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 attached or call Dunn & Associates for a copy.

Important Questions	Or	Why This Matters:
What is the overall deductible?	$3,000 individual/$6,000 family for in-network and $6,000 individual/$12,000 family for out of network.	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 policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Preventative care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventative services without cost-sharing and before you meet your deductible. See a list of covered preventative services at https://www.healthcare.gov/coverage/preventative-care-benefits.
Are there other deductibles for specific services?	$75 individual for diagnostic testing and $50 individual for dental expenses.	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?	$6,500 individual/$13,000 family for in-network and $13,000 individual/$26,000 family for out of network.	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, balanced billed charges, and health care this plan does not cover.	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?	See www.encoreconnect.com or call 1-800-446-5844 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 (a balance bill). 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?	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	20% after deductible	40% after deductible	5 visits per year at 100% no deductible this applies to urgent care and walk in clinics (combined maximum).
	Specialist visit	20% after deductible	40% after deductible	None.
	Preventive care/screening/ immunization	No charge.	40% after deductible	You may have to pay for charges that are not preventative. Ask your provider if the services you need are preventative, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab test at designated facility – no charge after deductible. All other testing 40% after deductible	50% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service. X-ray services received at any other facility other than the designated facility a $75 deductible will apply.
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service. Services received at any other facility than the designated facility a $75 deductible will apply.
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	$4.00 copay 34- day supply - $8.00 at CVS/Walgreens $8.00 copay 90-day supply - $12.00 at CVS/Walgreens		COPAYS APPLY AFTER DEDUCTIBLE HAS BEEN MET. Covers up to a 34-day supply/Retail and a 90-day supply/Mail Order. If an insured elects to not purchase a generic drug when available and approved by the responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased.
	Preferred brand drugs	20% or $20 greater of 34-day supply – 30% or $40 at CVS/Walgreens 20% or $40 greater of 90-day supply – 30% or $80 at CVS/Walgreens		
	Non-preferred brand drugs	30% or $50 greater of 34-day supply – 50% or $60 at CVS/Walgreens 30% or $60 greater of 90-day supply – 50% or $120 at CVS/Walgreens		
	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.

* For more information about limitations and exceptions, see the plan or policy document at www.dunnbenefit.com.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Physician/surgeon fees	20% after deductible	40% after deductible	
If you need immediate medical attention	Emergency room care	20% after deductible	20% after deductible	None.
	Emergency medical transportation	20% after deductible	20% after deductible	None.
	Urgent care	20% after deductible	40% after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Physician/surgeon fees	20% after deductible	40% after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	40% after deductible	
	Inpatient services	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
If you are pregnant	Office visits	20% after deductible	40% after deductible	Cost sharing does not apply to certain preventative care services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Childbirth/delivery professional services	20% after deductible	40% after deductible	
	Childbirth/delivery facility services	20% after deductible	40% after deductible	
If you need help recovering or have other special health needs	Home health care	20% after deductible	40% after deductible	100 visits 4-hour maximum per visit/calendar year. Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Rehabilitation services	20% after deductible	40% after deductible	20 visits/calendar year. Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Habilitation services	20% after deductible	40% after deductible	
	Skilled nursing care	20% after deductible	40% after deductible	100 days/per calendar year. Precertification might be required. Failure to obtain precertification may result in a reduction in

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				benefits of the total cost of service.
	Durable medical equipment	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Hospice services	20% after deductible	40% after deductible	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
If your child needs dental or eye care	Children's eye exam	No charge.	Not covered.	Coverage limited to one exam/year as required under the preventative care benefit for dependent children.
	Children's glasses	Not covered.	Not covered.	If offered/elected additional benefits are available to Certified Teachers and Administrators.
	Children's dental check-up	No charge.	Not covered.	Coverage limited to one exam/year as required under the preventative care benefit for dependent children. If offered/elected additional dental benefits are available.

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.)

- Infertility Treatment
- Long-Term Care
- Private Duty Nursing
- Bariatric Banding

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic Care
- Cosmetic Surgery (accidental injury only)
- Dental Care
- Non-Emergency care when traveling outside of the United States.
- Morbid Obesity Care
- Hearing Aids
- Eye Care (Adults/Children)
- Routine Foot Care (Diabetics/Circulatory conditions)
- Weight Loss Programs/Gym Memberships

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 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? 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? 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) 880-9960

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800) 880-9960

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 800) 880-9960

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800) 880-9960

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 www.dunnbenefit.com.

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	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$3,000
Copayments	$16
Coinsurance	$2,343
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,419

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

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$3,000
Copayments	$124
Coinsurance	$1,275
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$4,454

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

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,925

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