The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-833-422-4690. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-833-422-4690 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: \$4,900 person / \$9,800 family. Out of Network: \$10,000 person / \$20,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary care services and Specialist services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. In Network: \$600 Individual / \$1,200 Family for prescription drug coverage. There are no other specific deductibles.	You must pay all costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In Network: \$10,600 / \$21,200 & Out of Network: \$21,200 / Out of Network: \$42,400 For Participating providers	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limits.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.jeffersonhealthplans.com/individ uals-families or call 1-833-422-4690 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays <u>(balance billing)</u> . Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$\$35/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <u>providers</u> are covered in full.	
If you visit a health care <u>provider's</u> office or clinic	Specialist visit	\$85/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <u>providers</u> are covered in full.	
	Preventive care/screening/ Immunization	No charge.	50% After Deductible	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$50/Visit (lab work). \$100/Visit (X-Ray)	50% After Deductible	none	
	Imaging (CT/PET scans, MRIs)	\$\$350/Scan After Deductible	50% After Deductible	Some services may require prior authorization. See your policy for more details	
If you need drugs to treat your illness or condition	Generic drugs	Retail/Mail Order (1-30 days supply) \$5/Fill for tier 1, \$25/fill for tier 2.	Not Covered.	Prior authorization, age, and quantity limits for some drugs; days supply limits on retail & mail order. See your policy for more detail. Low-Cost Generics will be available at a reduced cost.	
More information about prescription drug	Preferred brand drugs	50% After Rx Deductible.	Not Covered.		
coverage is available at [www.jeffersonhealthpla	Non-preferred brand drugs	50% After Rx Deductible.	Not Covered.		
ns.com/individuals- families]	Specialty drugs	50% After Rx Deductible.	Not Covered.		
If you have outpatient	Facility fee (e.g.,	\$400/visit After	50% After Deductible	Some services may require prior authorization, or no	

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
surgery	ambulatory surgery center)	Deductible.		benefits will be paid. See your policy for more details.
	Physician/surgeon fees	20% coinsurance After Deductible.	50% After Deductible	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Emergency room care	\$500/Visit.	\$500/Visit.	none
If you need immediate	Emergency medical transportation	\$200/Visit.	\$200/Visit	none
medical attention	<u>Urgent care</u>	\$85/Visit.	50% After Deductible	Your costs for <u>urgent care</u> are based on care received at a designated <u>urgent care</u> center or facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$900/Day After Deductible. Max of 5 Copayment(s)/ Admission.	50% After Deductible	Prior authorization is required, or no benefits will be paid.
· ,	Physician/surgeon fees	20% coinsurance After Deductible.	50% After Deductible	
If you need mental	Outpatient services	\$85/Visit.	50% After Deductible	
health, behavioral health, or substance abuse services	Inpatient services	\$900/Day After Deductible. Max of 5 Copayment(s)/Admissions	50% After Deductible	
	Office visits	\$35/Visit After Deductible.	50% After Deductible	Depending on the type of service a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% Coinsurance After Deductible.	50% After Deductible	
	Childbirth/delivery facility services	\$900/Day After Deductible. Max of 5	50% After Deductible	

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Copayment(s) / Admissions		
If you need help recovering or have other special health needs	Home health care	50% Coinsurance After Deductible.	50% After Deductible	Limited to 60 visits per benefit period. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Rehabilitation services	\$85 Visit After Deductible for Physical and Occupational Therapy, \$85/Visit After Deductible for Speech Therapy.	50% After Deductible	Rehabilitative Speech Therapy limited to 30 services per benefit period. Rehabilitative Physical Therapy and Rehabilitative Occupational Therapy limited to 30 combined services per benefit period.
	Habilitation services	\$85/Visit After Deductible for Physical and Occupational Therapy, \$100/Visit After Deductible for Speech Therapy.	50% After Deductible	Habilitative Speech Therapy limited to 30 services per benefit period. Habilitative Physical Therapy and Habilitative Occupational Therapy limited to 30 combined services per benefit period.
	Skilled nursing care	\$900/Day. Max of 5 Copayment(s) / Admissions	50% After Deductible	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.
	Durable medical equipment	50% Coinsurance After Deductible.	50% After Deductible	Some items may require prior authorization. See your policy for more details.
	Hospice services	50% Coinsurance After Deductible.	50% After Deductible	none
If your child needs dental or eye care	Children's eye exam	No Charge	50% After Deductible	One (1) refraction visit per Benefit Period.
	Children's glasses	No Charge	50% After Deductible	3 pairs of glasses (lenses/frames) or contacts per Calendar Year.
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.

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
- Children's dental check-up
- Cosmetic surgery

- Dental care (Adult)
- Hearing aids
- Long Term Care
- Non-emergency care when traveling outside the
- 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

Abortion

Infertility treatment (only covered for artificial insemination)

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: Pennsylvania Insurance Department. 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 Pennie.gov or call 1-844-844-8040.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact the Plan at 1-833-422-4690.

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? Not Applicable

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 1-833-422-4690.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-422-4690.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-833-422-4690.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-833-422-4690.

To see examples of how this <u>plan</u> 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 \$4.900 Specialist copayment \$85/Visit

Hospital (facility) copayment \$900/Day

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	\$13,405		
In this example, Peg would pay:			
Cost Sharing			
<u>Deductibles</u>	\$4,900		
<u>Copayments</u>	\$1,600		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$6,560		

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

■ The plan's overall deductible \$4,900 ■ Specialist copayment \$85/Visit ■ Hospital (facility) copayment \$900/Day

■ 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	\$8,216	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$800	
Copayments	\$1,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,820	

Mia's Simple Fracture

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

plan's overall deductible \$4.900 ■ Specialist copayment \$85/Visit ■ Hospital (facility) copayment \$900/day **■** 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	\$2,408	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,000	
Copayments	\$1,100	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,100	