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, call 1-800-324-9396 or visit our website www.kemptongroup.com. 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.kemptongroup.com or call 1-866-335-9057 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** Individual / **$3,000** Family	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. Services rendered through a **Delta Health** provider, preventive services, physician office services, urgent care, certain therapy services, sterilization services, and services through the **KPP*Free*™** program and **QuestSelect** laboratories.	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?	*Medical:* **$3,500** Individual / **$7,000** Family *Prescription Drug:* **$1,500** Individual / **$3,000** Family	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, cost containment penalties, manipulative therapy, massage therapy, acupuncture, amounts over the maximum allowable charge, and health care this plan doesn't 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. See ww.kemptongroup.com or call 1-866-335-9057 for a list of network providers. ***All services available through Delta Health, except OBGYN, are REQUIRED to be done through a Delta Health provider or the claim(s) will be denied.*** **Out-of-Network charges are held to a percentage of Medicare** (Reference Based Pricing).	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 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.

Services available through Delta Health providers are covered at 100% (deductible waived), and do not require preauthorization.				
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	$40 copay, (deductible waived)		Copay includes office visit, lab, x-rays, allergy services, and non-surgical injections. All other services are deductible then 20% coinsurance.
	Specialist visit	$40 copay, (deductible waived)		Copay includes office visit, lab, x-rays, allergy services, and non-surgical injections. All other services are deductible then 20% coinsurance.
	Preventive care/screening/ immunization	No charge		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance		No charge when a **QuestSelect** or a directly contracted laboratory is used.
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance		Preauthorization required to avoid a claim denial. No charge if the plan is primary and the **KPP*Free*™** program is used.

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

Services available through Delta Health providers are covered at 100% (deductible waived), and do not require preauthorization.				
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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medone-rx.com or 1-866-335-9057	**Generic drugs**: Retail: 1-34 days Mail order: 1-90 days	$15 copay $30 copay	Not covered	There is a **$1,500** Individual / **$3,000** Family out-of-pocket maximum for prescription drugs (separate from the Medical). You will pay the copay, PLUS the difference in cost between the generic and the brand name drug if generic is available.
	Preferred drugs: Retail: 1-34 days Mail order: 1-90 days	Lesser of 35% coinsurance or $150 Lesser of 35% coinsurance or $150	Not covered	
	Non-Preferred drugs: Retail: 1-34 days Mail order: 1-90 days	Lesser of 40% coinsurance or $200 Lesser of 35% coinsurance or $200	Not covered	
	Specialty drugs Limited to 30 days	$200 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay, deductible then 20% coinsurance		Preauthorization required for to avoid a claim denial. No charge if the plan is primary and the **KPP*Free*™** program is used.
	Physician/surgeon fees	Deductible then 20% coinsurance		No charge if the plan is primary and the **KPP*Free*™** program is used.
If you need immediate medical attention	Emergency room care	$300 copay, deductible then 20% coinsurance		Copay waived if admitted.
	Emergency medical transportation	Deductible then 20% coinsurance		Air ambulance is limited to 120% of the Medicare rate.
	Urgent care	$75 copay, (deductible waived)		——————None——————

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

Services available through Delta Health providers are covered at 100% (deductible waived), and do not require preauthorization.				
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 have a hospital stay	Facility fee (e.g., hospital room)	$300 copay per admission, deductible then 20% coinsurance		Preauthorization required to avoid a claim denial. No charge if services rendered through the **KPP*Free*™** program.
	Physician/surgeon fees	Deductible then 20% coinsurance		No charge if services rendered through the **KPP*Free*™** program.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office setting*: $20 copay, (deductible waived) *Facility/hospital setting:* deductible then 20% coinsurance		——————None——————
	Inpatient services	$300 copay per admission, deductible then 20% coinsurance		Preauthorization required to avoid a claim denial.
If you are pregnant	Office visits	Deductible then 20% coinsurance		A $40 office visit copay may apply for the initial visit only. Preauthorization is recommended to avoid a claim denial as it is required if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery. ***Benefits are limited to employee or spouse.***
	Childbirth/delivery professional services	Deductible then 20% coinsurance		
	Childbirth/delivery facility services	Deductible then 20% coinsurance		

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

Services available through Delta Health providers are covered at 100% (deductible waived), and do not require preauthorization.				
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 need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance		Limited to 60 visits per calendar year.
	Rehabilitation services	*Acupuncture, manipulative, and massage therapy:* $30 copay, up to a maximum of $75 per visit, (deductible waived) *Occupational, physical, and speech therapy:* $40 copay, (deductible waived) *All other services:* Deductible then 20% coinsurance		Acupuncture, manipulative, and massage are limited to 12 visits each per calendar year. Occupational, physical, and speech therapy are limited to 26 visits each per calendar year. Cardiac and pulmonary rehabilitation are limited to 36 visits each per calendar year.
	Habilitation services			
	Skilled nursing care	Deductible then 20% coinsurance		Limited to 30 days per calendar year.
	Durable medical equipment	Deductible then 20% coinsurance		——————None——————
	Hospice services	Deductible then 20% coinsurance		——————None——————
If your child needs dental or eye care	Children's eye exam	Not covered		Limited to certain preventive services required under the ACA.
	Children's glasses	Not covered		Limited to certain preventive services required under the ACA.
	Children's dental check-up	Not covered		Limited to certain preventive services required under the ACA.

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.)

- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the US.
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA(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.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/. 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 1-800-324-9396. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-9323 x61565 or www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 **1-800-521-1711**.

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.kemptongroup.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	$1,500
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

The plan's overall deductible	$1,500
Specialist copay	$40
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	$1,500
Specialist copay	$40
Emergency Room (facility) copay	$300
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 1-800-324-9396.

عربي Arabic	إذا كانت لديك أو لدى أي شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث إلى مترجم فوري، اتصل برقم خدمة العملاء الموجود على ظهر بطاقة العضو الخاصة بك. إذا لم تكن عضوًا، أو ليس لديك بطاقة، فاتصل بالرقم 1-800-324-9396.
հայերեն Armenian	Եթե դուք կամ որևէ մեկը, ում օգնում եք, ունեք հարցեր, դուք իրավունք ունեք անվճար օգնություն և տեղեկատվություն ստանալ ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք ձեր անդամ քարտի հետևի մասում գտնվող հաճախորդների սպասարկման համարին: Եթե անդամ չեք կամ չունեք քարտ, զանգահարեք 1-800-324-9396 հեռախոսահամարով:
中国人 Chinese	**如果您或您正在帮助的人有疑**问，您有权免费获得以您的语言提供的帮助和信息。如需与口译员交谈，请拨打会员卡背面的客户服务电话。如果您不是会员或没有会员卡，请致电 1-800-324-9396。
हिंदी Hindi	यदि आपके या जिसकी आप मदद कर रहे हैं, उसके पास कोई प्रश्न है, तो आपको बिना किसी कीमत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। दुभाषिया से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 1-800-324-9396 पर कॉल करें।
Filipino Filipino	Kung ikaw, o isang taong tinutulungan mo, ay may mga katanungan, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tawagan ang numero ng customer service sa likod ng iyong member card. Kung hindi ka miyembro, o walang card, tumawag sa 1-800-324-9396.
Français French	Si vous, ou quelqu'un que vous aidez, avez des questions, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le numéro du service client indiqué au dos de votre carte de membre. Si vous n'êtes pas membre ou n'avez pas de carte, appelez le 1-800-324-9396.
Deutsch German	Wenn Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie die Kundendienstnummer auf der Rückseite Ihrer Mitgliedskarte an. Wenn Sie kein Mitglied sind oder keine Karte haben, rufen Sie 1-800-324-9396 an.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, avete il diritto di ricevere aiuto e informazioni gratuitamente nella vostra lingua. Per parlare con un interprete, chiama il numero del servizio clienti sul retro della tua tessera membro. Se non sei membro o non hai una carta, chiama il numero 1-800-324-9396.
한국인 Korean	귀하 또는 귀하가 돕고 있는 사람에게 질문이 있는 경우 귀하는 무료로 귀하의 언어로 도움과 정보를 얻을 권리가 있습니다. 통역사와 통화하려면 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니거나 카드가 없는 경우 1-800-324-9396으로 전화하세요.
Polski Polish	Jeżeli Ty lub osoba, której pomagasz, macie pytania, macie prawo uzyskać bezpłatną pomoc i informacje w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer obsługi klienta podany na odwrocie karty członkowskiej. Jeśli nie jesteś członkiem lub nie masz karty, zadzwoń pod numer 1-800-324-9396.
Português Portuguese	Se você, ou alguém que você está ajudando, tiver dúvidas, você tem o direito de obter ajuda e informações em seu idioma, sem nenhum custo. Para falar com um intérprete, ligue para o número de atendimento ao cliente indicado no verso do seu cartão de membro. Se você não é membro ou não possui cartão, ligue para 1-800-324-9396.
Русский Russian	Если у вас или у кого-то, кому вы помогаете, есть вопросы, вы имеете право бесплатно получить помощь и информацию на вашем языке. Чтобы поговорить с переводчиком, позвоните по номеру службы поддержки клиентов, указанному на обратной стороне вашей карты участника. Если вы не являетесь участником или у вас нет карты, позвоните по телефону 1-800-324-9396.
Español Spanish	Si usted o alguien a quien está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número de servicio al cliente que figura en el reverso de su tarjeta de miembro. Si no es miembro o no tiene tarjeta, llame al 1-800-324-9396.
Tiếng Việt Vietnamese	Nếu bạn hoặc ai đó bạn đang giúp đỡ có thắc mắc, bạn có quyền nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, hãy gọi đến số dịch vụ khách hàng ở mặt sau thẻ thành viên của bạn. Nếu bạn không phải là thành viên hoặc không có thẻ, hãy gọi 1-800-324-9396.
יידיש Yiddish	אויב איר, אָדער עמעצער איר העלפֿט, האָבן פֿראגן, איר האָט די רעכט צו באַקומען הילף און אינפֿאָרמאַציע אין דיין שפּראַך אָן קיין קאָס. צו רעדן צו אַן יבערזעצער, רופן די קונה סערוויס נומער אויף די צוריק פון דיין מיטגליד קאָרט. אויב איר זענט נישט אַ מיטגליד אָדער טאָן ניט האָבן אַ קאָרט, רופן 1-800-324-9396.