Prince Avenue Baptist Church & School Health Benefit Plan – Option I

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 9/1/2022-8/31/2023
Coverage for: All levels **Plan Type:** PPO

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.groupresources.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-749-9963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network - **$500** person **$1,500** family Out-of-network - **$1,000** person **$3,000** family	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. There is no deductible for routine/preventive services performed in-network, prescription drug coverage, or for any services that require co-payments.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	In-network - **$1,000** person **$2,000** family Out-of-network - **$4,000** person **$12,000** family Prescriptions - **$750** person **$1,500** family	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.
What is not included in the out-of-pocket limit?	Premiums, penalties, balance-billed charges, and health care 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 for a list of network providers.	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).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

All **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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-payment per visit	30% coinsurance	Co-payment covers visit charge only.
	Specialist visit	$50 co-payment per visit	30% coinsurance	
	Preventive care/screening/ immunizations	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if services you need are preventive. Then check what your plan covers.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	No
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Must be pre-certified or a $250 penalty will apply.
If you need drugs to treat your illness or condition, call (877) 635-9545 or visit **www.proactrx.com** to determine specific drug coverage.	Generic drugs	$15 co-payment retail or $15 co-payment mail order	Not covered	Covers up to a 30 day supply (retail) or 90-day supply (mail order).
	Preferred brand drugs	$35 co-payment retail or $70 co-payment mail order	Not covered	
	Non-preferred brand drugs	$60 co-payment retail or $180 co-payment mail order	Not covered	
	Specialty drugs	20% coinsurance per prescription up to $200 co-payment	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	Must be pre-certified or a $250 penalty will apply.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care – facility fees	$150 co-payment per visit for both in-network and out-of-network providers.		Co-payment is waived if admitted.
	Emergency room care – professional fees	20% coinsurance subject to in-network deductible and out-of-pocket limit for both in-network and out-of-network providers.		None
	Emergency medical transportation	0% coinsurance subject to in-network deductible and out-of-pocket limit for both in-network and out-of-network providers.		None
	Urgent care	$60 co-payment per visit	30% coinsurance	Co-payment covers visit charge only.

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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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Must be pre-certified or benefits will be reduced by 50%.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health and substance abuse services are covered like any other illness. To determine benefits, please check this grid for the provider or facility that is performing the service.		None
	Inpatient services			Must be pre-certified a $250 penalty will apply.
If you are pregnant	Office visits	$25 co-payment for initial visit, then 0% coinsurance for all other visits	30% coinsurance	$25 co-payment applies to initial visit only
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Pre-certification is not required.
If you need help recovering or have other special health needs	Home health care	$25 co-payment per visit	30% coinsurance	Coverage limited to 100 visits per plan year. Must be pre-certified a $250 penalty will apply.
	Rehabilitation services	$25 co-payment per visit	30% coinsurance	Physical/occupational therapy combined - limited to 20 visits per plan year. Speech therapy 20 visits per plan year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 150 days per plan year
	Durable medical equipment	0% coinsurance	30% coinsurance	Must be pre-certified a $250 penalty will apply.
	Hospice services	0% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Routine eye exam is covered under preventive care under age 19.
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		None

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.com.]

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.)

- Bariatric surgery
- Hearing aids
- Long-term care
- Non-emergency care if 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
- Chiropractic care (Limited to 20 visits per person per plan year)
- Pain management/pain therapy (Must be pre-certifed or a $250 penalty will apply)
- Private duty nursing
- Sleep disorders treatment (Limited to $2500 per plan year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: US Dept of Labor, Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also call Group Resources at (800) 749-9963. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: Group Resources 770-623-8383 or the Department of Labor's Employee Benefit Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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: (202) 727-4559.

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

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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** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$570**

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

- **The plan's overall deductible** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$880
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1020**

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

- **The plan's overall deductible** **$500**
- **Specialist** **$50 co-payment/visit**
- **Hospital (facility) *coinsurance*** **0%**
- **Other *coinsurance*** **0%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$10
Copayments	$0
Coinsurance	$990
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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