



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>\$0</b> person / <b>\$0</b> family. Out of Network: not covered.                                                                                                                            | 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>             | No, 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>\$0</b> / <b>\$0</b> . Out of Network: not covered.                                                                                                                                         | 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                                      | Limitations, Exceptions, & Other Important Information |                                                    |                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                      |                                                            | Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                 |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                               | Primary care visit to treat an injury or illness           | No Charge                                              | Not Covered.                                       | 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                           | No Charge                                              | Not Covered.                                       | 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><br>Immunization | No Charge                                              | Not Covered.                                       | 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 |
| If you have a test                                                                                                                                                                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)        | No Charge                                              | Not Covered.                                       | —————none—————                                                                                                                                                                                                                  |
|                                                                                                                                                                                                      | Imaging (CT/PET scans, MRIs)                               | No Charge                                              | Not Covered.                                       | Some services may require prior authorization. See your policy for more details                                                                                                                                                 |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">[www.jeffersonhealthplans.com/individuals-</a> | Generic drugs                                              | No Charge                                              | 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                                      | No Charge                                              | Not Covered.                                       |                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                      | Non-preferred brand drugs                                  | No Charge                                              | Not Covered.                                       |                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                      | <a href="#">Specialty drugs</a>                            | No Charge                                              | Not Covered.                                       |                                                                                                                                                                                                                                 |

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

| Common Medical Event                                                      | Services You May Need                            | Limitations, Exceptions, & Other Important Information |                                                    |                                                                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                         |
| families]                                                                 |                                                  |                                                        |                                                    |                                                                                                                                                                         |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | No Charge                                              | Not Covered.                                       | Some services may require prior authorization, or no benefits will be paid. See your policy for more details.                                                           |
|                                                                           | Physician/surgeon fees                           | No Charge                                              | Not Covered.                                       | 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>              | No Charge                                              | No Charge                                          | _____none_____                                                                                                                                                          |
|                                                                           | <a href="#">Emergency medical transportation</a> | No Charge                                              | No Charge                                          | _____none_____                                                                                                                                                          |
|                                                                           | <a href="#">Urgent care</a>                      | No Charge                                              | Not Covered.                                       | 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)               | No Charge                                              | Not Covered.                                       | Prior authorization is required, or no benefits will be paid.                                                                                                           |
|                                                                           | Physician/surgeon fees                           | No Charge                                              | Not Covered.                                       |                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No Charge                                              | Not Covered.                                       |                                                                                                                                                                         |
|                                                                           | Inpatient services                               | No Charge                                              | Not Covered.                                       |                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | No Charge                                              | Not Covered.                                       | 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        | No Charge                                              | Not Covered.                                       |                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services            | No Charge                                              | Not Covered.                                       |                                                                                                                                                                         |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No Charge                                              | Not Covered.                                       | 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.                  |
|                                                                           | <a href="#">Rehabilitation services</a>          | No Charge                                              | Not Covered.                                       | Rehabilitative Speech Therapy limited to 30                                                                                                                             |

| Common Medical Event                          | Services You May Need                     | Limitations, Exceptions, & Other Important Information |                                                    |                                                                                                                                                                                                |
|-----------------------------------------------|-------------------------------------------|--------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | Network Provider<br>(You will pay the least)           | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                |
|                                               |                                           |                                                        |                                                    | services per benefit period. Rehabilitative Physical Therapy and Rehabilitative Occupational Therapy limited to 30 combined services per benefit period.                                       |
|                                               | <a href="#">Habilitation services</a>     | No Charge                                              | Not Covered.                                       | 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>      | No Charge                                              | Not Covered.                                       | Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.                                                                                          |
|                                               | <a href="#">Durable medical equipment</a> | No Charge                                              | Not Covered.                                       | Some items may require prior authorization. See your policy for more details.                                                                                                                  |
|                                               | <a href="#">Hospice services</a>          | No Charge                                              | Not Covered.                                       | —————none—————                                                                                                                                                                                 |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | No Charge.                                             | Not Covered.                                       | One (1) refraction visit per Benefit Period.                                                                                                                                                   |
|                                               | Children's glasses                        | No Charge.                                             | Not Covered.                                       | One (1) item per Benefit 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 U.S</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> |

**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: NJ Department of Banking and Insurance. 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 [NJ.gov/GetCoveredNJ](#) 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): Dinek'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.*

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## 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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ 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>\$12,750</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Peg would pay is</b> | <b>\$0</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ 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>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Joe would pay is</b> | <b>\$0</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ 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>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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