
 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, 503-238-6961 or 1-866-230-6313. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 503-238-6961 or 1-866-230-6313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$200/individual or \$600/family	Generally, you must pay all of the costs from providers 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-network preventive care</a> , primary care, and emergency room 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.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$1,200/indiv. <a href="#">in-network</a> ; \$1,700/indiv. <a href="#">out-of-network</a> . Prescription: \$1,000/indiv. <a href="#">in-network</a> ; \$1,500/indiv. <a href="#">out-of-network</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">copayments</a> on certain services, 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Call 1-800-768-4695 or 1-800-768-4695 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 plan's <a href="#">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> ).
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> .

 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)	
<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	\$20 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Physical therapy must be prescribed by a physician.
	<a href="#">Preventive care/screening/immunization</a>	\$20 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply. (\$0 copay if qualifies as preventive exam)	Not covered	Adult immunizations and immunizations solely for foreign travel or foreign residence are not covered. Some services will include frequency limits. 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 <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>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<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>	Generic drugs	Retail: 10% <a href="#">coinsurance</a> with \$10 minimum. Mail-order and Option 90: \$20 <a href="#">copayment</a> .	Retail: 15% <a href="#">coinsurance</a> with \$15 minimum. Mail-order: not covered.	Not all prescription drugs are covered and some prescription drugs require prior authorization. To determine if a drug is covered or requires prior authorization, e-mail Kroger at <a href="mailto:rxplans@kroger.com">rxplans@kroger.com</a> or call 1-800-482-1285.  Retail: <a href="#">in-network</a> retailers are limited to Fred Meyer, QFC, Safeway, Lower Umpqua Hospital Pharmacy, and Reedsport Pharmacy.  Option 90 (90-day supply from retail): <a href="#">in-network</a> retailers are limited to Fred Meyer and QFC.
	Preferred brand drugs	Retail: 10% <a href="#">coinsurance</a> with \$20 minimum. Mail-order and Option 90: \$40 <a href="#">copayment</a> .	Retail: 15% <a href="#">coinsurance</a> with \$25 minimum. Mail-order: not covered.	
	Non-preferred brand drugs	Retail: 20% <a href="#">coinsurance</a> with \$40 minimum. Mail-order and Option 90: \$80 <a href="#">copayment</a> .	Retail: 25% <a href="#">coinsurance</a> with \$45 minimum. Mail-order: not covered.	
	<a href="#">Specialty drugs</a>	Same cost as for generic, preferred, and non-preferred brand drugs, as applicable.		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Must be recommended and approved by physician. Private duty nursing care is not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a> then 20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	\$100 <a href="#">copayment</a> then 30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	<a href="#">Copayment</a> is waived if directly admitted to hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to continental U.S., Hawaii, Puerto Rico, and Canada. Air ambulance limited to nearest hospital qualified to give the treatment.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Must be authorized by a physician.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Coverage only for MD, DO, psychologist, licensed clinical social worker, or licensed counselor.
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$10 <a href="#">copayment</a> ; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Dependent children's pregnancy expenses are not covered.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to services of registered professional nurse who is not related to the patient.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Services must begin within 14 days of the patient's release from a hospital stay that is at least three days long. Maximum of 120 days per confinement less the days hospitalized.

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)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	No charge	Physician must certify the patient is terminally ill with six or fewer months to live.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per 12-month period.
	Children's glasses	Standard lenses: no charge. Frames: costs above \$130 <u>or</u> Contact lenses: costs above \$155 + \$60 exam <a href="#">copayment</a>	Lenses: costs above \$50/\$75/\$100 by type. Frames: costs above \$70 <u>or</u> Contact lenses: costs above \$155	Lens limit: one per 12-month period. Frame limit: one per 24-month period. Go to <a href="http://www.vsp.com">www.vsp.com</a> or call 800-877-7195 for list of <a href="#">network</a> vision <a href="#">providers</a> .
	Children's dental check-up	\$50/individual and \$150/family calendar-year <a href="#">deductible</a> then 20% <a href="#">coinsurance</a>		Oral exams and bitewing x-rays are limited to two each calendar year. Full mouth x-rays are limited to once every five-year period.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan 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</li> <li>Habilitation services</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Pregnancy expenses of dependent children</li> <li>Private-duty nursing</li> <li>Routine foot care</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 (26 maximum visits every six months; spinal manipulation only; dependents covered only to treat accidental injury)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</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: U.S. Department of Labor, 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: Trust Administrator at 503-238-6961 or 1-866-230-6313.

**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 866-230-6313.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-230-6313.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码866-230-6313.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 866-230-6313.

—————*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](#) \$200
- [Specialist copayment](#) \$20
- 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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$1000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,200</b>

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$10

**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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$200
Coinsurance	\$1000
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,320</b>

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

- The [plan's](#) overall [deductible](#) \$200
- [Specialist copayment](#) \$20
- 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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$80
Coinsurance	\$340
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$540</b>