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, visit 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.dol.gov/ebsa/healthreform or call 1-800-324-9396 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$2,500** Individual / **$5,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family per calendar year	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 services; primary care, specialists, and urgent care visits; and services though the **KPP*Free*™** program, **QuestSelect**, and directly contracted laboratories.	This plan covers some items and services even if you haven't yet met the deductible amount. 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?	In-Network: **$3,000** Individual / **$6,000** Family Out-of-Network: **$6,000** Individual / **$12,000** Family per calendar year	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-billing charges, preauthorization benefit reductions, amounts in excess of the maximum allowable amount, 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 www.kemptongroup.com or call 1-800-324-9396 for a list of network providers. ***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.

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	$45 copay per visit (Deductible does not apply)	$45 copay per visit (Deductible does not apply)	Copay includes office visit, x-rays, laboratory, non-surgical injections, and allergy testing and treatment.
	Specialist visit	$45 copay per visit (Deductible does not apply)	$45 copay per visit (Deductible does not apply)	Copay includes office visit, x-rays, laboratory, non-surgical injections, and allergy testing and treatment.
	Preventive care/screening/ immunization	No charge	Deductible then 50% coinsurance	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 30% coinsurance	Deductible then 50% coinsurance	No charge when a **QuestSelect** laboratory or a directly contracted laboratory is used.
	Imaging (CT/PET scans, MRIs)	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Preauthorization is required to avoid claim denial. No charge if the plan is primary and the **KPP*Free*™** program is used.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Pharmacy (You will pay the least)	Out-of-Network Pharmacy (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.savrx.com or by calling **1-800-228-3108.**	Generic drugs (Retail & mail order) • 30 day supply • 31-90 day supply	$15 copay per prescription $30 copay per prescription	Not covered	Certain OTC drugs are available at no charge. Contact Sav-Rx for details. If a generic drug is available, you pay the copay PLUS the difference in cost between the generic and the brand name drug. **Maintenance drugs** are covered up to 90-day supply through Sav-Rx or mail order with applicable copay. For specialty drugs contact **Sav-Rx** at 1-800-228-3108.
	Preferred drugs (Retail & mail order) • 30 day supply • 31-90 day supply	$45 copay per prescription $90 copay per prescription	Not covered	
	Non-Preferred drugs (Retail & mail order) • 30 day supply • 31-90 day supply	$60 copay per prescription $120 copay per prescription	Not covered	
	Specialty drugs (30 day supply only)	30% coinsurance to a maximum of $250 per prescription to the covered person	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Preauthorization is required to avoid claim denial. No charge if the plan is primary and the **KPP*Free*™** program is used.
	Physician/surgeon fees	Deductible then 30% coinsurance	Deductible then 50% coinsurance	No charge if the plan is primary and the **KPP*Free*™** program is used.

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 immediate medical attention	Emergency room care	$300 copay per visit, deductible then 30% coinsurance	*Emergency:* $300 copay per visit, deductible then 30% coinsurance *Non-Emergency:* $300 copay per visit, deductible then 50% coinsurance	Emergency room copay waived if admitted as inpatient.
	Emergency medical transportation	Deductible then 30% coinsurance		Air Ambulance limited to 120% of the Medicare rate.
	Urgent care	$45 copay per visit (Deductible does not apply)	$45 copay per visit (Deductible does not apply)	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Preauthorization is required to avoid claim denial. No charge if the plan is primary and the **KPP*Free*™** program is used.
	Physician/surgeon fees	Deductible then 30% coinsurance	Deductible then 50% coinsurance	No charge if the plan is primary and the **KPP*Free*™** program is used.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	*Office setting:* $45 copay per visit (Deductible does not apply) *Other:* Deductible then 30% coinsurance	*Office setting:* $45 copay per visit (Deductible does not apply) *Other:* Deductible then 50% coinsurance	----------None----------
	Inpatient services	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Preauthorization is required to avoid claim denial.

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 are pregnant	Office visits	$45 copay for initial visit only (Deductible does not apply)	$45 copay for initial visit only (Deductible does not apply)	Preauthorization is recommended to avoid claim denial. Benefits are limited to employee or spouse.
	Childbirth/delivery professional services	Deductible then 30% coinsurance	Deductible then 50% coinsurance	
	Childbirth/delivery facility services	Deductible then 30% coinsurance	Deductible then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Limited to 60 visits per calendar year.
	Rehabilitation services	*Physical, occupational, speech, and manipulative therapy:* $45 copay per visit (Deductible does not apply) *All other therapy services:* Deductible then 30% coinsurance	*Physical, occupational, speech, and manipulative therapy:* $45 copay per visit (Deductible does not apply) *All other therapy services:* Deductible then 50% coinsurance	Manipulative therapy is limited to $75 maximum benefit per visit. Physical, occupational, speech, and manipulative therapy are each limited to 26 visits per calendar year. Cardiac and pulmonary rehabilitation are each limited to 36 visits per calendar year.
	Habilitation services			
	Skilled nursing care	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Limited to 30 days per calendar year. Preauthorization is required for in-patient to avoid claim denial.
	Durable medical equipment	Deductible then 30% coinsurance	Deductible then 50% coinsurance	----------None----------
	Hospice services	Deductible then 30% coinsurance	Deductible then 50% coinsurance	Preauthorization is required for in-patient to avoid claim denial.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------None----------
	Children's glasses	Not covered	Not covered	----------None----------
	Children's dental check-up	Not covered	Not covered	----------None----------.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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 (limitations apply)
- Hearing aids (limited to age 19 and under)

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.

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	$2,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$45
Coinsurance	$455
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

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

The plan's overall deductible	$2,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

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

The plan's overall deductible	$2,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

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