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.covenantservicesgroup.com or call 1-800-680-8728. 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 1-800-680-8728 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers, **$400** per person and **$1,200** per family. For out-of-network providers, **$800** per person and **$2,400** per 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 deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Inpatient pregnancy charges are covered before you meet your deductible.	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?	For network providers, **$2,500** per person and **$7,500** per family. For out-of-network providers, **unlimited**.	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, precertification penalties, balance-billed charges, & 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. Call IBG at 888-511-1878 or 912-489-7300 for a list of network providers.	This plan uses a provider network. You pay the least if you use a network provider. 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.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an 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	20% co-insurance	50% co-insurance	----------none----------
	Specialist visit	20% co-insurance	50% co-insurance	
	Preventive care/screening/ immunization	No charge	Not Covered except COVID-19 tests	Mammograms and pap tests are limited to one per calendar year. Cost for mammograms from out-of-network providers is 50% coinsurance
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	50% co-insurance	Services from LabCorp are available at no charge.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or 1-800-207-2568.	Generic drugs	20% co-insurance		Coverage is limited to a 30-day supply for a retail prescription and a 90-day supply for a mail order prescription.
	Preferred brand drugs	20% co-insurance		
	Non-preferred brand drugs	20% co-insurance		
	Specialty drugs	20% co-insurance		Limited to a 30-day supply through BriovaRx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	50% co-insurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% up to a maximum of $500.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	----------none----------
If you need immediate medical attention	Emergency room care	20% co-insurance	50% co-insurance	----------none----------
	Emergency medical transportation	20% co-insurance	50% co-insurance	----------none----------
	Urgent care	20% co-insurance	50% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	50% co-insurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% up to a maximum of $500.
	Physician/surgeon fees	20% co-insurance	50% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	50% co-insurance	----------none----------
	Inpatient services	20% co-insurance	50% co-insurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% up to a maximum of $500.
If you are pregnant	Office visits	20% co-insurance	50% co-insurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$250 copay Deductible does not apply	50% co-insurance	
	Childbirth/delivery facility services	$250 copay Deductible does not apply	50% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	50% co-insurance	Benefits are limited to 120 visits each calendar year.
	Rehabilitation services	20% co-insurance	50% co-insurance	Benefits are limited to 60 visits each calendar year for physical and occupational therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services.
	Skilled nursing care	20% co-insurance	50% co-insurance	Benefits are limited to 60 days each calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% up to a maximum of $500.
	Durable medical equipment	20% co-insurance	50% co-insurance	----------none----------
	Hospice services	20% co-insurance	50% co-insurance	Benefits are limited to 30 inpatient days and 15 outpatient days each calendar year.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Eye exams are not covered
	Children's glasses	Not Covered	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Not Covered	Dental services are not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.covenantservicesgroup.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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult or Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult or Child)
- Routine foot care, and
- Weight loss programs

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

- Chiropractic care

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: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other options to continue coverage are 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: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Additionally, a consumer assistance program can help you file your appeal. Contact: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, http://www.oci.ga.gov/ConsumerService/Home.aspx (website).

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.

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

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

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	**$400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	**$400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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