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 deductible?	For Tier 1: \$8,500 Individual / \$15,800 Family; For Tier 2: \$9,200 Individual / \$18,400 Family.	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 deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	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> ?	For participating providers \$9,200 Individual / \$18,400 Family.	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 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 <u>network provider</u> ?	Yes. See http://www.jeffersonhealthplans.co m/individuals-families or call 833-422-4690 for a list of network providers .	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 specialist you choose without a referral.

			What You Will Pay			
Common Medical Event	Services You May Need	In-Network Tier 1 - Enhanced (You will pay the least)	Enhanced (You will Standard (You will pay the		Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	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 provider's	Specialist visit	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	Not Covered.	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine providers are covered in full.	
office or clinic	Preventive care/screening/immunization	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
	Diagnostic test (x-ray, blood work)	Subject to deductible and 0% coinsurance.	Subject to deductible and 0% coinsurance.	Not Covered.	none	
If you have a test	Imaging (CT/PET scans, MRIs)	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	Subject to <u>deductible</u> and 0% <u>coinsurance</u> .	Not Covered.	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.Jeffersonhealt hplans.com]	Generic drugs	Retail/Mail Order (1-30 days' supply) \$35/Fill. <u>Deductible</u> does not apply.	Retail/Mail Order (1-30 days' supply) \$35/Fill. <u>Deductible</u> does not apply.	Not Covered.	Prior authorization, age, and quantity limits for some drugs; days' supply limits on retail	
	Preferred brand drugs	Subject to deductible and 0% coinsurance	Subject to deductible and 0% coinsurance	Not Covered.	& mail order. See your policy for more detail. Low-cost generics will be available at	
	Non-preferred brand drugs	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to deductible and 0% coinsurance	Not Covered.	a reduced cost.	
	Specialty drugs	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.		

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at http://www.jeffersonhealthplans.com/individuals-families.

			What You Will Pay		
Common Medical Event	Services You May Need	In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have	Facility fee (e.g., ambulatory surgery center)	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	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	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Emergency room care	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Covered at in- network level.	none
If you need immediate medical attention	Emergency medical transportation	Subject to deductible and 0% coinsurance	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Covered at in- network level.	none
auention	Urgent care	Subject to deductible and 0% coinsurance	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	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)	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	Prior authorization is required, or no benefits
hospital stay	Physician/surgeon fees	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	will be paid.
If you need mental	Outpatient services	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	none
health, behavioral health, or substance abuse services	Inpatient services	Subject to deductible and 0% coinsurance	Subject to deductible and 0% coinsurance	Not Covered.	none
If you are pregnant	Office visits	Subject to deductible and 0% coinsurance	Subject to deductible and 0% coinsurance	Not Covered.	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	Subject to deductible	Subject to deductible	Not Covered.	none

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{http://www.jeffersonhealthplans.com/individuals-families}}$.

			What You Will Pay		
Common Medical Event	Services You May Need	In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	professional services	and 0% coinsurance	and 0% coinsurance		
	Childbirth/delivery facility services	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	none
	Home health care	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	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.
	Rehabilitation services	Subject to Subject to deductible and 0% coinsurance for Physical, Occupational and Speech Therapy.	Subject to Subject to deductible and 0% coinsurance for Physical, Occupational and Speech Therapy.	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.
If you need help recovering or have other special health needs	Habilitation services	Subject to Subject to deductible and 0% coinsurance for Physical, Occupational and Speech Therapy.	Subject to Subject to deductible and 0% coinsurance for Physical, Occupational and Speech Therapy.	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	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.
	Durable medical equipment	Subject to deductible and 0% coinsurance	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	Some items may require prior authorization. See your policy for more details.
	Hospice services	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Subject to <u>deductible</u> and 0% <u>coinsurance</u>	Not Covered.	none
If your child needs	Children's eye exam	No Charge.	No Charge.	Not Covered.	One (1) refraction visit per benefit period.
dental or eye care	Children's glasses	No Charge.	No Charge.	Not Covered.	3 pairs of glasses (lenses/frames) or contacts per calendar year.
	Children's dental	Not Covered.	Not Covered.	Not Covered.	Not Covered.

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{http://www.jeffersonhealthplans.com/individuals-families}}$.

			What You Will Pay		
Common Medical Event	Services You May Need	In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	check-up				

Excluded Services & Other Covered Services:

Se	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	•	Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

U.S

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 <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 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].]

^{*} For more information about limitations rappe sceptions is see the plan propolicy document at http://www.rieffersonbealthelaps.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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$8,500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ 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)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$8,500	
Copayments	\$140	
Coinsurance	\$4	
What isn't covered		
Limits or exclusions	\$0	
The total Peg would pay is	\$8,644	

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$8,500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$8,800
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$6,556
Copayments	\$1085
Coinsurance	\$6
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$7,648

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$8,500
■ Specialist copayment	\$0
■ Hospital (facility) copayment	\$0
■ Other copayment	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,923	
Copayments	\$0	
Coinsurance	\$2	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,925	

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.