




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>	\$1,250/individual; \$2,500/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="#">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. \$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>	\$8,000/individual; \$16,000/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>	Amounts applied toward <a href="#">non-network</a> charges; <a href="#">premiums</a> ; <a href="#">balance-billing</a> charges; dental or vision services (except those covered under major medical); 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 1-833-664-2851 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

Important Questions	Answers	Why This Matters:
		your <a href="#">provider</a> before you get services.
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 office</a> 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	Not covered	<p><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>.</p> <p>No charge for visits completed through LiveHealth Online (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</p> <p>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.</p>
	<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	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	Not covered	<p><a href="#">Preauthorization</a> is required for genetic testing. No coverage if you fail to obtain <a href="#">preauthorization</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>.</p> <p><a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a>. Certain services received from <a href="#">non-network providers</a> while at an in-<a href="#">network</a> facility will be covered</p>
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	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)	
				as in- <a href="#">network</a> .
<b>If you need drugs to treat your illness or condition</b> More information 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.	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 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	Not covered	<p><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 covered through two separate <a href="#">plans</a>, there is a single <a href="#">out-of-pocket limit</a>.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><a href="#">Specialty drugs</a> must be filled through Axiom Healthcare Pharmacy.</p>
	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> –	15% <a href="#">coinsurance</a> not to exceed	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)	
	Preferred brand drugs	\$250 per prescription; <a href="#">deductible</a> does not apply		
	<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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> if use BDC or BDC+ facility for certain services)	Not covered	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> . To qualify for the lower <a href="#">coinsurance</a> on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, you must use an <a href="#">in-network</a> hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+). Facility fees for these surgeries are not covered when using <a href="#">non-network providers</a> . Certain services received from <a href="#">non-network providers</a> while at an <a href="#">in-network</a> facility will be covered as <a href="#">in-network</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">deductible</a> /visit and 30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</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>	Covered as In- <a href="#">Network</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	Not covered	<a href="#">Copay</a> applies only to professional service charge. Other charges are subject to <a href="#">deductible</a> and <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 <a href="#">in-network</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 have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> (20% <a href="#">coinsurance</a> if use BDC or BDC+ facility for certain services)	Not covered	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> . To qualify for the lower <a href="#">coinsurance</a> on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, you must use an <a href="#">in-network</a> hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+). Facility fees for these surgeries are not covered when using <a href="#">non-network providers</a> . Certain services received from <a href="#">non-network providers</a> while at an <a href="#">in-network</a> facility will be covered as <a href="#">in-network</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	Not covered	
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	Not covered	<a href="#">Copay</a> applies only to professional service charge. Other charges are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	Not covered	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.
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	Not covered	<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> . Certain services received from <a href="#">non-network providers</a> while at an <a href="#">in-network</a> facility will be covered as <a href="#">in-network</a> .
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. No coverage if you fail to obtain <a href="#">preauthorization</a> .
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	Not covered	<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>	Not covered	<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>	Not covered	None.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	Not covered	<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>	Not covered	None.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	All charges in excess of \$45; <a href="#">deductible</a> does not apply	Coverage limited to one exam every 12 months.
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	All charges in excess of \$35-\$75 (depending on lens type) and \$50 for frames; <a href="#">deductible</a> does not apply	Available after 12 consecutive months of enrollment. Coverage limited to one set of prescribed glasses every 12 months. Additional charges will apply for frames purchased from a <a href="#">network provider</a> over \$100 retail value
	Children's dental check-up	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Available after 5 consecutive months of enrollment. Coverage limited to one exam every 6 months and \$500 annual maximum

## 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](#).)

- Cosmetic surgery, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Hearing aids
- 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)
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- In-[network](#) Bariatric surgery, if pre-certified and determined to be medically necessary
- Chiropractic care, limited to 24 visits/year
- Dental care (adult), available after 5 consecutive months of enrollment, limited to \$500 annual max
- Infertility treatment, except for services related to artificial insemination or assisted reproductive technology procedures
- Private-duty nursing
- Routine eye care (Adult), available after 12 consecutive months of enrollment
- 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](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](#) \$1,250
- [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>	\$1,250
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$3,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,720</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$1,250
- [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>	\$400
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,800</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$1,250
- [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> *	\$1,450
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,840</b>

\* 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.