The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the contribution or premium) will be provided separately. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call (800) 480-9967 to request a copy.

### Important Questions

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

Questions: Call 1-800-244-6224 or visit www.mycigna.com. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cpg.org/uniform-glossary or call 1-800-480-9967 to request a copy.
* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>If you need mental health, behavioral health, or substance abuse services.</em></td>
<td><strong>Outpatient services</strong></td>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient services</strong></td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Colleague Group</strong></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td>Prior authorization required for inpatient, partial hospitalization, and intensive outpatient services.</td>
<td></td>
</tr>
</tbody>
</table>

*If you are pregnant*  
Office visits  
$30 copay PCP/$45 specialist  
50% coinsurance  
**Copay** applies only to the visit to confirm pregnancy. In-network **Deductible** does not apply.  
Childbirth/delivery professional services  
20% coinsurance  
50% coinsurance  
Well-newborn care is covered. Newborn must be enrolled in the Plan within 30 days of birth.  
Childbirth/delivery facility services  
20% coinsurance  
50% coinsurance  

*If you need help recovering or have other special health needs*  
**Home health care**  
20% coinsurance  
50% coinsurance  
Limited to 210 visits per plan year. Prior authorization is required.  
**Rehabilitation services**  
$30 PCP/$45 specialist copay  
50% coinsurance  
Benefits include hearing/speech, physical, and occupational therapy. Limited to 60 visits per plan year, combined facility and office, per each of the three therapies.  
**Habilitation services**  
$30 PCP/$45 specialist copay  
50% coinsurance  
Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.  
**Skilled nursing care**  
20% coinsurance  
50% coinsurance  
Limited to 60 days per plan year, combined with acute rehabilitation. Prior authorization is required.  
**Durable medical equipment**  
20% coinsurance  
50% coinsurance  
Prior authorization is required.  
**Hospice services**  
No charge.  
50% coinsurance  
Prior authorization is required.  

*If your child needs dental or eye care*  
**Children’s eye exam**  
Not covered.  
Not covered.  
Vision benefits are available through EyeMed Vision Care.  
**Children’s glasses**  
Not covered.  
Not covered.  
**Children’s dental check-up**  
Not covered.  
Not covered.  

*For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.*
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Standard Prescription Plan</td>
<td>Premium Prescription Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retail</td>
<td>Home Delivery</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Up to $10</td>
<td>Up to $25</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Up to $40</td>
<td>Up to $100</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Up to $80</td>
<td>Up to $200</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

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

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

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

* For more information about limitations and exceptions, see the plan or policy document at www.cpg.org.
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. Nonetheless, subscribers and/or their enrolled dependents will have the opportunity to continue benefits for a limited time in certain instances when coverage through the health plan would otherwise cease. Individuals who elect to continue coverage must pay for the coverage. Call (800) 480-9967 for more information.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Cigna or Express Scripts as appropriate.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

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

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

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

---

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:  
Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

**Total Example Cost**: $12,731

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60 |

**The total Peg would pay is**: $3,560

---

**Managing Joe’s type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,000
- **Specialist [cost sharing]**: $45
- **Hospital (facility) [cost sharing]**: 20%
- **Other [cost sharing]**: 20%

This EXAMPLE event includes services like:  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,160</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$372</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $55 |

**The total Joe would pay is**: $1,588

---

**Mia’s Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $1,000
- **Specialist [cost sharing]**: $45
- **Hospital (facility) [cost sharing]**: 20%
- **Other [cost sharing]**: 20%

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

**Total Example Cost**: $1,925

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$125</td>
</tr>
<tr>
<td>Copayments</td>
<td>$255</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$172</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $55 |

**The total Mia would pay is**: $552

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The plan would be responsible for the other costs of these EXAMPLE covered services.