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?	No deductible in-network **$500** Individual/**$1,500** Family out-of-network Deductible does not apply to preventive care 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?	Yes, **$50** deductible for prescription drug coverage when using a retail pharmacy	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. Prescription drug benefits are through Express Scripts.
Is there an out–of–pocket limit on my expenses?	Yes**, $2,000** Individual/**$4,000** Family network **$2,600** Individual/**$7,800** Family out-of-network (includes deductible)	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. See page 5 for the out-of-pocket limit on your pharmacy benefit.
What is not included in the out–of–pocket limit?	Contributions (premiums), balance-billed charges, healthcare 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.myuhc.com or call 1-866-204-8533.	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, $25) 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	$25 copay/visit	30% coinsurance	None
	Specialist visit	$25 copay/visit	30% coinsurance	None
	Other practitioner office visit	$25 per visit for chiropractor and acupuncture	30% coinsurance for chiropractor and acupuncture	Limited to 20 visits per year for chiropractor services, 12 visits per year for acupuncture combined in- and out-of-network
	Preventive care/screening/immunization	No charge	30%	Preventive care is based on guidelines from the U.S. Preventive Services Task Force, American Cancer Society, The Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. Coverage for child immunizations is based on the published guidelines of the American Academy of Pediatrics.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Prior authorization required for out-of-network services. Copay applies only if office visit is charged.
	Imaging (CT/PET scans, MRIs)	$25 copay/visit	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None

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 need immediate medical attention	Emergency room services	$100 copay/visit	$100/visit	The $100 copay will be waived if you are admitted to the hospital as an inpatient within 24 hours .
	Emergency medical transportation	No charge	No charge	Non-emergency services are not covered.
	Urgent care	$50 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per day copayment to a maximum of $600. Applies to facility charge only.	30% coinsurance	Prior authorization is required.
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs. Your mental health/ substance abuse benefits are provided through Cigna Behavioral Health. For more information, visit cignabehavorial.com or call 1-866-395-7794	Mental/Behavioral health outpatient services	$20 copay/visit	30% coinsurance	None**. Benefits are provided through Cigna, NOT UHC.**
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	None. **Benefits are provided through Cigna, NOT UHC.**
	Mental/Behavioral health inpatient services	$100 per day copayment to a maximum of $600	30% coinsurance	Prior authorization is required. **Benefits are through Cigna, NOT UHC.**
	Substance use disorder inpatient services	$100 per day copayment to a maximum of $600	30% coinsurance	Prior authorization is required. **Benefits are provided through Cigna, NOT UHC.**
	Colleague group	30% coinsurance	30% coinsurance	The plan will reimburse 70% up to a maximum reimbursable fee (MRF) of $40. The member is responsible for all costs above that amount. **Benefits are provided through Cigna, NOT UHC.**
	Prenatal and postnatal care	No charge	30% coinsurance	None

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 are pregnant	Delivery and all inpatient services	$100 per day copayment, to a maximum of $600	30% coinsurance	Prior authorization is required. Well-newborn care is also covered.
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	30% coinsurance	Limited to 210 visits per plan year combined in- and out-of-network. Combined with private duty nursing. Prior authorization is required.
	Rehabilitation services	$25 copay/visit	30% 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	$25 copay/visit	30% coinsurance	
	Skilled nursing care (facility)	$100 per day copayment, to a maximum of $600	30% coinsurance	Limited to 60 days per Plan year, combined in- and out-of-network. Prior authorization is required.
	Durable medical equipment	$25 copay diabetic supplies, no charge for other DME	30% coinsurance	Precertification required if cost is more than $1,000 per device (either purchase or cumulative rental).
	Hospice service	$100 per day copayment, to a maximum of $600	30% coinsurance	Limited to one episode per lifetime. Prior authorization 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	Services You May Need	Your cost if you have	Limitations & Exceptions

Event		Standard Prescription Plan		Premium Prescription Plan		
		Retail	Mail Order	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	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 the mail order pharmacy. There is a $50 deductible when using a retail pharmacy.
	Preferred brand drugs	Up to $35	Up to $90	Up to $25	Up to $70	
	Non-preferred brand drugs	Up to $60	Up to $150	Up to $45	Up to $110	
	Specialty drugs	Your cost is based on whether the specialty drug is a preferred brand or non-preferred brand drug.				
	The annual out-of-pocket limit for pharmacy benefits, which is separate from your medical out-of-pocket limit, is $2,500 individual/$5,000 family in-network. Prescription drugs received out-of-network or over-the-counter are not included in the out-of-pocket limit.					

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
- Non-emergency care when traveling outside the United States
- 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
- Private duty nursing

Your Rights to Continue Coverage:

The Plan's Extension of Benefits program is similar, but not identical, to the healthcare continuation coverage provided under Federal law (known as "COBRA") for non-church plans. Because the Plan is a church plan as described under Section 3(33) of ERISA, the Plan is exempt from COBRA requirements[1]. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call 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 UnitedHealthcare at 1-866-204-8533.

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** $7,170
- **Patient pays** $370

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	$0
Copays	$220
Coinsurance	$0
Limits or exclusions	$150
Total	**$370**

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 UnitedHealthcare at 1-866-204-8533.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,230
- **Patient pays** $1,170

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	$0
Copays	$1,090
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,170**

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.