

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

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: HDHP



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 - \$3,000 person \$5,000 family Out-of-network - \$6,000 person \$12,000 family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual <u>deductible</u> until the total amount of the <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible ?	Yes. There is no <u>deductible</u> for routine/preventive services performed in-network, or for any services that require <u>co-payments</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>co-payment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 - \$5,000 person \$10,000 family Out-of-network - \$10,000 person \$20,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>).
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a referral.

 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	20% coinsurance	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% coinsurance	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunizations</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services you need are <u>preventive</u> . Then check what your <u>plan</u> covers.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	40% <u>coinsurance</u>	No
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% <u>coinsurance</u>	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 <u>co-payment</u> retail or \$15 <u>co-payment</u> mail order (PPO deductible applies)	Not covered	Covers up to a 30 day supply (retail) or 90-day supply (mail order).
	Preferred brand drugs	\$35 <u>co-payment</u> retail or \$70 <u>co-payment</u> mail order (PPO deductible applies)	Not covered	
	Non-preferred brand drugs	\$60 <u>co-payment</u> retail or \$180 <u>co-payment</u> mail order (PPO deductible applies)	Not covered	
	Specialty drugs	20% <u>coinsurance</u> per prescription up to \$200 <u>co-payment</u> (PPO deductible applies)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be pre-certified or a \$250 penalty will apply.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u> –	20% coinsurance subject to in-network deductible and out-of-pocket limit for both in-network and out-of-network providers.		None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> subject to in-network <u>deductible</u> and <u>out-of-pocket</u> limit for both in-network and out-of-network providers.		None

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)	
	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

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

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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be pre-certified or benefits will be reduced by 50%.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification is not required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% <u>coinsurance</u>	100 visits per plan year. Must be pre-certified a \$250 penalty will apply.
	Rehabilitation services	20% coinsurance	40% <u>coinsurance</u>	Physical/occupational therapy combined 20 visits per plan year. Speech therapy 20 visits per plan year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	150 days per plan year. Must be pre-certified a \$250 penalty will apply.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Must be pre-certified a \$250 penalty will apply.
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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

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-certified 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.—————

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	\$3000
Copayments	\$10
Coinsurance	\$1910
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4980

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	\$3000
Copayments	\$250
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3430

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	\$2800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2800