



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, call 1-800-435-5694 or visit us at www.pbaclaims.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 www.healthcare.gov/sbc-glossary/ or call 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	KSB Providers: \$1,000 Individual / \$2,000 Family PPO Providers: \$1,500 Individual / \$2,500 Family <u>Copayments</u> don't count toward the <u>deductible</u> .	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. KSB preventive care and prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	KSB Providers: \$1,500 Individual / \$2,500 Family PPO Providers: \$3,000 Individual / \$5,500 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 <u>plan</u> , they have to meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copays</u> , non-compliance penalties, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. However, your overall individual KSB/PPO <u>out-of-pocket limit</u> that includes copays (including drug copays) will not exceed \$9,450.	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 <u>network provider</u> ?	Yes. For a list of network providers visit www.myCigna.com or call (800) 435-5694	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . 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 provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a referral.

Katherine Shaw Bethea Hospital: Employee Health Plan (KSB)

 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	What You Will Pay			Limitations, Exceptions, & Other Important Information
		KSB Provider (You'll pay the least)	PPO Provider (You'll pay mid-range)	Non-PPO Provider (You'll pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u> after \$20 <u>copay</u> /visit	20% <u>coinsurance</u> after \$35 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies only to an office visit charge.
	<u>Specialist</u> visit				
	Chiropractic manipulations	20% <u>coinsurance</u> after \$35 <u>copay</u> /visit (KSB <u>deductible</u> and <u>out-of-pocket limit</u> apply)		Not Covered	Chiropractic limit: \$1,000/year. <u>Copay</u> applies only to an office visit charge.
	Chiropractic x-ray & labs	50% <u>coinsurance</u> (KSB <u>deductible</u> and <u>out-of-pocket limit</u> apply)		Not Covered	
	<u>Preventive care/screening/Immunization</u>	No charge (no <u>deductible</u>)	10% <u>coinsurance</u> (no <u>deductible</u>), up to \$350/year.	50% <u>coinsurance</u> (no <u>deductible</u>), up to \$250/year	PPO and Non-PPO preventive care limits are combined and do not apply to KSB providers. Breast pumps: No charge (up to \$250) for purchase of one breast pump per pregnancy instead of rental.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at www.epiphanyrx.com or (844) 820-3260	Generic drugs	KSB Pharmacy: \$15 <u>copay</u> (30-day supply) or \$30 <u>copay</u> (90-day supply) EpiphanyRx: \$25 <u>copay</u> (30-day supply)			<u>Deductible</u> does not apply. A 90-day supply is available only when the prescription is filled at the KSB pharmacy.
	Preferred brand drugs	KSB Pharmacy: \$30 <u>copay</u> (30-day supply) or \$60 <u>copay</u> (90-day supply) EpiphanyRx: \$45 <u>copay</u> (30-day supply)			
	Non-preferred brand drugs	KSB Pharmacy: \$75 <u>copay</u> (30-day supply) \$150 <u>copay</u> (90-day supply) EpiphanyRx: \$100 <u>copay</u> (30-day supply)			<u>Cost sharing</u> does not apply to certain <u>preventive services</u> .
	<u>Specialty drugs</u>	KSB Pharmacy: \$200 <u>copay</u> (30-day supply) Other Pharmacy (Limited Distribution): \$300 <u>copay</u> (30-day supply)			<u>Preauthorization</u> is required. Specialty drugs must be filled through the KSB Pharmacy unless the drug is available only from another pharmacy due to limited distribution.

Katherine Shaw Bethea Hospital: Employee Health Plan (KSB)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		KSB Provider (You'll pay the least)	PPO Provider (You'll pay mid-range)	Non-PPO Provider (You'll pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required with non-KSB providers. The non-compliance penalty is \$250.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	No charge after \$250 <u>copay</u>	20% <u>coinsurance</u> after \$250 <u>copay</u> /visit (KSB <u>deductible</u> and <u>out-of-pocket limit</u> apply)		—————none—————
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> (KSB <u>deductible</u> and <u>out-of-pocket limit</u> apply)			—————none—————
	<u>Urgent care</u>	10% <u>coinsurance</u> after \$75 <u>copay</u> /visit	20% <u>coinsurance</u> after \$75 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies to visit charge
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after \$100 <u>copay</u> /admission	20% <u>coinsurance</u> after \$100 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> is required with non-KSB providers. The non-compliance penalty is \$250.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Not Covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Office visit	10% <u>coinsurance</u> after \$20 <u>copay</u> /visit	20% <u>coinsurance</u> after \$35 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies only to an office visit charge
	Other outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	
	Inpatient services	No charge after \$100 <u>copay</u> /admission	20% <u>coinsurance</u> after \$100 <u>copay</u> /admission	Not Covered	<u>Preauthorization</u> is required with non-KSB providers. The non-compliance penalty is \$250.

Katherine Shaw Bethea Hospital: Employee Health Plan (KSB)

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		KSB Provider (You'll pay the least)	PPO Provider (You'll pay mid-range)	Non-PPO Provider (You'll pay the most)	
If you are pregnant	Office visits	10% <u>coinsurance</u> after \$20 <u>copay</u> /visit	20% <u>coinsurance</u> after \$35 <u>copay</u> /visit	Not Covered	<u>Copay</u> applies only to an office visit charge. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . <u>Preauthorization</u> may be required for non-KSB providers. The non-compliance penalty is \$250.
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	No charge after \$100 <u>copay</u> /admission	20% <u>coinsurance</u> after \$100 <u>copay</u> /admission	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	Limit: 90 visits/year
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
	<u>Skilled nursing care</u>	Inpatient: No charge Outpatient: 10% <u>coinsurance</u>	20% <u>coinsurance</u> (KSB deductible/out-of-pocket limit apply)	Not Covered	Inpatient limit: 180 days/year; 360 days/lifetime. <u>Preauthorization</u> is required for non-KSB providers prior to an inpatient admission. The non-compliance penalty is \$250.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Not Covered	—————none—————
	<u>Hospice services</u>	Inpatient: No charge Outpatient: 10% <u>coinsurance</u>	20% <u>coinsurance</u> (KSB deductible/out-of-pocket limit apply)	Not Covered	—————none—————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Vision and Dental coverage are available separate from the Employee Health Plan.
	Children's glasses	Not Covered	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Not Covered	

Katherine Shaw Bethea Hospital: Employee Health Plan (KSB)

Excluded Services & Other Covered Services:

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

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|--|---|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Routine eye care• Routine foot care |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---|---|--|
| <ul style="list-style-type: none">• Bariatric surgery• Chiropractic care | <ul style="list-style-type: none">• Hearing aids (\$1,500 max every 2 years)• Private-duty nursing | <ul style="list-style-type: none">• Weight loss programs |
|---|---|--|

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 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 1-800-435-5694.

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

About these Coverage Examples (assumes services are provided by KSB Providers): :



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 <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$115
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$15
The total Peg would pay is	\$1,130

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$1,670
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,670

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,380

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