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.dunnbenefit.com or call 1-800-880-9960 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,500 Single/$7,000 Family for in and $7,000 Single/$14,000 Family out of network providers	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 is 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,000 Single/$14,000 Family for in and $14,000 Single/$28,000 Family out of network providers	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.pvcooperative.com or call 1-800-880-9960 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	10% coinsurance	30% coinsurance	None.
	Specialist visit	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Preventive care/screening/ immunization	No charge.	30% coinsurance	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)	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truerx.com	Generic drugs	0% after deductible		Covers up to a 30-day supply/Retail and a 90-day supply/Mail Order. For out-of-network covered person must pay for the entire cost of the drug at the time filled and file a claim for reimbursement. 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. Narrow formulary will be utilized and higher copays may apply.
	Preferred brand drugs	0% after deductible		
	Non-preferred brand drugs	0% after deductible		
	Specialty drugs	Not covered. Please contact TrueRx for assistance.		

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None.
	Emergency medical transportation	10% coinsurance	30% coinsurance	$5,000 per trip maximum.
	Urgent care	10% coinsurance	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	
	Inpatient services	10% coinsurance	30% coinsurance	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	10% coinsurance	30% coinsurance	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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	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	10% coinsurance	30% coinsurance	30 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	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	60 days per convalescent period. Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification might be required. Failure to obtain precertification may result in a reduction in benefits of the total cost of service.
	Hospice services	10% coinsurance	30% coinsurance	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.
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.	
	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.

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	• Eye Care (Adult/Child(ren))	• Long-Term Care
• Bariatric Surgery	• Hearing Aids	• Private-Duty Nursing
• Cosmetic Surgery	• Infertility Treatment	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Non-Emergency care when traveling outside of the United States.	• Routine Foot Care
• Dental Care (Adult/Child(ren))		

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight (877) 267-2323 xt 61565 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 (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: Dunn & Associates Benefit Administrators, Inc. (800) 880-9960.

Does this plan provide Minimum Essential Coverage? Yes. 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. 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'

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

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About these Coverage Examples:

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

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** **$3,500**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$3,500
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,500**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$3,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,920**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,500**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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