




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:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network providers</a> : \$750/individual; \$1,500/family. <a href="#">Non-Network providers</a> : \$1,500/individual; \$3,000/family.	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. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive services</a> , <a href="#">In-Network provider</a> office visits, <a href="#">prescription drugs</a> , preventive dental services and vision services are covered before you meet your <a href="#">deductible</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. \$200 per visit for <a href="#">emergency room care</a> ; Dental services - \$50/individual. 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>	<b>This Plan's Limit:</b> <a href="#">In-Network providers</a> : \$5,000/individual; \$10,000/family. <a href="#">Non-Network providers</a> : \$10,000/individual; \$20,000/family. <b>Your <a href="#">Prescription Drug Plan's Limit</a>:</b> \$9,450/individual; \$18,900/family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<b>This Plan's Limit:</b> <a href="#">Premiums</a> , <a href="#">balance billing</a> , penalties for failure to obtain <a href="#">preauthorization</a> , dental or vision services (except those covered under major medical), <a href="#">prescription drugs</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	<b>Your <a href="#">Prescription Drug Plan's Limit:</a> <a href="#">Premiums, balance billing</a>, medical charges, dental or vision services, and health care your Kroger Prescription Drug <a href="#">plan</a> doesn't cover.</b>	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.bcbst.com">www.bcbst.com</a> or call 1-800-565-9140 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	Visits at Convenience Care Clinics in the <a href="#">plan's network</a> are \$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage for chiropractic x-rays is limited to \$80/year. Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug</a>	Generic or Biosimilar drugs	Greater of 10% <a href="#">coinsurance</a> or: \$10 <a href="#">copay</a> / prescription if Retail-30; \$27.50 <a href="#">copay</a> /prescription	Not Covered unless previously authorized or in an emergency	<a href="#">Prescription Drugs</a> are provided by Kroger and are not covered under this Plan. Benefits (including <a href="#">out-of-pocket limits</a> 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)	
<a href="#">coverage</a> is available at <a href="http://www.kpp-rx.com">www.kpp-rx.com</a>		if Retail-90; \$25 <a href="#">copay</a> /prescription if Home-Delivery; or \$10 <a href="#">copay</a> / prescription if <a href="#">Specialty Drug</a> . <a href="#">Deductible</a> does not apply		pay for covered <a href="#">Prescription Drugs</a> do not apply toward this Plan's <a href="#">out-of-pocket limit</a> and amounts you pay for other benefits under this Plan do not apply towards your <a href="#">Prescription Drug</a> Plan's <a href="#">out-of-pocket limit</a> .
	Preferred Brand drugs	Greater of 25% <a href="#">coinsurance</a> or: \$30 <a href="#">copay</a> / prescription if Retail-30; \$82.50 <a href="#">copay</a> /prescription if Retail-90; \$75 <a href="#">copay</a> /prescription if Home-Delivery; or \$30 <a href="#">copay</a> / prescription if <a href="#">Specialty Drug</a> . <a href="#">Deductible</a> does not apply	Not Covered unless previously authorized or in an emergency	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 <a href="#">preauthorization</a> obtained.
	Non-preferred Brand drugs	Greater of 50% <a href="#">coinsurance</a> or: \$80 <a href="#">copay</a> / prescription if Retail-30; \$220 <a href="#">copay</a> /prescription if Retail-90; \$200 <a href="#">copay</a> /prescription if Home-Delivery; or \$80 <a href="#">copay</a> / prescription if <a href="#">Specialty Drug</a> . <a href="#">Deductible</a> does not apply	Not Covered unless previously authorized or in an emergency	Coverage for certain medications may be subject to step therapy, <a href="#">preauthorization</a> or other utilization management programs. Failure to obtain <a href="#">preauthorization</a> will result in the drug not being covered.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Physician/surgeon fees	20% <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 immediate medical attention	<a href="#">Emergency room care</a>	\$200/visit then 20% <a href="#">coinsurance</a>	Covered as <a href="#">In-Network</a>	If admitted to the hospital, the \$200 <a href="#">deductible</a> is waived.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as <a href="#">In-Network</a>	None
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	Emergency services provided at a <a href="#">non-network</a> Urgent Care center licensed to operate as a freestanding emergency department may be covered as in- <a href="#">network</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for non-emergency admissions. Failure to obtain <a href="#">preauthorization</a> may result in a 50% reduction in the <a href="#">allowed amount</a> . Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Physician/surgeon fees	20% <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. <a href="#">Deductible</a> does not apply. 20% <a href="#">coinsurance</a> / other outpatient services	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for non-emergency admissions and electroconvulsive therapy. Failure to obtain <a href="#">preauthorization</a> may result in a 50% reduction in the <a href="#">allowed amount</a> .
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$40 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	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> and <a href="#">deductible</a> 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 <a href="#">preventive services</a> obtained from <a href="#">network providers</a> . Certain services received from <a href="#">non-network providers</a> while at an in- <a href="#">network</a> facility will be covered as in- <a href="#">network</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <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>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 60 days per disability. <a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> will result in a 50% reduction in the <a href="#">allowed amount</a> .
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> will result in a 50% reduction in the <a href="#">allowed amount</a> . Extended care facility coverage is limited to 60 days per disability.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is requested.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for charges in excess of \$500. Failure to obtain <a href="#">preauthorization</a> will result in a 50% reduction in the <a href="#">allowed amount</a> .
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> will result in a 50% reduction in the <a href="#">allowed amount</a> .
If your child needs dental or eye care	Children's eye exam	No Charge. <a href="#">Deductible</a> does not apply.	\$30 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Limited to one exam every 12 months. Not included in <a href="#">out-of-pocket limit</a> .
	Children's glasses	No Charge. <a href="#">Deductible</a> does not apply.	All charges in excess of \$40-\$80 (varies by lens type); \$25 (frames). <a href="#">Deductible</a> does not apply.	Limited to one set of standard lenses/year. Coverage for frames purchased from a <a href="#">network provider</a> limited to \$150 every 12 months. Coverage for contact lenses limited to \$150 per year. Not included in <a href="#">out-of-pocket limit</a> .
	Children's dental check-up	No Charge. <a href="#">Deductible</a> does not apply.	All charges over <a href="#">UCR</a> . <a href="#">Deductible</a> does not apply.	Limited to one exam every six months. Not included in <a href="#">out-of-pocket limit</a> .

## 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>• Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Pregnancy of a dependent child, except for mandated <a href="#">preventive services</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>• 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>• Bariatric surgery, if pre-certified and determined to be medically necessary</li><li>• Chiropractic care, limited to 26 visits/year and \$675/year.</li></ul>	<ul style="list-style-type: none"><li>• Dental care (adult), limited to \$1,500/year</li><li>• Hearing aids, limited to \$3,000/ear in a 36-month period</li><li>• Non-emergency care when traveling outside the U.S. (call 1-800-565-9140)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing, limited to services provided in home health care setting</li><li>• Routine eye care (Adult)</li><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: 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). 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 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](http://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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,360
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,180</b>

### 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,050
<a href="#">Coinsurance</a>	\$810
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,880</b>

### 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*)

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

Cost Sharing	
<a href="#">Deductibles</a> *	\$950
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$280
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,320</b>

\*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.