



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: <b>\$10,000</b> person / <b>\$20,000</b> family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , Primary care services and <a href="#">Specialist</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. In Network: <b>\$500</b> Individual / <b>\$1,000</b> Family for prescription drug coverage. There are no other specific <a href="#">deductibles</a> .	You must pay all costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In Network: <b>\$1,250</b> / <b>\$2,500</b> & Out of Network: <b>\$15,000</b> / Out of Network: <b>\$30,000</b> For Participating <a href="#">providers</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limits</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.jeffersonhealthplans.com/individuals-families">www.jeffersonhealthplans.com/individuals-families</a> or call 1-833-422-4690 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$5/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <a href="#">providers</a> are covered in full.
	<a href="#">Specialist</a> visit	\$20/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine <a href="#">providers</a> are covered in full.
	<a href="#">Preventive care/screening/</a> Immunization	No charge.	50% After Deductible	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10/Visit (lab work). \$50/Visit (X-Ray)	50% After Deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	\$100/Scan	50% After Deductible	Some services may require prior authorization. See your policy for more details
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at [www.jeffersonhealthplans.com/individuals-families]	Generic drugs	Retail/Mail Order (1-30 days supply) \$0/Fill for tier 1, \$0/fill for tier 2.	Not Covered.	Prior authorization, age, and quantity limits for some drugs; days supply limits on retail & mail order. See your policy for more detail. Low-Cost Generics will be available at a reduced cost.
	Preferred brand drugs	\$20	Not Covered.	
	Non-preferred brand drugs	50%	Not Covered.	
	<a href="#">Specialty drugs</a>	50% After Rx Deductible.	Not Covered.	
<b>If you have outpatient</b>	Facility fee (e.g., ambulatory surgery)	\$250/visit.	50% After Deductible	Some services may require prior authorization, or no benefits will be paid. See your policy for more

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	center)			details.
	Physician/surgeon fees	0% coinsurance.	50% After Deductible	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500/Visit.	\$500/Visit.	—————none—————
	<a href="#">Emergency medical transportation</a>	\$200/Visit.	\$200/Visit	—————none—————
	<a href="#">Urgent care</a>	\$20/Visit.	50% After Deductible	Your costs for <a href="#">urgent care</a> are based on care received at a designated <a href="#">urgent care</a> center or facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350/Day. Max of 5 Copayment(s)/ Admission.	50% After Deductible	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	0% coinsurance.	50% After Deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20/Visit.	50% After Deductible	
	Inpatient services	\$350/Day. 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 <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% Coinsurance.	50% After Deductible	
	Childbirth/delivery facility services	\$350/Day. Max of 5 Copayment(s)/Admissions	50% After Deductible	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% Coinsurance.	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.
	<a href="#">Rehabilitation services</a>	\$20 Visit for Physical and	50% After Deductible	Rehabilitative Speech Therapy limited to 30 services

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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)	
		Occupational Therapy, \$20/Visit for Speech Therapy.		per benefit period. Rehabilitative Physical Therapy and Rehabilitative Occupational Therapy limited to 30 combined services per benefit period.
	<a href="#">Habilitation services</a>	\$20/Visit for Physical and Occupational Therapy, \$20/Visit for Speech Therapy.	50% After Deductible	Habilitative Speech Therapy limited to 30 services per benefit period. Habilitative Physical Therapy and Habilitative Occupational Therapy limited to 30 combined services per benefit period.
	<a href="#">Skilled nursing care</a>	\$350/Day. Max of 5 Copayment(s) / Admissions	50% After Deductible	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.
	<a href="#">Durable medical equipment</a>	50% Coinsurance.	50% After Deductible	Some items may require prior authorization. See your policy for more details.
	<a href="#">Hospice services</a>	50% Coinsurance.	50% After Deductible	—————none—————
<b>If your child needs dental or eye care</b>	Children’s eye exam	\$0	50% After Deductible	One (1) refraction visit per Benefit Period.
	Children’s glasses	\$0	50% After Deductible	3 pairs of glasses (lenses/frames) or contacts per Calendar Year.
	Children’s dental check-up	Not Covered.	Not Covered.	Not Covered.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Children’s dental check-up</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the 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>

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**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, 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](#) \$0
- [Specialist copayment](#) \$20/Visit
- Hospital (facility) [copayment](#) \$350/Day
- 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>\$13,405</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$580
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$640</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20/Visit
- Hospital (facility) [copayment](#) \$350/Day
- Other [coinsurance](#) 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>\$8,216</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$265
<a href="#">Copayments</a>	\$160
<a href="#">Coinsurance</a>	\$825
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,305</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20/Visit
- Hospital (facility) [copayment](#) \$350/day
- Other [coinsurance](#) 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>\$2,408</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$18
<a href="#">Copayments</a>	\$790
<a href="#">Coinsurance</a>	\$18
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$827</b>

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