




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:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network</a> : \$1,150/individual <a href="#">Non-Network</a> : \$3,000/individual	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Prescription drugs</a> , dental benefits, vision benefits, <a href="#">In-Network provider</a> office visits and <a href="#">preventive services</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$150 for <a href="#">hospitalization</a> ; \$200 for <a href="#">emergency room care</a> ; \$50 for dental services. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">In-Network</a> : \$7,500/individual <a href="#">Non-Network</a> : unlimited	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Amounts applied toward <a href="#">non-network</a> charges; <a href="#">premiums</a> ; <a href="#">balance-billing</a> charges; vision benefits; dental benefits for individuals age 19 and older; and healthcare this <a href="#">plan</a> doesn't cover (except <a href="#">prescription drugs</a> covered under The Kroger Company Plan)	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-BLUE (2583) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> , except that the <a href="#">plan</a> 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 (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	<a href="#">Copay</a> applies only to professional service charge. Other charges incurred during visit are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to office visit	50% <a href="#">coinsurance</a>	No charge for visits completed through LiveHealth Online ( <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> )
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. No charge for Cologuard® for colorectal cancer screening up to \$700; amounts over \$700 subject to <a href="#">deductible</a> and 20% <a href="#">coinsurance</a> if you participate in the <a href="#">plan's</a> wellness program or 30% <a href="#">coinsurance</a> if no wellness participation.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for genetic testing. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
If you need drugs to treat your illness or condition More information	Generic drugs	Retail: Greater of 10% <a href="#">coinsurance</a> or \$10 <a href="#">copay</a> per prescription, not to exceed \$40 per prescription; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Prescription Drugs</a> 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kpp-rx.com">www.kpp-rx.com</a> or by calling 1-800-482-1285.		Mail Order: Greater of 10% <a href="#">coinsurance</a> or \$25 <a href="#">copay</a> per prescription, not to exceed \$80 per prescription; <a href="#">deductible</a> does not apply		covered through two separate <a href="#">plans</a> , there is a single <a href="#">out-of-pocket limit</a> .  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 <a href="#">plan's</a> chosen prescription drug list. Certain medications may be subject to quantity limits, step therapy, reference based pricing, <a href="#">preauthorization</a> or other utilization management programs. Failure to obtain <a href="#">preauthorization</a> will result in the drug not being covered.  <a href="#">Specialty drugs</a> must be filled through Axiom Healthcare Pharmacy.
	Preferred brand drugs	Retail: Greater of 20% <a href="#">coinsurance</a> or \$20 <a href="#">copay</a> per prescription, not to exceed \$70 per prescription; <a href="#">deductible</a> does not apply  Mail Order: Greater of 30% <a href="#">coinsurance</a> or \$50 <a href="#">copay</a> per prescription, not to exceed \$140 per prescription; <a href="#">deductible</a> does not apply	Not covered	
	Non-preferred brand drugs	Retail: Greater of 30% <a href="#">coinsurance</a> or \$35 <a href="#">copay</a> per prescription, not to exceed \$125 per prescription; <a href="#">deductible</a> does not apply  Mail Order: Greater of 30% <a href="#">coinsurance</a> or \$75 <a href="#">copay</a> per prescription, not to exceed \$250 per prescription; <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> – Generic/ Bio-Similar	8% <a href="#">coinsurance</a> not to exceed \$100 per prescription; <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> – Preferred brand drugs	15% <a href="#">coinsurance</a> not to exceed \$250 per prescription; <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> – Non-preferred brand drugs	25% <a href="#">coinsurance</a> not to exceed \$400 per prescription; <a href="#">deductible</a> does not apply	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 40 visits per year and must receive <a href="#">preauthorization</a> . No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage is excluded for dependents.
	Children's glasses	Not covered	Not covered	Coverage is excluded for dependents.
	Children's dental check-up	Not covered	Not covered	Coverage is excluded for dependents.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li> <li>Dental care (child)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Pregnancy related charges for dependent children, except those covered under <a href="#">preventive care</a></li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Prescription drugs</a> (<a href="#">prescription drugs</a> are provided by your employer)</li> <li>Routine eye care (child)</li> <li>Substance abuse services</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic care, limited to 24 visits/year</li> <li>Dental care (adult), limited to \$500 annual max</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> </ul>

**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](http://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](http://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](http://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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$1,300
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,380
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,750</b>

### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$760
<a href="#">Coinsurance</a>	\$650
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,760</b>

### 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$1,350
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,810</b>

\* 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.