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 contact your Human Resources Department. 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.dol.gov/ebsa/healthreform or call 1-877-236-0844 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** individual / **$1,500** family for 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** individual / **$5,000** family for 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, balance-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?	Yes. For a list of participating network providers: Alabama residents see Alabama Premier Network at www.alabamapremiernetwork.com or call 1-800-636-2624; Mississippi residents see Mississippi Physicians Care Network at www.mpcn-ms.com or call 1-800-931-8533; All other state residents see PHCS Physician & Ancillary Only at www.multiplan.com/phcspracanc or call 1-877-952-7427.	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 (balance billing). 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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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 Network Provider	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/visit	None
	Specialist visit	$25 copay/visit	None
	Preventive care/screening/immunization	No charge; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check for what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	$250 copay	Prior Authorization is required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.EnvolveRx.com or call 1-833-827-6467**	Generic Drugs	Retail & Maintenance: $10 copay/prescription Mail Order: $10 copay/prescription	Retail: up to 30-day supply, Maintenance: up to 60-day supply Mail Order: up to 90-day supply
	Preferred Brand Drugs	Retail & Maintenance: $35 copay/prescription Mail Order: $35 copay/prescription	
	Non-Preferred Brand Drugs	Retail & Maintenance: $55 copay/prescription Mail Order: $55 copay/prescription	
	Specialty drugs	Preferred Brand: $35 copay/prescription Non-Preferred Brand: $55 copay/prescription	limited to 30-day supply only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Prior Authorization is required.
	Physician/surgeon fees	No charge; deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay Network Provider	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	Facility: $250 copay/visit Physician: $25 copay/visit	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance after deductible	None
	Urgent care	$25 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day first 10 days then covered 100%	Prior Authorization is required.
	Physician/surgeon fee	No charge; deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Includes Partial Day Program
	Inpatient services	$250 copay/day first 10 days then covered 100%	Prior Authorization is required. Includes residential treatment
If you are pregnant	Office visits	$25 copay/visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance, and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior Authorization may be required.
	Childbirth/delivery professional services	No charge; deductible does not apply	
	Childbirth/delivery facility services	$250 copay/day first 10 days then covered 100%	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	Prior Authorization is required. Limited to 40 visits per calendar year.
	Rehabilitation services	30% coinsurance after deductible	Prior Authorization is required for Physical, Occupational and Speech therapy after first six (6) visits. Cardiac & Pulmonary therapy limited to 36 visits per calendar year. Occupational and Speech therapy limited to 20 visits per calendar year. Physical therapy limited to 20 visits per diagnosis/injury per calendar year.
	Habilitation services	30% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay Network Provider	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	Not covered	Not Covered
	Durable medical equipment	30% coinsurance after deductible	None
	Hospice services	30% coinsurance after deductible	Prior Authorization is required. Limited to less than 6 months.
If your child needs dental or eye care	Children's eye exam	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not covered	Not covered.
	Children's dental check-up	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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.)

- Abortion
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Long Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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.)

- Bariatric Surgery (limited to Lap-Band and sleeve gastrectomy)
- Chiropractic Care (limited to 20 visits per calendar year)
- Hearing Aids (limited to $2000 per impaired ear every 3 calendar years)
- Infertility Treatment (limited to up to diagnosis only)
- Non-emergency care when traveling outside the U.S. only if part of KISx

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-877-236-0844. 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/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 the plan at Dunn Companies Health Plan c/o Lucent Health Solutions, LLC at PO Box 7020 Appleton, WI 54912-7020 or call 877-236-0844. 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/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. "Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-487-2365 or http://www.dol.gov/ebsa/consumer_info_health.html." A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this Coverage 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 Coverage Meet the Minimum Value Standard? **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: **1-877-236-0844**
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助，请拨打这个号码
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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 copay**	**$25**
▪ **Hospital (facility) copay**	**$250**
▪ **Other coinsurance**	**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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,015
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,075**

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 copay**	**$25**
▪ **Hospital (facility) copay**	**$250**
▪ **Other coinsurance**	**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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$965
Coinsurance	$368
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,889**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ **The plan's overall deductible**	**$500**
▪ **Specialist copay**	**$25**
▪ **Hospital (facility) copay**	**$250**
▪ **Other coinsurance**	**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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$152
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,452**