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:
What is the overall deductible?	In Network: **$500** person / **$1,000** family. Out of Network: **$10,000** person / **$20,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary care services and Specialist services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. In Network: **$250** Individual / **$500** Family for prescription drug coverage. There are no other specific deductibles.	You must pay all costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In Network: **$4,000** / **$8,000** Out of Network: **$15,000** / **$30,000**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums 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 network provider?	Yes. See www.jeffersonhealthplans.com/individuals-families or call 1-833-422-4690 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine providers are covered in full.
	Specialist visit	$50/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine providers 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 provider if the services needed are preventive. Then check what your plan will pay for
If you have a test	Diagnostic test (x-ray, blood work)	$20/Visit (lab work). $75/Visit (X-Ray)	50% After Deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	$250/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 More information about **prescription drug coverage** is available at [www.jeffersonhealthplans.com/individuals-families]	Generic drugs	Retail/Mail Order (1-30 days supply) $0/Fill for tier 1, $10/fill for tier 2. Rx deductible does not apply.	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	Subject to 50% coinsurance Rx deductible does not apply.	Not Covered.	
	Non-preferred brand	Subject to Rx deductible	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	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)	
	drugs	and 50% coinsurance		
	Specialty drugs	Subject to Rx deductible and 50% coinsurance	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300/visit after deductible	50% After Deductible	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Physician/surgeon fees	10% coinsurance	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	Emergency room care	$450/Visit.	$450/Visit.	——————none——————
	Emergency medical transportation	$200/Visit.	$200/Visit	——————none——————
	Urgent care	$50/Visit.	50% After Deductible	Your costs for urgent care are based on care received at a designated urgent care center or facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	$550/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	10% coinsurance	50% After Deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/Visit.	50% After Deductible	
	Inpatient services	$550/Day after deductible. Max of 5 Copayment(s)/Admissions	50% After Deductible	
If you are pregnant	Office visits	$20/Visit.	50% After Deductible	Depending on the type of service a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	50% After Deductible	

* 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	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)	
	Childbirth/delivery facility services	$550/Day after deductible. Max of 5 Copayment(s)/Admissions	50% After Deductible	
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	$65/Visit for Physical and Occupational Therapy, $65/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.
	Habilitation services	$65/Visit for Physical and Occupational Therapy, $65/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.
	Skilled nursing care	$550/Day after deductible. 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	$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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Private-duty nursing
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Children's dental check-up	• Long Term Care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S	• 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 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, kwiijigo holne'1-833-422-4690.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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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 plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (facility) copayment	**$550**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,260**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (facility) copayment	**$550**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	**$500**
Specialist copayment	**$50**
Hospital (facility) copayment	**$450**
Other coinsurance	**50%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,770**

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

Jefferson Health Plans

Discrimination is Against the Law

Jefferson Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

Jefferson Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Jefferson Health Plans provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Relations at **1-833-422-4690 (TTY 1-877-454-8477).**

If you believe that Jefferson Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Jefferson Health Plans
Attn: Complaints, Grievances & Appeals Unit
1101 Market Street, Suite 3000
Philadelphia, PA 19107
Phone: 1-833-422-4690 (TTY 1-877-454-8477)
Fax: 1-215-991-4105

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or email at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).
OCRMail@hhs.gov

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Jefferson Health Plans is underwritten by Health Partners Plans, Inc., and Partners Insurance Company, Inc., which hold Pennsylvania Licenses as a Health Maintenance Organization, Insurer, and Preferred Provider Organization, Insurer, respectively, and Qualified Health Plan Issuers in the Pennsylvania Health Insurance Marketplace.

Jefferson Health Plans

Notices of Availability

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-422-4690 (TTY 1-877-454-8477) or speak to your provider.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-422-4690 (TTY 1-877-454-8477) o hable con su proveedor.

Chinese; Mandarin
注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-833-422-4690（文本电话：1-877-454-8477）或咨询您的服务提供商。

Nepali
सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि: शुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि नि: शुल्क उपलब्ध छन्। 1-833-422-4690 (TTY 1-877-454-8477) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Russian
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-422-4690 (TTY: 1-877-454-8477) или обратитесь к своему поставщику услуг.

Arabic
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-422-4690 (1-877-454-8477) أو تحدث إلى مقدم الخدمة.

Haitian Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-833-422-4690 (TTY: 1-877-454-8477) oswa pale avèk founisè w la.

Vietnamese
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-422-4690 (Người khuyết tật: 1-877-454-8477) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Ukrainian
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-833-422-4690 (TTY: 1-877-454-8477) або зверніться до свого постачальника.

Chinese; Cantonese
注意：如果您說中文, 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-833-422-4690 (TTY: 1-877-454-8477) 或與您的提供者討論。

Portuguese
ATENÇÃO: Se você fala português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-833-422-4690 (TTY: 1-877-454-8477) ou fale com seu provedor.

Bengali
মনোযোগ দি: দি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-833-422-4690 (TTY: 1-877-454-8477) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

French
ATTENTION: Si vous parlez Français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-422-4690 (TTY: 1-877-454-8477) ou parlez à votre fournisseur.

Cambodian
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃដែរ។ ហៅទូរសព្ទទៅ 1-833-422-4690 (TTY: 1-877-454-8477) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។

Korean
주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-422-4690 (TTY: 1-877-454-8477)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Gujarati
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-833-422-4690 (TTY: 1-877-454-8477) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.