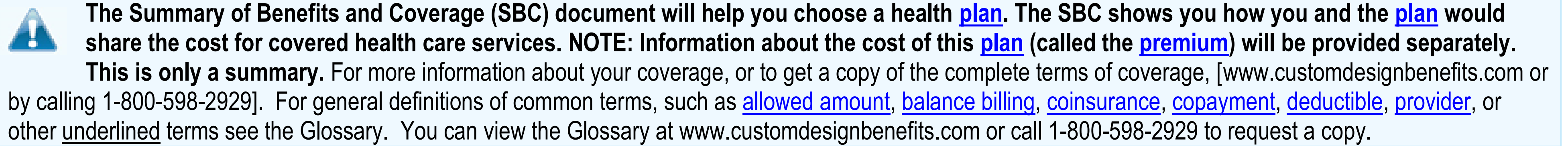

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [www.customdesignbenefits.com or by calling 1-800-598-2929]. 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.customdesignbenefits.com or call 1-800-598-2929 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	This plan does not have an overall deductible. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	This plan does not have deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 individual / $8,000 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?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization.	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?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit; deductible does not apply	If the member chooses The Christ Hospital Plan and goes to a Christ physician, the copay for primary care physician visits is waived.
	Specialist visit	$40 copay/visit	None
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. See the Schedule of Benefits in the Summary Plan Description for any limitations on preventive care/screening that may apply.
If you have a test	Diagnostic test (x-ray, blood work)	$0	None
	Imaging (CT/PET scans, MRIs)	CT Scan: $150 copay/test non-hospital; $300 copay/test hospital PET Scan: $500 copay/test MRI: $250 copay/test non-hospital; $500 copay/test hospital	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.customdesignbenefits.com	Generic Drugs	Copays/prescription: Retail, all pharmacies* — $15 Kroger-owned retail/mail order — $30	* Prescriptions not filled at a Kroger-owned pharmacy when one is with 10 miles aren't covered. Covers up to a 30-day supply (retail, all pharmacies); 90-day supply (Kroger-owned retail/mail order). Specialty drugs are covered up to a 30-day supply.
	Brand Preferred	Copays /prescription: Retail, all pharmacies* — $45 Kroger-owned retail/mail order — $90	
	Non-preferred	Copays /prescription: Retail, all pharmacies* — $70 Kroger-owned retail/mail order — $140	
	Specialty drugs	Biosimilars — 8% coinsurance Preferred — 25% coinsurance Non-Preferred — 35% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	Preauthorization required unless performed in Physician's office or benefits could be reduced by $250.
	Physician/surgeon fees	$0	None
If you need immediate medical attention	Emergency room care	$350 copay/visit	Emergency room copay waived if admitted.
	Emergency medical transportation	$250 copay/use ground; $500 copay/use air	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Urgent care	$50 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/day up to 3 days maximum	Preauthorization required or benefits could be reduced by $250.
	Physician/surgeon fees	$0	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply	If the member chooses The Christ Hospital Plan and goes to a Christ physician, the copay for mental/behavioral health or substance abuse primary care physician visits is waived. Preauthorization required for inpatient services or benefits could be reduced by $250.
	Inpatient services	$500 copay/day up to 3 days maximum	
If you are pregnant	Office visits	$0	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$0	
	Childbirth/delivery facility services	$500 copay/day up to 3 days maximum	
If you need help recovering or have other special health needs	Home health care	$25 copay/ visit	40 visits/plan year. Preauthorization required or benefits could be reduced by $250.
	Rehabilitation services	$50 copay/office visit	45 visits/plan year each. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$50 copay/office visit	
	Skilled nursing care	$100 copay/day	60 days/plan year. Preauthorization required or benefits could be reduced by $250.
	Durable medical equipment	20% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization required if over $1,200 or benefits could be reduced by $250.
	Hospice services	$0	$10,000/plan year.
If your child needs dental or eye care	Children's eye exam	No charge	Routine exam under preventive care
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

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
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs
- Services performed at any Children's Hospital or

	U.S.	its affiliated facility for members 18 or over

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

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: 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: Custom Design Benefits at 1-800-598-2929 or customdesignbenefits.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 1-800-598-2929.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-598-2929.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-598-2929.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-598-2929.]

Notice of Nondiscrimination (for covered entities subject to ACA Section 1557)

Carespring Health Care Management complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Carespring Health Care Management does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Carespring Health Care Management:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages

If a Participant needs these services, he or she should contact the Civil Rights Coordinator

If a Participant believes that Carespring Health Care Management has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with: the Civil Rights Coordinator, 390 Wards Corner Road, Loveland, Ohio 45140, 513-943-4000. The Participant can file a grievance in person or by mail, fax, or email. If a Participant needs help filing a grievance, the Civil Rights Coordinator is available to help him or her.

Participants can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

[Spanish] ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 513-943-4000 .

[Chinese] 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 513-943-4000.

[Vietnamese] CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 513-943-4000 .

[Cushite] XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 513-943-4000 .

[Korean] 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 513-943-4000 번으로 전화해 주십시오.

[Russian] ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 513-943-4000.

[Arabic]

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 513-943-4000 (رقم

[French] ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 513-943-4000.

[Italian] ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 513-943-4000 .

[German] ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 513-943-4000 .

[Japanese] 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。513-943-4000。

[Ukrainian] УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 513-943-4000.

[Dutch] AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 513-943-4000 .

[Romanian] ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 513-943-4000 .

[Pennsylvania Dutch] Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 513-943-4000 .

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** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copay** **$500**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copay** **$500**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,385**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$40**
- **Hospital (facility) copay** **$500**
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,070
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,077**

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