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, [insert contact information]. 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.klhwf.com or call 1-800-598-7330 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $500/person & $1,500/family; Out of Network: $1,500/person & $3,000/family	Generally, you must pay all costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes	This plan covers preventive services without cost sharing and before you meet your deductible. See list of covered preventive services at: https://www.healthcare.gov/coverage/precventive-care-benefits/
Are there other deductibles for specific services?	There are no other specific deductibles.	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?	Medical In-Network $6,650/person Out of Network $7,500/person Prescription In-Network $1,700/person Out of Network: N/A	The out of pocket limit is the most you could pay for covered services.
What is not included in the out-of-pocket limit?	Premium, balance billing charges, contributions, Delta Dental benefits, vision and non-covered services	Even though you pay these expenses, they do not count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-676-BLUE for coverage while traveling 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 the provider for the difference between the provider's charge and what the plan pays (balance billing). Be aware your provider may use an out of network provider for some services (ie. Lab work). Check with your provider prior to getting services.
Do you need a referral to see a specialist?	No	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	30% coinsurance	50% coinsurance	Anthem LiveHealth Online visits are covered at 100%, not subject to deductible or coinsurance. All other telehealth visits are covered the same as regular office visits subject to deductibles, coinsurance and out of pocket limit.
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	0% coinsurance	50% coinsurance	Services required by ACA are provided.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$15 retail & $30 mail order copayment	N/A	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescriptions).
	Preferred brand drugs	$40 retail & $80 mail order copayment	N/A	
	Non-preferred brand drugs	$75 retail & $150 mail order copayment		
	Specialty drugs	$15 generic, $40 preferred brand & $75 non-preferred brand copayment		Certain drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copayment per visit & 50% coinsurance	$250 copayment per visit & 50% coinsurance	$250 copayment waived if hospital inpatient admission or treatment at urgent care/doctor's office for same/related diagnosis within 24 hours of ER visit.
	Emergency medical transportation	30% coinsurance	50% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.klhwf.com or call 1-800-598-7330.]

	Urgent care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Out of Network Inpatient Services must be obtained within a 200 mile radius of your primary residence to be covered.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Out of Network Inpatient Services must be obtained within a 200 mile radius of your primary residence to be covered.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Out of Network Inpatient Services must be obtained within a 200 mile radius of your primary residence to be covered.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	120 visits per calendar year payable at 4 hours per visit.
	Rehabilitation services	30% coinsurance	50% coinsurance	None
	Habilitation services	30% coinsurance	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	1st 60 days after confinement, see Summary Plan Description.
	Durable medical equipment	30% coinsurance	50% coinsurance	Paid as rental up to purchase price.
	Hospice services	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A Retiree Plan, Children are not eligible.
	Children's glasses	N/A	N/A	
	Children's dental check-up	N/A	N/A	N/A Retiree Plan, Children are not eligible.

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
- Cosmetic Surgery
- Private-Duty Nursing
- Treatments that are investigational/experimental
- Infertility Treatment
- Non-Emergency Care when traveling outside of the U.S.
- Weight Loss Programs
- Routine Foot Care
- Long Term Care
- Treatment for TMJ
- Services for Seasonal Affective Light Disorder

[* For more information about limitations and exceptions, see the plan or policy document at www.klhwf.com or call 1-800-598-7330.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Home Health Care (limitations apply) • Speech and Physical Therapy	• Chiropractic Care • Orthotics and orthopedic appliances	• Most coverage provided outside the United States. See SPD or contact Fund Office or www.anthem.com

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [Yes/No]
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/No/Not Applicable]
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 1-800-598-7330.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-598-7330.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-598-7330.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-598-7330.]

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	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$3770
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,340**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$990
Coinsurance	$580
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,070**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$260
Coinsurance	$730
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,490**

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