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: **$0** Individual / **$0** Family; For Tier 2: **$500** Individual / **$1,000** 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?	No.	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?	For participating providers **$9,200** Individual / **$18,400** Family.	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
		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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/Visit. Deductible does not apply.	$75/Visit. Deductible does not apply.	Not Covered.	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine providers are covered in full.
	Specialist visit	$75/Visit. Deductible does not apply.	$100/Visit. Deductible does not apply.	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.	No Charge.	Not Covered.	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)	$80/Visit for x-ray, $5/Visit for lab work. Deductible does not apply.	$120/Visit for x-ray, $65/Visit for lab work. Deductible does not apply.	Not Covered.	——————none——————
	Imaging (CT/PET scans, MRIs)	$120/Scan. Deductible does not apply.	$150/Scan. Deductible does not apply.	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.Jeffersonhealthplans.com]	Generic drugs	Retail/Mail Order (1-30 days' supply) $20/Fill. Deductible does not apply.	Retail/Mail Order (1-30 days' supply) $20/Fill. 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	$100/Fill. Deductible does not apply.	$100/Fill. Deductible does not apply.	Not Covered.	
	Non-preferred brand drugs	Subject to deductible and 50% coinsurance.	Subject to deductible and 50% coinsurance.	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
		In-Network Tier 1 - Enhanced (You will pay the least)	In-Network Tier 2 - Standard	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Subject to deductible and 50% coinsurance.	Subject to deductible and 50% coinsurance.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible and $200/Visit.	Subject to deductible and $300/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 deductible and 10% coinsurance.	Subject to deductible and 25% coinsurance.	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	Emergency room care	$450/Visit. Deductible does not apply.	$450/Visit. Deductible does not apply.	Covered at in-network level.	——————none——————
	Emergency medical transportation	$150/Visit. Deductible does not apply.	$150/Visit. Deductible does not apply.	Covered at in-network level.	——————none——————
	Urgent care	$75/Visit. Deductible does not apply.	$100/Visit. Deductible does not apply.	Not Covered.	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)	Subject to deductible and $350/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $550/Day. Max of 5 Copayment(s)/ Admission.	Not Covered.	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	Subject to deductible and 10% coinsurance.	Subject to deductible and 25% coinsurance.	Not Covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75/Visit for office visit. Deductible does not apply.	$75/Visit for office visit. Deductible does not apply.	Not Covered.	——————none——————
	Inpatient services	Subject to deductible and $350/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $350/Day. Max of 5 Copayment(s)/ Admission.	Not Covered.	——————none——————

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	$25/Visit. Deductible does not apply.	$75/Visit. Deductible does not apply.	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 professional services	Subject to deductible and 10% coinsurance.	Subject to deductible and 25% coinsurance.	Not Covered.	——————none——————
	Childbirth/delivery facility services	Subject to deductible and $350/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $550/Day. Max of 5 Copayment(s)/ Admission.	Not Covered.	——————none——————
If you need help recovering or have other special health needs	Home health care	Subject to deductible and 50% coinsurance.	Subject to deductible and 50% coinsurance.	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	$75/Visit for Physical and Occupational Therapy, $75/Visit for Speech Therapy. Deductible does not apply.	$100/Visit for Physical and Occupational Therapy, $100/Visit for Speech Therapy. Deductible 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.
	Habilitation services	$75/Visit for Physical and Occupational Therapy, $75/Visit for Speech Therapy. Deductible does not apply.	$100/Visit for Physical and Occupational Therapy, $100/Visit for Speech Therapy. Deductible 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.
	Skilled nursing care	$350/Day. Max of 5 Copayment(s)/ Admission. Deductible does not	$550/Day. Max of 5 Copayment(s)/ Admission. Deductible does not	Not Covered.	Limited to 120 days per benefit period. Prior authorization is required, or no benefits will be paid.

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)	
		apply.	apply.		
	Durable medical equipment	Subject to deductible and 50% coinsurance.	Subject to deductible and 50% coinsurance.	Not Covered.	Some items may require prior authorization. See your policy for more details.
	Hospice services	Subject to deductible and 50% coinsurance.	Subject to deductible and 50% coinsurance.	Not Covered.	——————none——————
If your child needs dental or eye care	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:

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
- Bariatric surgery
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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].

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

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.*

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	**$75**
Hospital (facility) copayment	**$350**
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	$0
Copayments	$3,170
Coinsurance	$239
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,469**

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	**$75**
Hospital (facility) copayment	**$350**
Other copayment	**$25**

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	**$5,700**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$4,245
Coinsurance	$864
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$5,164**

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

The plan's overall deductible	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$150**
Other copayment	**$80**

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	$0
Copayments	$785
Coinsurance	$470
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$955**

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