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 800-241-2136. 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:/healthcare.gov/sbc-glossary or call 1-800-241-2136 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,150/individual; $2,300/family Non-Network: $3,000/individual; $6,000/family If you qualify for the Standard Enhancements by participating in the plan's wellness program: In-Network: $900/individual; $1,800/family Non-Network: $2,500/individual; $4,500/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. Prescription drugs, dental benefits, vision benefits, In-Network provider office visits and preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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?	Yes. $150 for hospitalization; $200 for emergency room care; $50 for dental services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $7,500/individual; $15,000/family Non-Network: 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?	Amounts applied toward non-network charges; premiums; balance-billing charges; vision benefits; dental benefits for individuals age 19 and older; and healthcare this plan doesn't cover (except prescription drugs covered under The Kroger Company Plan)	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.anthem.com or call 1-800-810-BLUE (2583) 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

Important Questions	Answers	Why This Matters:
		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, except that the plan will not cover tests or examinations performed by an Audiologist unless ordered by your doctor.

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
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-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	$30 copay/office visit; 20% coinsurance for other outpatient services; deductible does not apply to office visit	$30 copay/office visit; 30% coinsurance for other outpatient services; deductible does not apply to office visit	50% coinsurance	Copay applies only to professional service charge. Other charges incurred during visit are subject to deductible and coinsurance. No charge for visits completed through LiveHealth Online (www.livehealthonline.com)
	Specialist visit	$40 copay/office visit; 20% coinsurance for other outpatient services; deductible does not apply to office visit	$40 copay/office visit; 30% coinsurance for other outpatient services; deductible does not apply to office visit	50% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. No charge for Cologuard® for colorectal cancer screening up to $700; amounts over $700 subject to deductible and 20% coinsurance if you participate in the plan's wellness program or 30% coinsurance if no wellness participation.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required for genetic testing. No coverage if you fail to obtain preauthorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. No coverage if you fail to obtain preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kpp-rx.com or by calling 1-800-482-1285.	Generic drugs	Retail: Greater of 10% coinsurance or $10 copay per prescription, not to exceed $40 per prescription; deductible does not apply Mail Order: Greater of 10% coinsurance or $25 copay per prescription, not to exceed $80 per prescription; deductible does not apply		Not covered	Prescription Drugs are provided under The Kroger Company Plan and are not covered under this Plan. Benefits are shown here to provide information on all of your benefits in a single document. While covered through two separate plans, there is a single out-of-pocket limit. Coverage is limited to 30-day supply for retail and specialty drugs. Maintenance medications may be available for up to a 90-day supply at retail. Coverage is limited to 90-day supply for mail order. If you receive a brand name drug when a generic drug is available, you will also pay the difference in cost between the generic and brand name drug. Coverage is excluded for medications not on the plan's chosen prescription drug list. Certain medications may be subject to quantity limits, step therapy, reference based pricing, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered. Specialty drugs must be filled through Axium Healthcare Pharmacy.
	Preferred brand drugs	Retail: Greater of 20% coinsurance or $20 copay per prescription, not to exceed $70 per prescription; deductible does not apply Mail Order: Greater of 30% coinsurance or $50 copay per prescription, not to exceed $140 per prescription; deductible does not apply		Not covered	
	Non-preferred brand drugs	Retail: Greater of 30% coinsurance or $35 copay per prescription, not to exceed $125 per prescription; deductible does not apply Mail Order: Greater of 30% coinsurance or $75 copay per prescription, not to exceed $250 per prescription; deductible does not apply		Not covered	
	Specialty drugs – Generic/ Bio-Similar	8% coinsurance not to exceed $100 per prescription; deductible does not apply		Not covered	
	Specialty drugs – Preferred brand drugs	15% coinsurance not to exceed $250 per prescription; deductible does not apply		Not covered	
	Specialty drugs – Non-preferred brand drugs	25% coinsurance not to exceed $400 per prescription; deductible does not apply		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. No coverage if you fail to obtain preauthorization.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 deductible/visit and 20% coinsurance	$200 deductible/visit and 30% coinsurance	$200 deductible/ visit and 30% coinsurance	Separate emergency room deductible is waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	30% coinsurance	50% coinsurance	None.
	Urgent care	$75 copay/visit; 20% coinsurance for other outpatient services; deductible does not apply to office visit	$75 copay/visit; 30% coinsurance for other outpatient services; deductible does not apply to office visit	50% coinsurance	Copay applies only to professional service charge. Other charges are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 deductible/ confinement, then 20% coinsurance	$150 deductible/ confinement, then 30% coinsurance	50% coinsurance	Admissions must be preauthorized or certified. No coverage for stays/days if you fail to obtain preauthorization or certification.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit; 20% coinsurance for other outpatient services; deductible does not apply to office visit	$30 copay/office visit; 30% coinsurance for other outpatient services; deductible does not apply to office visit	50% coinsurance	Copay applies only to professional service charge. Other charges are subject to deductible and coinsurance. Coverage is excluded for substance abuse services.
	Inpatient services	$150 deductible/ confinement, then 20% coinsurance	$150 deductible/ confinement, then 30% coinsurance	50% coinsurance	Admissions must be preauthorized or certified. No coverage for stays/days if you fail to obtain preauthorization or certification. Coverage is excluded for substance abuse services.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Provider Standard Enhancements (You will pay the least)	In-Network Provider Basic Level if No Wellness Participation	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$150 deductible/ confinement, then 20% coinsurance	$150 deductible/ confinement, then 30% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent child pregnancy charges excluded, except for mandated preventive services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	Coverage is limited to 40 visits per year and must receive preauthorization. No coverage if you fail to obtain preauthorization.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	Services require letter of medical necessity from the referring provider.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	None.
	Skilled nursing care	20% coinsurance	30% coinsurance	50% coinsurance	None.
	Durable medical equipment	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. No coverage if you fail to obtain preauthorization.
	Hospice services	20% coinsurance	30% coinsurance	50% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	All charges in excess of $30; deductible does not apply	Coverage limited to one exam every 12 months.
	Children's glasses	No charge; deductible does not apply	No charge; deductible does not apply	All charges in excess of $35-$75 (depending on lens type) and $50 for frames; deductible does not apply	Coverage limited to one set of prescribed glasses every 12 months. Additional charges will apply for frames purchased from a network provider over $100 retail value
	Children's dental check-up	25% coinsurance; deductible does not apply	30% coinsurance; deductible does not apply	Not covered	Coverage limited to one exam every 6 months and $500 maximum ($1,500 if qualify for Standard Enhancements)

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, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Hearing aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Pregnancy related charges for dependent children, except those covered under preventive care
- Prescription drugs (prescription drugs are provided by your employer)
- Substance abuse services
- 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, limited to 24 visits/year
- Dental care (adult), limited to $500 annual max ($1,500 if qualify for Standard Enhancements)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: the Plan at 1-800-241-2136 or 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 1-800-241-2136.

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	$1,150
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$1,300
Copayments	$10
Coinsurance	$3,380
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,750**

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

The plan's overall deductible	$1,150
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$350
Copayments	$760
Coinsurance	$650
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,760**

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

The plan's overall deductible	$1,150
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$1,350
Copayments	$90
Coinsurance	$370
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Plan at: 1-800-678-4656.
* This plan's has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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