



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 1-833-422-4690. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-833-422-4690 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                    | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | In Network: <b>\$1,500</b> person / <b>\$3,000</b> family. Out of Network: <b>\$10,000</b> person / <b>\$20,000</b> family.                                                                                | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                           |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> , Primary care services and <a href="#">Specialist</a> services are covered before you meet your <a href="#">deductible</a> .                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                      |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. In Network: <b>\$500</b> Individual / <b>\$1,000</b> Family for prescription drug coverage. There are no other specific <a href="#">deductibles</a> .                                                 | You must pay all costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | In Network: <b>\$10,600</b> / <b>\$21,200</b><br>Out of Network: <b>\$21,200</b> / <b>\$42,400</b>                                                                                                         | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                            |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.                                                                                                                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.jeffersonhealthplans.com/individuals-families">www.jeffersonhealthplans.com/individuals-families</a> or call 1-833-422-4690 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.                                                                                                                                                                                                        | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

 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) |                                                                                                                                                                                                                                 |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                                                             | Primary care visit to treat an injury or illness        | \$15/Visit                                                                      | 50% After Deductible                            | Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <a href="#">providers</a> are covered in full.                                                          |
|                                                                                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                        | \$45/Visit                                                                      | 50% After Deductible                            | Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <a href="#">providers</a> are covered in full.                                                          |
|                                                                                                                                                                                                                                                                           | <a href="#">Preventive care/screening/</a> 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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for |
| <b>If you have a test</b>                                                                                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$15/Visit (lab work).<br>\$50/Visit (X-Ray)                                    | 50% After Deductible                            | —————none—————                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                            | \$100/Scan after <a href="#">deductible</a> .                                   | 50% After Deductible                            | Some services may require prior authorization. See your policy for more details                                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.jeffersonhealthplans.com/individuals-families">www.jeffersonhealthplans.com/individuals-families</a> | Generic drugs                                           | Retail/Mail Order (1-30 days supply) \$0/Fill for tier 1, \$20/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.                                |
|                                                                                                                                                                                                                                                                           | Preferred brand drugs                                   | \$50                                                                            | Not Covered.                                    |                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                           | Non-preferred brand drugs                               | Subject to RX <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .  | Not Covered.                                    |                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                           | <a href="#">Specialty drugs</a>                         | Subject to RX <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .  | Not Covered.                                    |                                                                                                                                                                                                                                 |
| <b>If you have outpatient</b>                                                                                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery)                 | \$200/visit after <a href="#">deductible</a> ..                                 | 50% After Deductible                            | Some services may require prior authorization, or no benefits will be paid. See your policy for more                                                                                                                            |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.jeffersonhealthplans.com/individuals-families](http://www.jeffersonhealthplans.com/individuals-families).

| 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) |                                                                                                                                                                         |
| surgery                                                                   | center)                                          |                                                                                 |                                                 | details.                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                           | 0% coinsurance after <a href="#">deductible</a> .                               | 50% After Deductible                            | Some services may require prior authorization, or no benefits will be paid. See your policy for more details.                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$250/Visit.                                                                    | \$250/Visit.                                    | —————none—————                                                                                                                                                          |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$200/Visit.                                                                    | \$200/Visit                                     | —————none—————                                                                                                                                                          |
|                                                                           | <a href="#">Urgent care</a>                      | \$45/Visit.                                                                     | 50% After Deductible                            | Your costs for <a href="#">urgent care</a> are based on care received at a designated <a href="#">urgent care</a> center or facility.                                   |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | \$400/Day after <a href="#">deductible</a> .. Max of 5 Copayment(s)/ Admission. | 50% After Deductible                            | Prior authorization is required, or no benefits will be paid.                                                                                                           |
|                                                                           | Physician/surgeon fees                           | 0% coinsurance After Deductible.                                                | 50% After Deductible                            |                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$45/Visit.                                                                     | 50% After Deductible                            |                                                                                                                                                                         |
|                                                                           | Inpatient services                               | \$400/Day after <a href="#">deductible</a> .. Max of 5 Copayment(s)/Admissions  | 50% After Deductible                            |                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | \$45/Visit after <a href="#">deductible</a> ..                                  | 50% After Deductible                            | Depending on the type of service a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 0% Coinsurance after <a href="#">deductible</a> ..                              | 50% After Deductible                            |                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services            | \$400/Day after <a href="#">deductible</a> .. Max of 5 Copayment(s)/Admissions  | 50% After Deductible                            |                                                                                                                                                                         |
| If you need help recovering or have                                       | <a href="#">Home health care</a>                 | 50% Coinsurance after <a href="#">deductible</a> ..                             | 50% After Deductible                            | Limited to 60 visits per benefit period. Some services may require prior authorization, or no benefits will be                                                          |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.jeffersonhealthplans.com/individuals-families](http://www.jeffersonhealthplans.com/individuals-families).

| 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) |                                                                                                                                                                                                      |
| <b>other special health needs</b>             |                                           |                                                                                  |                                                 | paid. See your policy for more details.                                                                                                                                                              |
|                                               | <a href="#">Rehabilitation services</a>   | \$50 Visit for Physical and Occupational Therapy, \$50/Visit 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. |
|                                               | <a href="#">Habilitation services</a>     | \$50/Visit for Physical and Occupational Therapy, \$50/Visit 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.       |
|                                               | <a href="#">Skilled nursing care</a>      | \$400/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.                                                                                                |
|                                               | <a href="#">Durable medical equipment</a> | 50% Coinsurance after deductible.                                                | 50% After Deductible                            | Some items may require prior authorization. See your policy for more details.                                                                                                                        |
|                                               | <a href="#">Hospice services</a>          | 50% Coinsurance after deductible.                                                | 50% After Deductible                            | —————none—————                                                                                                                                                                                       |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | \$0                                                                              | 50% After Deductible                            | One (1) refraction visit per Benefit Period.                                                                                                                                                         |
|                                               | Children's glasses                        | \$0                                                                              | 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                            |                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Children's dental check-up</li> <li>Cosmetic surgery</li> </ul>                                            | <ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Hearing aids</li> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.jeffersonhealthplans.com/individuals-families](http://www.jeffersonhealthplans.com/individuals-families).

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

U.S

**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 [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 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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne'1-833-422-4690.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.jeffersonhealthplans.com/individuals-families](http://www.jeffersonhealthplans.com/individuals-families).

of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$400   |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$1,200        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,760</b> |

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$400   |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$800          |
| <a href="#">Copayments</a>        | \$700          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$250   |
| ■ Other <a href="#">coinsurance</a>                             | 0%      |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$700          |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.