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 1-800-241-3473. 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 1-800-241-3473 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $750/individual; $1,500/family. Non-Network providers: $1,500/individual; $3,000/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. Preventive services, In-Network provider office visits, prescription drugs, preventive dental services and vision services 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. 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. $200 per visit for emergency room care; Dental services - $50/individual. 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?	**This Plan's Limit:** In-Network providers: $5,000/individual; $10,000/family. Non-Network providers: $10,000/individual; $20,000/family. **Your Prescription Drug Plan's Limit**: $9,100/individual; $18,200/family.	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?	**This Plan's Limit:** Premiums, balance billing, penalties for failure to obtain preauthorization, dental or vision services (except those covered under major medical), prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
	Your Prescription Drug Plan's Limit: Premiums, balance billing, medical charges, dental or vision services, and health care your Kroger Prescription Drug plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.bcbst.com or call 1-800-565-9140 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 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	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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	50% coinsurance	Visits at Convenience Care Clinics in the plan's network are $15 copay/visit, deductible does not apply
	Specialist visit	$40 copay/visit Deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Coverage for chiropractic x-rays is limited to $80/year. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic or Biosimilar drugs	Greater of 10% coinsurance or: $10 copay/ prescription if Retail-30; $27.50 copay/prescription	Not Covered unless previously authorized or in an emergency	Prescription Drugs are provided by Kroger and are not covered under this Plan. Benefits (including out-of-pocket limits on page 1) are shown here to provide information on all of your benefits in a single document. Amounts you

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)	
coverage is available at www.kpp-rx.com		if Retail-90; $25 copay/prescription if Home-Delivery; or $10 copay/ prescription if Specialty Drug. Deductible does not apply		pay for covered Prescription Drugs do not apply toward this Plan's out-of-pocket limit and amounts you pay for other benefits under this Plan do not apply towards your Prescription Drug Plan's out-of-pocket limit. Covers up to 90-day supply at Retail or Home Delivery; 30-day supply at Specialty Pharmacy. If brand name drug is requested when there is an equivalent generic alternative, you will be required to pay the difference in cost between the brand name and generic, unless preauthorization obtained. Coverage for certain medications may be subject to step therapy, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered. Specialty drugs must be obtained through the Accredo Specialty Pharmacy.
	Preferred Brand drugs	Greater of 25% coinsurance or: $30 copay/ prescription if Retail-30; $82.50 copay/prescription if Retail-90; $75 copay/prescription if Home-Delivery; or $30 copay/ prescription if Specialty Drug. Deductible does not apply	Not Covered unless previously authorized or in an emergency	
	Non-preferred Brand drugs	Greater of 50% coinsurance or: $80 copay/ prescription if Retail-30; $220 copay/prescription if Retail-90; $200 copay/prescription if Home-Delivery; or $80 copay/ prescription if Specialty Drug. Deductible does not apply	Not Covered unless previously authorized or in an emergency	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

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 immediate medical attention	Emergency room care	$200/visit then 20% coinsurance	Covered as In-Network	If admitted to the hospital, the $200 deductible is waived.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	None
	Urgent care	$75 copay/visit Deductible does not apply	50% coinsurance	Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required for non-emergency admissions. Failure to obtain preauthorization may result in a 50% reduction in the allowed amount. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit. Deductible does not apply. 20% coinsurance/ other outpatient services	50% coinsurance	Preauthorization is required for non-emergency admissions and electroconvulsive therapy. Failure to obtain preauthorization may result in a 50% reduction in the allowed amount.
	Inpatient services	20% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$40 copay/office visit. Deductible does not apply.	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Coverage for dependent child pregnancy is limited to preventive services obtained from network providers. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per disability. Preauthorization is required. Failure to obtain preauthorization will result in a 50% reduction in the allowed amount.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization will result in a 50% reduction in the allowed amount. Extended care facility coverage is limited to 60 days per disability.
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization is requested.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization is required for charges in excess of $500. Failure to obtain preauthorization will result in a 50% reduction in the allowed amount.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required. Failure to obtain preauthorization will result in a 50% reduction in the allowed amount.
If your child needs dental or eye care	Children's eye exam	No Charge. Deductible does not apply.	$30 copay. Deductible does not apply.	Limited to one exam every 12 months. Not included in out-of-pocket limit.
	Children's glasses	No Charge. Deductible does not apply.	All charges in excess of $40-$80 (varies by lens type); $25 (frames). Deductible does not apply.	Limited to one set of standard lenses/year. Coverage for frames purchased from a network provider limited to $150 every 12 months. Coverage for contact lenses limited to $150 per year. Not included in out-of-pocket limit.
	Children's dental check-up	No Charge. Deductible does not apply.	All charges over UCR. Deductible does not apply.	Limited to one exam every six months. Not included in out-of-pocket limit.

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 • Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law	• Infertility treatment • Long-term care • Pregnancy of a dependent child, except for mandated preventive services	• Prescription drugs (prescription drugs are provided by your employer) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery, if pre-certified and determined to be medically necessary • Chiropractic care, limited to 26 visits/year and $675/year.	• Dental care (adult), limited to $1,500/year • Hearing aids, limited to $3,000/ear in a 36-month period • Non-emergency care when traveling outside the U.S. (call 1-800-565-9140)	• Private-duty nursing, limited to services provided in home health care setting • 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: the 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 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 1-800-241-3473 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For insured vision benefits, you can contact your State Department of Insurance. In Tennessee, contact the Tennessee Department of Commerce and Insurance at 1-800-342-4029.

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 1-800-241-3473.

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	**$750**
Specialist copayment	**$40**
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	$750
Copayments	$10
Coinsurance	$2,360
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,180**

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

The plan's overall deductible	**$750**
Specialist copayment	**$40**
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	$0
Copayments	$1,050
Coinsurance	$810
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,880**

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

The plan's overall deductible	**$750**
Specialist copayment	**$40**
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*	$950
Copayments	$90
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,320**

*Note: This plan 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.