Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period:01/01/2025 – 12/31/2025**
Jefferson Health Plans + $0 Deductible + Silver + PPO + 94%
Coverage for: Family| Plan Type: PPO

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:
What is the overall deductible?	In Network: **$0** person / **$0** family. Out of Network: **$5,000** person / **$10,000** 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?	Not Applicable.	Not Applicable.
Are there other deductibles for specific services?	Yes. In Network: **$500** Individual / **$1,000** Family for prescription drug coverage. There are no other specific deductibles.	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?	In Network: **$1,250** / **$2,500** & Out of Network: **$15,000** / Out of Network: **$30,000** For Participating providers	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
		Network Provider (You will pay the least)	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	$0/Visit	50% After Deductible	Cost share applies to both in-person and virtual services. Virtual care services from Jefferson designated telemedicine providers are covered in full.
	Specialist visit	$25/Visit	50% After Deductible	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.	50% After Deductible	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)	$15/Visit (lab work). $75/Visit (X-Ray)	50% After Deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	$125/Scan	50% After Deductible	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/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	$25/fill	Not Covered.	
	Non-preferred brand drugs	50%	Not Covered.	
	Specialty drugs	50% After Rx Deductible	Not Covered.	
If you have outpatient	Facility fee (e.g., ambulatory surgery	$300/visit	50% After Deductible	Some services may require prior authorization, or no benefits will be paid. See your policy for more

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	10% 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	Emergency room care	$500/Visit.	$500/Visit.	——————none——————
	Emergency medical transportation	$200/Visit.	$200/Visit	——————none——————
	Urgent care	$20/Visit.	50% After Deductible	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)	$400/Day. Max of 5 Copayment(s)/ Admission.	50% After Deductible	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	10% coinsurance	50% After Deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/Visit.	50% After Deductible	
	Inpatient services	$400/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 copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	50% After Deductible	
	Childbirth/delivery facility services	$400/Day. Max of 5 Copayment(s)/Admissions	50% After Deductible	
If you need help recovering or have other special health needs	Home health care	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.
	Rehabilitation services	$25 Visit for Physical and	50% After Deductible	Rehabilitative Speech Therapy limited to 30 services

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, $25/Visit for Speech Therapy.		per benefit period. Rehabilitative Physical Therapy and Rehabilitative Occupational Therapy limited to 30 combined services per benefit period.
	Habilitation services	$25/Visit for Physical and Occupational Therapy, $25/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.
	Skilled nursing care	$400/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.
	Durable medical equipment	50% Coinsurance	50% After Deductible	Some items may require prior authorization. See your policy for more details.
	Hospice services	50% Coinsurance	50% After Deductible	——————none——————
If your child needs dental or eye care	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 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

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

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, 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	**$20/Visit**
Hospital (facility) copayment	**$400/Day**
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	**$13,405**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$730
Coinsurance	$478
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,268**

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	**$500/Day**
Other coinsurance	**10%**

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	**$8,216**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$354
Copayments	$520
Coinsurance	$376
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,305**

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

The plan's overall deductible	**$0**
Specialist copayment	**$65/Visit**
Hospital (facility) copayment	**$500/day**
Other coinsurance	**10%**

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	**$2,408**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$18
Copayments	$835
Coinsurance	$137
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$990**

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