**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.dunnbenefit.com or by calling **1-800-880-9960.**

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** individual / **$2,000** family for In-Network and **$2,000** individual / **$4,000** family Out-of-Network<br>Doesn't apply to prescription drugs, preventative care, lab program, pediatric dental and vision exams. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other Deductibles for specific services?** | Yes. **$75** individual for diagnostic testing.<br>**$50** individual deductible for dental care.<br>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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$4,000** individual / **$8,000** family for In-Network Medical and **$8,000** individual / **$16,000** family for Out-of-Network Medical. **$1,500** individual / **$3,000** family for In-Network Rx and **$1,500** individual / **$3,000** family for Out-of-Network Rx. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in The out–of–pocket limit?** | Premiums, balance-billed charges, deductibles, penalties for failure to obtain preauthorization for services, prescription copayments, charges over usual, customary and reasonable and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | **Unlimited** per individual. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |
| **Does this plan use a network of providers?** | Yes, Encore Health Network. See www.encoreconnect.com or call **1-800-446-5844** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |

| | | |
|---|---|---|
| **a specialist?** | | |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 50% coinsurance | ————————none———————— |
| | Specialist visit | 20% coinsurance | 50% coinsurance | ————————none———————— |
| | Other practitioner office visit | 20% coinsurance for chiropractor and acupuncture | 50% coinsurance for chiropractor and acupuncture | Limited to 20 physiotherapy care & chiropractic care visits per calendar year (combined maximum). |
| | Preventive care/screening/immunization | No Charge | 50% coinsurance | ————————none———————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab Test a Designated Facility 0% coinsurance all other testing 40% coinsurance | 50% coinsurance | X-ray services received at any other facility other than the designated facility a $75 deductible will be applied. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Services received at any other facility other than the designated facility a $75 deductible will be applied. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **www.scriptcare.com**. | Generic drugs | $4/prescription (retail all other pharmacies) and $8 at CVS or Walgreens $6/prescription (retail/mail order all other pharmacies) and $12 at CVS or Walgreens. No benefits for out-of-network. | | Covers up to a 34-day supply (retail prescription); 90-day supply (mail order or retail prescription). See Plan Document for non-use of generic drug penalty.<br><br>Copay may not apply to preventative drugs and contraceptives. |
| | Preferred Brand drugs | 20% coinsurance or $20 greater of prescription (retail all other pharmacies) and 30% or $40 at CVS or Walgreens and 20% or $40 (retail/mail order all other pharmacies) and 30% or $80 at CVS or Walgreens. No benefits for out-of-network. | | |
| | Non-Preferred Brand drugs | 30% coinsurance or $50 greater of prescription (retail all other pharmacies) and 50% or $60 at CVS or Walgreen and 30% or $60 (retail/mail order all other pharmacies) and 50% or $120 at CVS or Walgreens. No benefits for out-of-network. | | |
| | Specialty drugs | 10% maximum of $150 for generic; 30% maximum of $250 for preferred brand and 50% maximum of $400 for Non-preferred brand. | | Limited to a 30-day supply and Axium Specialty Pharmacy. Please contact KPP for assistance with the specialty pharmacy benefit. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ————————none———————— |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance | Copay applies to facility charges. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ————————none———————— |
| | Urgent care | 20% coinsurance | 50% coinsurance | ————————none———————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| | Physician/surgeon fee | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | 50% coinsurance | ——————none—————— |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| | Substance use disorder outpatient services | 20% coinsurance | 50% coinsurance | ——————none—————— |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| **If you are pregnant** | Prenatal and postnatal care | Prenatal care 0% coinsurance; Postnatal care 20% coinsurance | 50% coinsurance | ——————none—————— |
| | Delivery and all inpatient services | 20% coinsurance | 50% coinsurance | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. Limited to 100 visits per calendar year; 4 hours per visit. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Limited to 20 visits per calendar year combined with the physiotherapy limits. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | Limited to 20 visits per calendar year combined with the physiotherapy benefits. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. Limited to 100 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| | Hospice service | 20% coinsurance | 50% coinsurance | Pre-certification is required in order to avoid a $250 penalty, please call Clinix at 1-800-227-2298. |
| **If your child needs dental or eye care** | Eye exam | 0% coinsurance | 50% coinsurance | Dependent Children up to age 19 limited to one exam per calendar year included under the preventative benefit paid at 100%. |
| | Glasses | Not covered | Not Covered | If offered and elected additional vision benefits are available to Certified Teachers and Administrators. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Dental check-up | Not covered | Not covered | Dependent Children up to age 19 limited to one exam per calendar year included under the preventative benefit paid at 100%. If offered and elected additional dental benefits are available. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Infertility treatment
- Long-term care (only skilled nursing benefits, no nursing homes)
- Private-duty nursing
- Bariatric Banding

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (20 visit maximum, included in physiotherapy benefit/maximum)
- Chiropractic care (20 visit maximum, included in physiotherapy benefit/maximum)
- Cosmetic surgery (for accidental related injury)
- Dental care
- Non-emergency care when traveling outside the U.S.
- Morbid Obesity care
- Hearing aids
- Eye care
- Routine foot care (for diabetic or circulatory problems/conditions)
- Foot care
- Weight Loss Program/Meetings with 75% attendance
- Gym Memberships with a minimum of 10 visits per month

**Your Rights to Continue Coverage:** If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-880-9960. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Your Grievance and Appeals Rights:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Dunn & Associates Benefit Administrators, Inc. at (800) 880 - 9960.

**Does this Coverage Provide Minimum Essential Coverage?** The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?** The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,230
- **Patient pays** $2,310

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $10 |
| Coinsurance | $1,150 |
| Limits or exclusions | $150 |
| **Total** | **$2,310** |

**These numbers assume the participant has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your cost may be higher. For more information please contact Dunn & Associates.**

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $300 |
| Coinsurance | $200 |
| Limits or exclusions | $80 |
| **Total** | **$1,580** |

**These numbers assume the participant is participating in the wellness program. If you have diabetes and do not participate in the wellness program your cost may be higher. For more information please contact Dunn & Associates.**

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.