




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 [1-866-500-4571] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For Tier 1: <b>\$7,900</b> Individual / <b>\$15,800</b> Family; For Tier 2: <b>\$9,200</b> Individual / <b>\$18,400</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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For participating <a href="#">providers</a> <b>\$9,200</b> Individual / <b>\$18,400</b> Family.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.jeffersonhealthplans.com/individuals-families">http://www.jeffersonhealthplans.com/individuals-families</a> or call 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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
		In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's office or clinic</a></b>	Primary care visit to treat an injury or illness	\$60/Visit. <a href="#">Deductible</a> does not apply.	\$95/Visit. <a href="#">Deductible</a> does not apply.	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	\$95/Visit. <a href="#">Deductible</a> does not apply.	\$150/Visit. <a href="#">Deductible</a> does not apply.	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/immunization</a>	No Charge.	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$175/Visit for x-ray, \$75/Visit for lab work. <a href="#">Deductible</a> does not apply.	\$250/Visit for x-ray, \$150/Visit for lab work. <a href="#">Deductible</a> does not apply.	Not Covered.	—————none—————
	Imaging (CT/PET scans, MRIs)	\$300/Scan. <a href="#">Deductible</a> does not apply.	\$350/Scan. <a href="#">Deductible</a> does not apply.	Not Covered.	Some services may require prior authorization. See your policy for more details.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">[www.Jeffersonhealthplans.com]</a>	Generic drugs	Retail/Mail Order (1-30 days' supply) \$35/Fill. <a href="#">Deductible</a> does not apply.	Retail/Mail Order (1-30 days' supply) \$35/Fill. <a href="#">Deductible</a> 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	\$150/Fill. <a href="#">Deductible</a> does not apply.	\$150/Fill. <a href="#">Deductible</a> does not apply.	Not Covered.	
	Non-preferred brand drugs	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Not Covered.	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	
	<a href="#">Specialty drugs</a>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to <a href="#">deductible</a> and \$750/Visit.	Subject to <a href="#">deductible</a> and \$900/Visit.	Not Covered.	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Physician/surgeon fees	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	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>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Covered at in-network level.	_____none_____
	<a href="#">Emergency medical transportation</a>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Covered at in-network level.	_____none_____
	<a href="#">Urgent care</a>	\$95/Visit. <a href="#">Deductible</a> does not apply.	\$150/Visit. <a href="#">Deductible</a> does not apply.	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)	Subject to <a href="#">deductible</a> and \$850/Day. Max of 5 <a href="#">Copayment</a> (s)/ Admission.	Subject to <a href="#">deductible</a> and \$1,000/Day. Max of 5 <a href="#">Copayment</a> (s)/ Admission.	Not Covered.	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 0% <a href="#">coinsurance</a> .	Not Covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$95/Visit for office visit. <a href="#">Deductible</a> does not apply.	\$95/Visit for office visit. <a href="#">Deductible</a> does not apply.	Not Covered.	_____none_____
	Inpatient services	Subject to <a href="#">deductible</a> and \$850/Day. Max of 5 <a href="#">Copayment</a> (s)/ Admission.	Subject to <a href="#">deductible</a> and \$850/Day. Max of 5 <a href="#">Copayment</a> (s)/ Admission.	Not Covered.	_____none_____

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$60/Visit. <a href="#">Deductible</a> does not apply.	\$95/Visit. <a href="#">Deductible</a> does not apply.	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	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 0% <a href="#">coinsurance</a> .	Not Covered.	—————none—————
	Childbirth/delivery facility services	Subject to <a href="#">deductible</a> and \$850/Day. Max of 5 <a href="#">Copayment(s)</a> / Admission.	Subject to <a href="#">deductible</a> and \$1,000/Day. Max of 5 <a href="#">Copayment(s)</a> / Admission.	Not Covered.	—————none—————
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	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>	\$135/Visit for Physical and Occupational Therapy, \$135/Visit for Speech Therapy. <a href="#">Deductible</a> does not apply.	\$150/Visit for Physical and Occupational Therapy, \$150/Visit for Speech Therapy. <a href="#">Deductible</a> does not apply.	Not Covered.	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>	\$135/Visit for Physical and Occupational Therapy, \$135/Visit for Speech Therapy. <a href="#">Deductible</a> does not apply.	\$150/Visit for Physical and Occupational Therapy, \$150/Visit for Speech Therapy. <a href="#">Deductible</a> does not apply.	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>	Subject to <a href="#">deductible</a> and \$850/Day. Max	Subject to <a href="#">deductible</a> and \$1000/Day. Max	Not Covered.	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	
		of 5 <a href="#">Copayment</a> (s)/ Admission.	of 5 <a href="#">Copayment</a> (s)/ Admission.		be paid.
	<a href="#">Durable medical equipment</a>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 0% <a href="#">coinsurance</a> .	Not Covered.	Some items may require prior authorization. See your policy for more details.
	<a href="#">Hospice services</a>	Subject to <a href="#">deductible</a> and 50% <a href="#">coinsurance</a> .	Subject to <a href="#">deductible</a> and 0% <a href="#">coinsurance</a> .	Not Covered.	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge.	No Charge.	Not Covered.	One (1) refraction visit per benefit period.
	Children's glasses	No Charge.	No Charge.	Not Covered.	3 pairs of glasses (lenses/frames) or contacts per calendar year.
	Children's dental check-up	Not Covered.	Not Covered.	Not Covered.	Not Covered.

**Excluded Services & Other Covered Services:**

<b>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>.)</b>		
<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>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Abortion</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (only covered for artificial insemination)</li> </ul>

**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, 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 [plan's](#) overall [deductible](#) \$7,900
- [Specialist copayment](#) \$95
- Hospital (facility) [copayment](#) \$850
- Other [coinsurance](#) 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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$4,403
<a href="#">Copayments</a>	\$3,600
<a href="#">Coinsurance</a>	\$1,198

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$9,260</b>
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**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$7,900
- [Specialist copayment](#) \$95
- Hospital (facility) [copayment](#) \$850
- Other [copayment](#) \$45

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>\$7,800</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$864
<a href="#">Copayments</a>	\$6,100
<a href="#">Coinsurance</a>	\$864

<i>What isn't covered</i>	
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Limits or exclusions	\$55
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<b>The total Joe would pay is</b>	<b>\$7,888</b>
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**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$7,900
- [Specialist copayment](#) \$95
- Hospital (facility) [copayment](#) 50%
- Other [copayment](#) \$175

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$693
<a href="#">Copayments</a>	\$1,085
<a href="#">Coinsurance</a>	\$693

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,471</b>
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.