child as a dependent is completed within 31 days from the child's date of birth.

EMPLOYEE COST PER PAYCHECK	PASTORAL/NON-PASTORAL 48 HOURS	SALARIED & HOURLY
Employee Only	**$0**	**$0**
Employee & Spouse	**$0**	**$245.76**
Employee & Children	**$0**	**$192.60**
Employee & Family	**$0**	**$477.89**

MAJOR MEDICAL PLAN A

COVERED SERVICES	NETWORK	NON-NETWORK
Family Monthly Deductible *(Co-Payments Do Not Apply)*	$750	
Coinsurance	100%	70%
Maximum Out-of-Pocket *(Includes Deductible, Coinsurance & Copays)*	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family
***Important Note:* The Maximum Out-of-Pocket Expense does not include amounts that may be "Balance Billed" by providers due to charges that exceed the Plan's Defined Allowable Reimbursement Schedule.**		
Lifetime Maximum Benefit All Medical Benefits	Unlimited	
Note: For Medically Necessary Services rendered by a Contracted or Non-Contracted Provider, the benefits of this Plan will be provided after the deductible has been met until out-of-pocket amounts are reached each Plan Year. Thereafter, this Plan will provide benefits at 100% of the Allowable charge for the remainder of the Plan Year for all covered medical expenses, unless otherwise specified. Any balances of charges not covered by this Plan will be your responsibility to pay.		
COVERED SERVICES	**NETWORK**	**NON-NETWORK**
Subject to Plan exclusions and limitations, the Allowable Amount for Contracted Providers will be the contracted allowable amount; and the Allowable Amount for Non-Contracted Providers is based on a limited fee schedule.		
Physician's Office Visit Includes all related services performed plus allergy testing and treatment, x-rays, laboratory tests. *Includes In-Office Surgery*	$20 Copay	$30 Copay *(Subject to the Plan Allowable)*
Specialist's Office Visit Includes all related services performed plus allergy testing and treatment, x-rays, laboratory tests. *Includes In-Office Surgery*	$30 Copay	$40 Copay *(Subject to the Plan Allowable)*
Preventive Care (Includes screenings, counseling, immunizations, birth control and other preventive care services) *For additional information, see the Preventive Care Services section of the Plan Document or https://www.healthcare.gov/what-are-my-preventive-care-benefits/*	Covered at 100% *(Subject to the Plan Allowable Amount)*	
Convenience Care Clinic Healthcare clinics located in Retail Stores, Supermarkets, and Pharmacies that treat routine family illness on a limited basis and provide basic health care services.	$20 Copay	$30 Copay *(Subject to the Plan Allowable)*
Urgent Care Clinic & Physician Services Freestanding Facility or Urgent Care Center	$100 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Outpatient Diagnostic Testing, Laboratory, and/or Radiology Hospital and Freestanding Facility Excludes Emergency Room Excludes MRIs, CT & PET Scans	$30 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Outpatient MRIs, CT & PET Scans	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Emergency Room Facility Charges Physician Services Emergency Services/Accidental Injury *No pre-authorization required for Emergency Services.*	$350 Copay *(Subject to the Plan Allowable)*	
Note: Emergency Services rendered for an Emergency Medical Condition by a Contracted provider will be payable at the Contracted level of benefits if choice of Hospital was beyond the control of the plan participant.		

COVERED SERVICES	NETWORK	NON-NETWORK
Hospital Service - Inpatient/Outpatient Daily Room and Board limited to the charges up to the semi-private room rate, unless the hospital only has private rooms available, then it will be the private room rate. *Intensive Care Unit limited to the Hospital's ICU charge.*	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Skilled Nursing Facility Inpatient Services Limited to 25 days per Plan Year unless otherwise stated in a separate provider agreement. *Subject to Prior Authorization and/or Case Management.*	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Hospital Confinement for Rehabilitation Subject to Prior Authorization and/or Case Management.	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Surgery ➢ Inpatient Hospital ➢ Outpatient Hospital ➢ Ambulatory Surgical Facility *(Includes surgeon, assistant surgeon and anesthesiologist services)*	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Home Health Care Limited to 90 Visits Per Plan Year	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Hospice Care	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Durable Medical Equipment and Supplies	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Prosthetics/Orthotics	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Outpatient Physical Therapy	$30 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Outpatient Occupational Therapy	$30 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Outpatient Speech Therapy	$30 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Maternity Services (Employee and Spouses Only)	Benefits will be the same as those stated under each covered services category.	
Outpatient Chemotherapy/Radiation/IV Therapy Hospital, Freestanding Facility or Physician's Office	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Mental Health/Substance Abuse	Benefits will be the same as those stated under each covered services category.	
Chiropractic/Spinal Manipulation Services	$30 Copay	Deductible and Coinsurance *(Subject to the Plan Allowable)*

COVERED SERVICES	NETWORK	NON-NETWORK
Dialysis Services	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
Organ/Marrow/Tissue Transplants	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*
All Other Covered Services	Covered at 100% after the deductible	Deductible and Coinsurance *(Subject to the Plan Allowable)*

PRESCRIPTION DRUG SERVICES

Southern Scripts will be the Prescription Benefit Manager for your Rx Program. You will see their logo and information on your ID Card. You can go to any pharmacy of your choice, however; you will notice greater discounts by utilizing a pharmacy in the Southern Scripts First Choice Network.

COVERED SERVICES	30-DAY SUPPLY	MAIL ORDER
Generic Drugs	$10 Copay	$30 Copay
Preferred Brand Name Drugs	$40 Copay	$120 Copay
Non-Preferred Brand Name Drugs	$70 Copay	$210 Copay
ACA Required Preventive Medications	$0 Copay	
Specialty Drugs (Specialty Network)	25% Copay	Not Applicable
Orphan Drugs	Not Covered	

Exclusions:

"Me-Too" Drugs
Chemically similar drugs that share the same mechanism of action to a less expensive existing approved chemical entity (i.e. Prilosec & Nexium).

Non-Essential
Medications in a dosage form that increased the cost for treatment, when other less expensive dosage forms are available (i.e. topical patches & creams).

VALUE ADDED

Cigna	Our plan utilizes the CIGNA Primary PPO Network. Utilizing the network offers our plan and its participants the contractual right to assign your benefit payments directly to the provider. You may visit them on the web at www.mycigna.com for a completed listing of providers. (833) 382-7878
ASK-A-NURSE 24/7 877-463-3435 Medical Helpline Medical Helpline ADVOCATE	To increase benefits and assist you in your medical needs, we have 24-hour access to "Ask-a-Nurse" 7 days a week. Whether you have a serious emergency or would just like to have a medical professional's advice regarding your daily health care needs, just contact Medical Helpline. The best thing about it is the cost - It's FREE! Your Plan contains a Pre-authorization/Utilization Review requirement. This means that prior to any inpatient hospital admission, you must contact Medical Helpline. Medical Helpline will monitor the confinement and make recommendations to help keep the charges realistic. This call must be made at least five (5) business days in advance of services being rendered or within two (2) days after an emergency. The employee, a family member, or your service provider is responsible for notifying Medical Helpline. Your medical plan I.D. Card will indicate on the back the proper number to call. 1-833-382-7875 Medical Helpline Advocate provides access to Support Services which will attempt to negotiate with a Provider in advance of services. If the services would be a payable claim under the terms of the Plan Document and Summary Plan Description and the provider will agree in advance to the defined Allowable Amount, this protects the patient against any balance billing for this episode of care. MHL Advocate coordinates getting this in writing from the providers. Call (833) 382-7878

FREQUENTLY ASKED QUESTIONS

IS MY COVERAGE PORTABLE?

Yes, COBRA is a federal law that enables you to continue coverage in the event of termination of employment or any other qualifying event. When purchasing COBRA coverage, your employer does not contribute towards the cost of coverage.

COBRA	PLAN A
Employee Only	**$775.74**
Employee & Spouse	**$1,394.78**
Employee & Child(ren)	**$1,260.88**
Employee & Family	**$1,979.48**

WHAT IS THE ACA?

This is the Affordable Care Act, also known as the Patient Protection and Affordable Care Act of 2010. This law was passed in March of 2010 and its major provisions, the individual mandate and the employer mandate, became effective in January 2014 and 2015, respectively.

WHAT IS THE HEALTH INSURANCE EXCHANGE?

The Health Insurance Exchange, also known as the Health Insurance Marketplace, is a way for individuals and families to shop multiple companies for health insurance on the internet or with phone assistance. For more information, see your employer's exchange notice.

HOW DO I RESEARCH THE QUALITY OF MY PROVIDERS?

There are many different websites that you may visit as a plan participant to see the quality of your providers. Below is a listing of just a few: The Leap Frog Group www.leapfroggroup.org, Health Grades www.healthgrades.com, MPIRICA www.mpirica.com and Vitals www.vitals.com

WHAT IS THE MAXIMUM OUT OF POCKET ACCORDING TO THE AFFORDABLE CARE ACT?

The 2022 maximum out-of-pocket amount is $8,700 for an individual and $17,400 for a family. This includes amounts you spend on deductibles, coinsurance, and co-pays. This amount does not include the amount you pay for premiums, balance billed amounts, or services this plan does not cover. Your plan is designed not to exceed the maximum out-of-pocket

DO I HAVE ACCESS TO AN ONLINE WEBSITE SO I CAN VIEW MY CLAIM ACTIVITY AND HAVE ACCESS TO MY PLAN DOCUMENT?

Yes, you have a claim dashboard available anytime 24/7 to privately access your claim activity, ID Cards and Plan Documents by going to www.enformed.com on any personal device. Download the mobile app, just search Enformed+ Mobile in the app store.

DOES THIS PLAN USE A NETWORK?

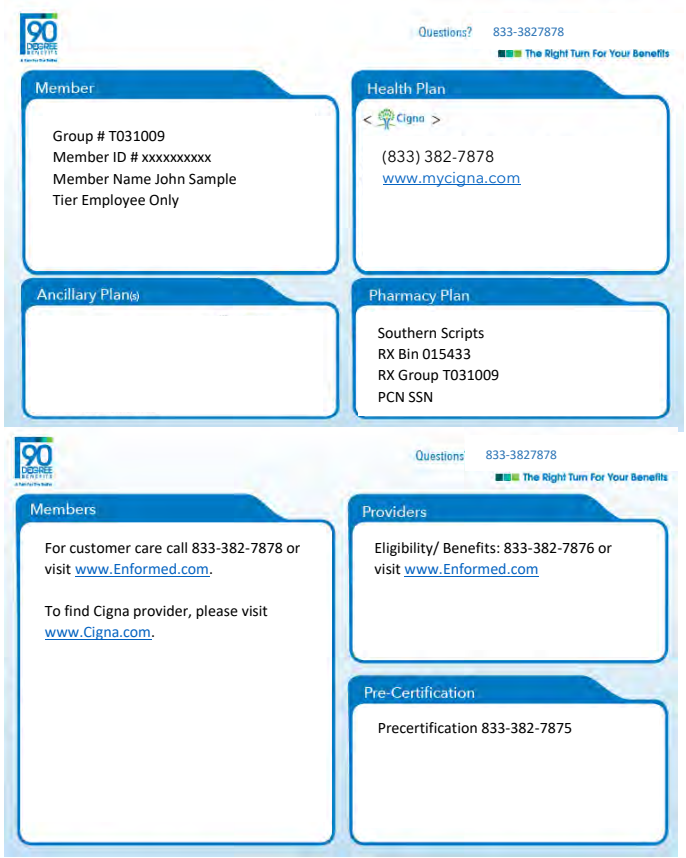
Our plan has the Cigna Network. Utilizing the network offers our plan and its participants the contractual right to assign your benefit payments directly to the provider. You may visit them on the web at www.mycigna.com for a listing of providers.

BENEFIT ID CARD SAMPLE

- Your Plan ID card includes important information for your provider about accessing your benefits, payment terms and claims submitted on your behalf.
- When you receive your ID card, it is important to verify that your personal information is accurate. If there are any errors, please notify 90 Degree Benefits immediately at: (800) 436-8787 x2 or contact your Account Executive.
- Your social security number will not appear on your ID card but may be used in submission of claims. In place of your social security number, you will be issued a unique member ID number. This serves to protect your personal health information even further while keeping you in compliance with HIPAA privacy provisions.
- Whenever seeking service, you should always show your ID card even with your current physicians or pharmacy. Since this ID card is new, make sure to give it to your provider at your next visit.
- Destroy your old cards immediately! These are no longer needed with your new benefit plan.
- Should you have any questions or concerns regarding your ID card (once received), or need additional cards for your dependents, please contact us directly at: (800) 436-8787 or contact your HR department.

BELOW IS A SAMPLE COPY OF YOUR 90 DEGREE BENEFITS BENEFIT ID CARD

ID CARD BELOW IS JUST A SAMPLE & NOT A REPRESENTATION OF YOUR PLANS ACTUAL ID CARD



Benefit Administrator

Group Number & Member Information

Other Benefits (If Applicable)

Provider Claims Submission Information

PPO Network Information

Pharmacy Information & Benefit Verification

Provider Verification of Benefits Information

Pre-Authorization and Utilization Review

Doctor Difficulties?

If you go to the doctor's office and they tell that they cannot locate you in the system, this does not mean that you do not have coverage. All this means is that they may not be verifying your eligibility correctly. Try these steps:

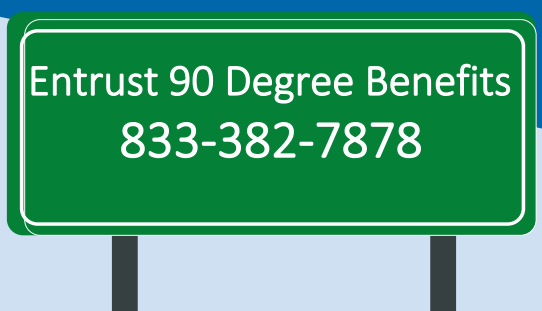
1. Tell your doctor that the PPO network is Cigna, but Entrust 90 Degree Benefits is the Plan Administrator.

2. If your doctor is unsure if they are a Cigna provider, they can call (833) 382-7876 for assistance.

3. You can search network providers on the Cigna website www.myCigna.com

4. If your doctor's office requests that you pay for the office visit 100%, ask them if they contacted Entrust 90 Degrees at (833) 382-7876.

5. It is rare to come to this point. If the doctor's office will not contact Entrust 90 Degree Benefits to verify your coverage and eligibility, then you can call and request a customer service representative call your doctor's office.



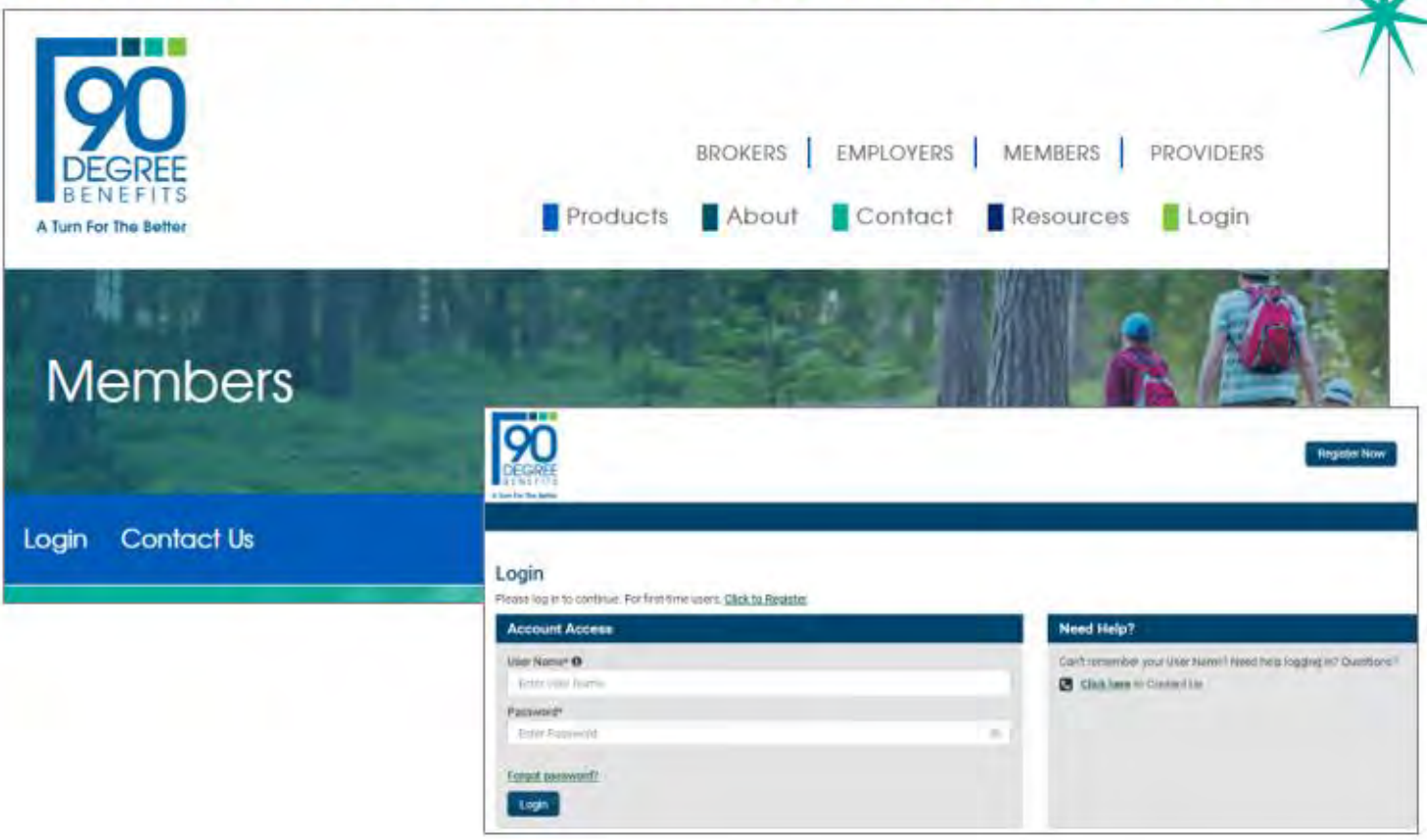
ENFORMED+

MEMBER PORTAL

Go to:
www.enformed.com

- Click on "Member Login"
- Register an account
- Download the Mobile App
- View ID Cards
- Check your Claims
- See your Plan Document
- View your coverage and Benefits
- Extra Plan Services
- Ask a Question

In 2022
New MEMBER PORTAL COMING SOON!



SOUTHERN SCRIPTS

firstchoice southernscripts & Retail

southernscripts.net/members

Members of Southern Scripts have access to reduced prescription costs at participating FirstChoice™ pharmacies. Present your member ID card when filling a prescription at any major retail chain or independent pharmacy across the country. If your pharmacy is not utilizing the Southern Scripts network, have your pharmacist call the number on your ID card to enroll.

The FirstChoice™ network will assist in reducing your prescription costs by providing the greatest discounts. To locate a FirstChoice™ pharmacy near you, please use the Network Pharmacy Locator on our website.

SHARx

What to expect from SHARx

Our advocates will be in touch if you have a medication over $350. Be ready for an email or phone call to enroll into the SHARx program.

Take a bite out of high cost medications

SHARx (pronounced "Sharks") is a pharmacy advocacy and concierge service to bring improved access to high cost medications. This services is included at no additional cost to you as a member enrolled in your employer's health plan. SHARx will be the dedicated resource to provide access to your eligible medications, delivered right to your door - often at $0 cost to you! These medications will no longer be available at your local or specialty pharmacy.

If you are taking a brand medication, then you should expect to hear from SHARx, so make sure to respond right away!

Easy to navigate self service portal!

Verify prescriptions & check on their status at any time!

Easy to keep in touch with your advocate - chat, text, call, or email!

Mail Order

southernscripts.net/members

To find a mail order pharmacy, call (800) 710-9341 or visit our member page.

Managing Your Pharmacy Plan

southernscripts.net/members

Get instant access to your benefits, price-check tools, and more by registering on our member page. Please note that registration is only available after your plan effective date.

v3

Dental Benefits

Metropolitan Life Insurance Company

Overview of Benefits for: COMPASS CHRISTIAN CHURCH

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type	**In-Network:** % of Negotiated Fee	**Out-of-Network:** % of R&C Fee[1]
Type A	100%	100%
Type B	80%	80%
Type C	50%	50%
Type D	50%	50%
Deductible: Individual/Family*	$50 (Type B, C, D)	$50 (Type B, C D)
Annual Maximum Benefit: Per Individual	**$1500**	**$1,500**
	Child Ortho to Age 19	Child Ortho to Age 19
Child Ortho- Lifetime Max Per Individual	**$1,000**	**$1,000**

Understanding Your Dental Benefits Plan

With the MetLife Preferred Dentist Program you can visit the dentist of your choice – an "in-network" dentist (a participating MetLife dentist) or an "out-of-network" dentist.

- Plan benefits for in-network services are based on the percentage of the Negotiated fee –the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be higher, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service. Please refer to the Selected Covered Services and Frequency Limitations page of this document for details regarding how R&C charges are defined under this plan.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits**and follow the easy registration instructions.

Certain plan benefits are based on a percentage of the negotiated fee. This is the amount that participating dentists have agreed to accept as payment in full. If your plan benefits are based on a percentage of the Reasonable and Customary (R&C) charges, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

* If you are enrolled for dependent coverage, a maximum family deductible may apply.
Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

Selected Covered Services and Frequency Limitations*

Type A	
• Oral Examinations	1 in 6 months.
• Cleanings	1 in 6 months.
• Fluoride	Children to age 14 / 1 in 12 months.
• Bitewing X-rays	Adult - 1 in 1 year / Children to age 14 - 2 in 1 year.
• Full Mouth X-rays	1 in 60 months.
Type B	
• Periodontal Maintenance	2 in 1 year less the number of teeth cleanings.
• Space Maintainers	
• Emergency Palliative Treatment	
• Periodontal Root Planing & Scaling	1 per quadrant in any 24 months period.
• Periodontal Surgery	1 in 36 months.
• Sealants (1st & 2nd permanent molars)	1 per tooth in 14 years of a dependent child up to 14th birthday.
• Amalgam & Composite Fillings	1 per surface in 24 months.
• Root Canal	1 in 24 months.
Type C	
• Crowns	1 in 60 months.
• Dentures	1 in 10 years.
• Bridges	1 in 10 years.
• Simple Extractions	
• Surgical Extractions	
• Repairs (Crowns)	1 in 12 months.
• Implants	1 in 60 months.

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

[1.] The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90 th percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.
2. Services for which You would not be required to pay in the absence of Dental Insurance.
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person.
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
20. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
21. Caries susceptibility tests.
22. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
23. Other fixed Denture prosthetic services not described elsewhere in this certificate.
24. Precision attachments.
25. Adjustment of a Denture
26 Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota. [1]
27 Orthodontic services or appliances. [1]
28. Repair or replacement of an orthodontic device.[1]
29. Duplicate prosthetic devices or appliances.
30. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
31. Intra and extraoral photographic images.

[1] Some of these exclusions may not apply. Please see your plan design and certificate for details.

COMMON QUESTIONS… IMPORTANT ANSWERS

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in full for services provided to plan participants. Based on internal analysis by MetLife, negotiated fees typically range from 15-45% below the average fees charged for the same services by dentists in the same geographic area.

*Negotiated Fees refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

How do I find a participating dentist?
You can access a list of participating dentists with directions and mapping capabilities online at www.metlife.com/dental or call 1-800-ASK-4-MET (800-275-4638) to have a list faxed or mailed to you based upon the requested ZIP code. **Please Note:** Be sure to verify provider participation when you make your appointment.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife program, your out-of-pocket expenses may be greater, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating dentist, you are only responsible for the difference between the in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for participation in network?
Yes. If your current dentist does not participate in the MetLife network and you would like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you, which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/dental or request one by calling 1-800-ASK-4-MET (800-275-4638).

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics). To receive a benefit estimate, simply have your dentist submit a request for a pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate online or by fax for most procedures while you are still in the office so you can discuss treatment and payment options and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Do I need an ID card?
No, you do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, eligible employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage elected after the 31-day application period is subject to the following waiting periods:*

- No waiting period for Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

***If the policy holder participates in a section 125 plan and has an annual open enrollment period, the dental coverage will not be subject to any waiting periods. Please consult your Benefits Administrator or your certificate for this plan information.**

Am I eligible for all benefits the first day of coverage?
Your plan may include benefit waiting periods. Please refer to the certificate of insurance or your Benefits Administrator for details about the services that are subject to the waiting periods and the length of time they apply.

How can I learn about what dentists in my area charge for different procedures?
If you have MyBenefits you can access the Dental Procedure Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area. * You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by VerifPoint, an independent vendor. Network fee information is supplied to VerifPoint by MetLife and is not available for providers who participate with MetLife through a third-party. Out-of-network fee information is provided by VerifPoint. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through MetLife's International Dental Travel Assistance program[1] you can obtain a referral to a local dentist by calling 1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network[2] benefits. Please remember to hold on to all receipts to submit a dental claim.

1 International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by Virginia Surety Company, Inc. AXA Assistance and Virginia Surety are not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

2 Refer to your dental benefits plan summary your out-of-network dental coverage.

CHANDLER CHRISTIAN CHURCH

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 SELECT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-299-1358**.
- 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	$10 Co-pay	Up to $35
Frames	$120 allowance; 20% off balance over $120	Up to $48
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $25
Bifocal	$25 Co-pay	Up to $40
Trifocal	$25 Co-pay	Up to $60
Standard Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40
Premium Progressive Lens	$25, 80% of charge less $55 allowance	Up to $40
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	20% off retail	N/A
Tint (Solid and Gradient)	20% off retail	N/A
Standard Plastic Scratch Coating	20% off retail	N/A
Standard Polycarbonate	20% off retail	N/A
Standard Anti-Reflective Coating	20% off retail	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 price	N/A
Contact Lenses		
Conventional	$135 allowance; 15% off balance over $135	Up to $95
Disposable	$135 allowance; plus balance over $135	Up to $95
Medically Necessary	$0 Co-pay; Paid-in-Full	Up to $200
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 24 months	

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. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

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

Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	**$10 Co-pay**	Up to $35
Frames (Once every 24 months)	**$120 allowance; 20% off balance over $120**	Up to $48
Single Vision Lenses (Once every 12 months)	**$25 Co-pay**	Up to $25
Or		
Contacts (Once every 12 months)	**$135 allowance; plus balance over $135**	Up to $95

Download the EyeMed Members App

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

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical

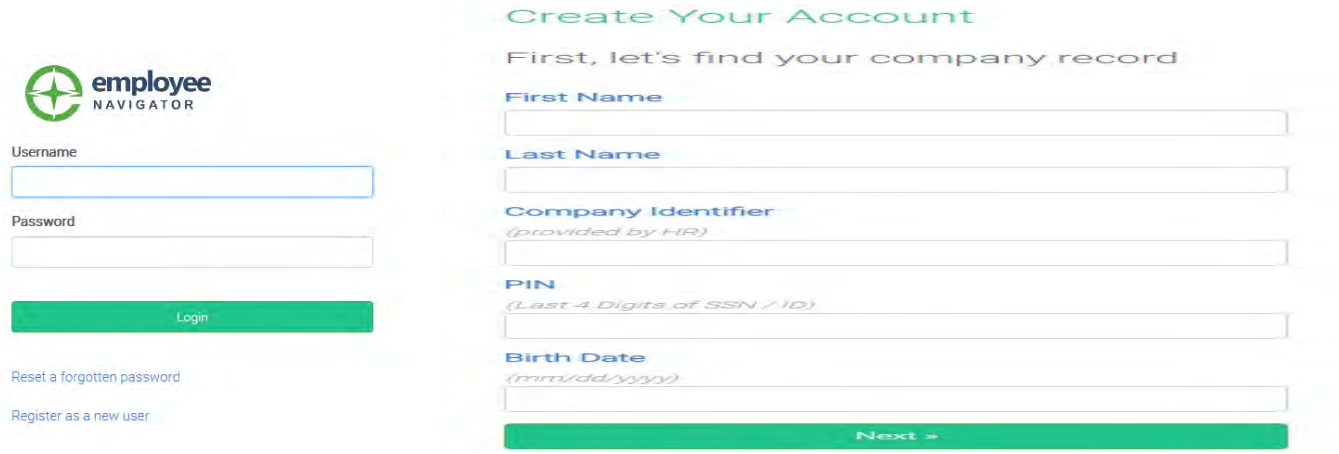
*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections.

Employee Navigator instructions: Employees enjoy convenient online access to their benefits coverage 24 hours a day, seven days a week. On this site you will be able to update to your personal profile, report life events, make eligible benefit elections and qualifying enrollment changes, and access a complete document library.

You may begin using Employee Navigator by going to www.employeenavigator.com/benefits

1. **Click Login**

2. **First time users will select "New User Registration" to create a Username & Password.**
3. **Your company identifier is: CCChurch**
4. **Existing users will proceed by entering their existing Username & Password.**



Key features for employees

Online Enrollment - The "New Hire Enrollment" link, located on the Employee Home Page, allows new hires to enroll into benefits outside of open enrollment or a qualifying event. During open season, employees can enroll into their benefits through the "Open Enrollment" link, also located on the Employee Home Page.

Enrollment Summary - Upon completion of enrollment, the employee will be prompted to agree to their benefits, and may print a copy of their enrollment summary.

Qualifying Event Changes - Employee Navigator allows employees to report qualifying events, such as marriage or the birth of a child, and make eligible benefit enrollment changes directly online

Update Profile - Employees can easily update their personal and dependent information, such as an address, at any time throughout the year.

My Benefits - Employees can access plan information at anytime by clicking the "Benefits" tab. From here, employees can view plan details, download plan summaries, review costs and enrolled dependent information.

Document Library - Under the "Documents" tab, employees can access a range of plan and HR specific documents. A few examples include benefit summaries, forms, and company policies or procedures.

Smart Phones – Employees can use the web browser on any smart phone; same as a computer. Go to the website EmployeeNavigator.com and follow the instructions above.

Compass Christian Church
Employee Cost Sheet

Plan Year January 1 thru December 31, 2022

	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family	Cost Per Paycheck
Cost per Paycheck					
FT Salaried & Hourly Medical Plan	$0.00	$245.76	$192.60	$477.89	$
FT Pastoral & Non-Pastoral Salaried 48 hour	$0.00	$0.00	$0.00	$0.00	$
MetLife Dental Plan	$20.08	$41.00	$37.72	$61.75	$
EyeMed Vision Plan	$3.13	$5.94	$6.26	$9.20	$
MetLife Life Insurance, $15,000 Life & AD&D			**Employer Paid**		$
MetLife Short Term Disability Income (STD)			**Employer Paid**		$
MetLife Long Term Disability Income (LTD)			**Employer Paid**		$

NOTES