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 1-800-567-5899. 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 www.ccio.cms.gov or call 1-800-567-5899 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,100 per person/$3,300 per family** Does not apply to preventive care or office visits	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and Office Visits 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. **$300** per confinement if inpatient hospital stay is not pre-certified.	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?	**$6,850 per person/ $13,700 per 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?	Premium, balance-billed charges, out- of-network claims and health care this plan doesn't cover, such as Prescription Drug expenses	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.uhss.welcometouhc.com or call 1-800-567-5899 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?	A referral to see a specialist is not required.	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
		Network Provider (You will pay the least)	Out-of-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	$35/visit	Not Covered	None
	Specialist visit	$60/visit	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	40%	Not Covered	Chiropractic – 50%
	Imaging (CT/PET scans, MRIs)	40%	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kpp-rx.com	Generic drugs	Not Covered	Not Covered	Prescription Drugs are provided by Kroger and not covered by the Plan.
	Preferred brand drugs	Not Covered	Not Covered	Prescription Drugs are provided by Kroger and not covered by the Plan.
	Non-preferred brand drugs	Not Covered	Not Covered	Prescription Drugs are provided by Kroger and not covered by the Plan.
	Specialty drugs	Not Covered	Not Covered	Prescription Drugs are provided by Kroger and not covered by the Plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40%	Not Covered	None
	Physician/surgeon fees	40%	Not Covered	None
If you need immediate medical attention	Emergency room care	40%	40%	$500 Copay for Sickness or Accident, waived if admitted to the same hospital within 48 hours
	Emergency medical transportation	40%	40%	None
	Urgent care	$25/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40%	Not Covered	Additional $300 Deductible applies for failure to Pre-Certify
	Physician/surgeon fees	40%	Not Covered	None

[* For more information about limitations and exceptions, see the plan or policy document at https://www.nebainc.com/med1000 .]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40%	Not Covered	None
	Inpatient services	40%	Not Covered	Additional $300 Deductible applies for failure to Pre-Certify
If you are pregnant	Office visits	$35/visit	Not Covered	None
	Childbirth/delivery professional services	40%	Not Covered	None
	Childbirth/delivery facility services	40%	Not Covered	None
If you need help recovering or have other special health needs	Home health care	40%	Not Covered	30 days maximum per calendar year
	Rehabilitation services	40%	Not Covered	Additional $300 Deductible applies for failure to Pre-Certify
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	40%	Not Covered	Additional $300 Deductible applies for failure to Pre-Certify
	Durable medical equipment	40%	Not Covered	None
	Hospice services	40%	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	Once every 6 months

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
- Care when traveling outside the U.S.
- Cosmetic surgery
- Hearing aids
- Infertility Treatment
- Long-term care
- Routine Foot Care
- Routine Eye Care (Adult)
- Prescription Drugs are provided by Kroger and not covered by the Plan
- 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
- Private-duty Nursing
- Dental care (Adult)

[* For more information about limitations and exceptions, see the plan or policy document at https://www.nebainc.com/med1000 .]

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: US Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the US Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) OR www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (800) 567-5899.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 567-5899.]

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 (800) 567-5899.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 567-5899.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at https://www.nebainc.com/med1000 .]

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** **$1,100**
- **Specialist *copayment*** **$60**
- **Hospital (facility) *coinsurance*** **40%**
- **Other *coinsurance*** **40%**

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	**$1,100**
Copayments	**$20**
Coinsurance	$4,599
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,779**

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

- **The plan's overall deductible** **$1,100**
- **Specialist *copayment*** **$60**
- **Hospital (facility) *coinsurance*** **40%**
- **Other *coinsurance*** **40%**

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$1,110
Coinsurance	$450
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,715**

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

- **The plan's overall deductible** **$1,100**
- **Specialist *copayment*** **$60**
- **Hospital (facility) *coinsurance*** **40%**
- **Other *copayment*** **$500**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	**$1,100**
Copayments	**$560**
Coinsurance	**$179**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,839**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. Coverage Example cost sharing assumes and includes the KPP coverage which is not part of this Plan.

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