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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In Network: \$0 person / \$0 family. Out of Network: not covered.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , Primary care services and <u>Specialist</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/.</u>
Are there other deductibles for specific services?	No, there are no other specific deductibles.	You must pay all costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In Network: \$0 / \$0. Out of Network: not covered.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limits.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.jeffersonhealthplans.com/individ uals-families or call 1-833-422-4690 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays <u>(balance billing)</u> . Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

		Limitation	t Information		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
	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 providers are covered in full.	
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	No Charge	Not Covered.	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	Not Covered.	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for	
If you have a test	Diagnostic test (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	Generic drugs	No Charge	Not Covered.		
treat your illness or condition	Preferred brand drugs	No Charge	Not Covered.	Prior authorization, age, and quantity limits	
More information about prescription	Non-preferred brand drugs	No Charge	Not Covered.	for some drugs; days supply limits on retail & mail order. See your policy for more	
drug coverage is available at [www.jeffersonhealthpl ans.com/individuals-	Specialty drugs	No Charge	Not Covered.	detail. Low-Cost Generics will be available at a reduced cost.	

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

		Limitation	t Information	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
families]				
lf you have	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.
outpatient surgery	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.
	Emergency room care	No Charge	No Charge	none
lf you need	Emergency medical transportation	No Charge	No Charge	none
immediate medical attention	<u>Urgent care</u>	No Charge	Not Covered.	Your costs for <u>urgent care</u> are based on care received at a designated <u>urgent care</u> center or facility.
If you have a	Facility fee (e.g., hospital room)	No Charge	Not Covered.	Prior authorization is required, or no
hospital stay	Physician/surgeon fees	No Charge	Not Covered.	benefits will be paid.
lf you need mental health, behavioral	Outpatient services	No Charge	Not Covered.	
health, or substance abuse services	Inpatient services	No Charge	Not Covered.	
lf you are pregnant	Office visits	No Charge	Not Covered.	Depending on the type of service a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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	Home health care	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.
needs	Rehabilitation services	No Charge	Not Covered.	Rehabilitative Speech Therapy limited to 30

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

		Limitatior	t Information	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				services per benefit period. Rehabilitative Physical Therapy and Rehabilitative Occupational Therapy limited to 30 combined services per benefit period.
	Habilitation services	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.
	Skilled nursing care	No Charge	Not Covered.	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.
	Durable medical equipment	No Charge	Not Covered.	Some items may require prior authorization. See your policy for more details.
	Hospice services	No Charge	Not Covered.	none
If your child needs	Children's eye exam	No Charge.	Not Covered.	One (1) refraction visit per Benefit Period.
dental or eye care	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 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: NJ Department of Banking and Insurance. Other coverage options may be available to you, too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact the Plan at 1-833-422-4690.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-422-4690.

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

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

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

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

\$0

\$0

0%

0%

Peg is Having a Baby
9 months of in-network pre-natal care and a
hospital delivery)

\$0

\$0 0%

0%

The <u>plan's</u> overall <u>deductible</u>
Specialist copayment
Hospital (facility) coinsurance
Other coinsurance

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

Total Example Cost	\$12,750
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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

The plan's overall deductible
Specialist copayment
Hospital (facility) coinsurance
Other <u>coinsurance</u>

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

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

The plan's overall deductible	\$0
Specialist copayment	\$0
Hospital (facility) coinsurance	0%
Other <u>coinsurance</u>	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)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

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