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 1-844-864-4352 or visit us at www.ibx.com. For 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 1-844-864-4352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: Jefferson & Affiliates Network **$100** person / **$300** family, Tier 2: Preferred Pediatric Network **$125** person / **$375** family, Tier 3: Independence Administrators **$1,000** person / **$3,000** family. Tier 4: Out-of-Network: **$3,000** person / **$9,000** 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. Tier 1, Tier 2, & Tier 3 providers' office visits, preventive care, prescription drugs, emergency care, and services that require a copay 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?	Yes. **$100** person / **$200** family deductible for prescription drug coverage. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: Jefferson & Affiliates Network providers **$1,750** person / **$3,500** family, Tier 2: Preferred Pediatric Network **$1,750** person / **$3,500** family, Tier 3: Independence Administrators **$2,500** person / **$5,000** family. Tier 4: Out-of-Network providers: **unlimited**. Prescription drugs: **$1,000** person / **$2,000** 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, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.ibx.com or call: 1-844-864-4352** for a list of **Jefferson 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
		Tier 1: Jefferson & Affiliates Network	Tier 2: Preferred Pediatric Network	Tier 3: Independence Administrators Network	Tier 4: Out-of-Network Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit Deductible waived	$20 copay per visit Deductible waived	$75 copay per visit Deductible waived	50% coinsurance	Telemedicine is included with applicable copay, deductible, or coinsurance.
	Specialist visit	$25 copay per visit Deductible waived	$50 copay per visit Deductible waived	$120 copay per visit Deductible waived	50% coinsurance	---None---
	Preventive care/ screening/immunization	No Charge Deductible waived	No Charge Deductible waived	No Charge Deductible waived	50% coinsurance except deductible doesn't apply to mammograms	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge Deductible waived	Deductible waived. $30 copay per visit for lab and radiology.	Deductible waived $45 copay per visit for lab work. $65 copay per visit for radiology.	50% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	Jefferson-owned pharmacy: $15 copay Retail Pharmacy Non-Maintenance: $20 copay Maintenance medications (Jefferson-owned): $30 copay Maintenance Medications (Non-Specialty): $40 copay			Not covered	Deductible does not apply to Generic drugs; Retail Pharmacy Non-Maintenance is up to a 30-day supply; Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs; Weight loss medications (including but not limited to Wegovy and Saxenda) have a $60 copay after deductible and Mounjaro for weight loss has a $40 copay after deductible that can only be filled at Jefferson Specialty pharmacy and is limited to a 30-day supply per fill. Note: Step Therapy and Prior Authorization may be required.
	Preferred brand drugs	Jefferson-owned pharmacy: $40 copay after deductible Retail Pharmacy Non-Maintenance: 20% coinsurance after deductible ($40 min. - $100 max.) Maintenance medications (Jefferson-owned): 20% coinsurance after deductible ($100 max.) Maintenance Medications (Non-Specialty): 25% coinsurance after deductible ($125 max.)			Not covered	
	Non-preferred drugs	Jefferson-owned pharmacy: $60 copay after deductible Retail Pharmacy Non-Maintenance: 40% coinsurance after deductible ($60 min. - $150 max.) Maintenance medications (Jefferson-owned): 40% coinsurance after deductible ($150 max.) Maintenance Medications (Non-Specialty): 45% coinsurance after deductible ($175 max.)			Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates Network	Tier 2: Preferred Pediatric Network	Tier 3: Independence Administrators Network	Tier 4: Out-of-Network Providers	
	Specialty drugs	Your cost is reduced to a $0 copay if opting into the PrudentRx Copay Program, otherwise 30% coinsurance.			Not covered	PrudentRx will contact impacted members directly.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	---None---
	Physician/surgeon fees	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	---None---
If you need immediate medical attention	Emergency room care	$250 copay per visit Deductible waived	$250 copay per visit Deductible waived	$250 copay per visit Deductible waived	$250 copay per visit Deductible waived	Copay is waived if admitted. Tier 4 out-of-network providers emergency use paid the same as in-network (Tier 1, Tier 2, Tier 3 providers). No coverage for non-emergency use.
	Emergency medical transportation	No Charge Deductible waived	No Charge Deductible waived	No Charge Deductible waived	No Charge Deductible waived	Tier 4 out-of-network providers emergency use paid the same as in-network (Tier 1, Tier 2, Tier 3). Non-emergency: 20% coinsurance for in-network (Tier 1, Tier 2, Tier 3); deductible does not apply. 50% coinsurance for out-of-network (Tier 4).
	Urgent care	$30 copay per visit Deductible waived	$55 copay per visit Deductible waived	$55 copay per visit Deductible waived	50% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	Precertification may be required. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.
	Physician/surgeon fees	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	---None---

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates Network	Tier 2: Preferred Pediatric Network	Tier 3: Independence Administrators Network	Tier 4: Out-of-Network Providers	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible waived $5 copay per visit for office counseling. $25 copay per visit for medication management.	Deductible waived $20 copay per visit for office counseling. $50 copay per visit for medication management. No charge for other outpatient services.	Deductible waived $75 copay per visit for office visits. $120 copay per visit for medication management; no charge for other services.	50% coinsurance	---None---
	Inpatient services	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	Precertification may be required. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates Network	Tier 2: Preferred Pediatric Network	Tier 3: Independence Administrators Network	Tier 4: Out-of-Network Providers	
If you are pregnant	Office visits	$25 copay for initial visit only; deductible waived.	$50 copay for initial visit only; deductible waived.	$120 copay for initial visit only; deductible waived.	50% coinsurance	Cost-sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification may be required for inpatient maternity services. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.
	Childbirth/delivery professional services	No Charge Deductible waived	10% coinsurance	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	Limited to 120 visits per calendar year. Precertification may be required. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.
	Rehabilitation services	$20 copay per visit Deductible waived	$40 copay per visit Deductible waived	$75 copay per visit Deductible waived	50% coinsurance	Limited to 60 visits per calendar year for Physical, Occupational, & Speech therapies combined, including outpatient hospital services.
	Habilitation services	$20 copay per visit Deductible waived	$40 copay per visit Deductible waived	$75 copay per visit Deductible waived	50% coinsurance	---None---
	Skilled nursing care	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	Limited to 120 days per calendar year. Precertification may be required. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.
	Durable medical equipment	No Charge Deductible waived	10% coinsurance Deductible waived	10% coinsurance Deductible waived	50% coinsurance	Durable medical equipment limited to one for same/similar purpose. Diabetic equipment and supplies covered at 100% (this does not include insulin or other diabetic medications). Excludes repairs for misuse/abuse.
	Hospice services	No Charge after deductible	10% coinsurance	40% coinsurance	50% coinsurance	Precertification may be required. There is a penalty of 50% of allowed amount for failure to precertify for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates Network	Tier 2: Preferred Pediatric Network	Tier 3: Independence Administrators Network	Tier 4: Out-of-Network Providers	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered	---None---
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	---None---
	Children's dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	---None---

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
- Cosmetic surgery
- Dental care (Adult)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Bariatric surgery (One surgery per lifetime for Jefferson providers only)
- Chiropractic care (30 visits per calendar year)
- Hearing Aids (One hearing aid per ear per 36 months)
- Infertility Treatment (Limitations may apply)
- Weight loss programs

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 www.HealthCare.gov or call 1-800-318-2596.

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: 1-844-864-4352 or www.ibx.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **Yes**
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 1-844-864-4352.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-864-4352.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-864-4352.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-864-4352.

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	$100
Specialist copayment	$25
Hospital (facility) no cost sharing	$0
Other no cost sharing	$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	
Deductibles	$100
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$200**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) no cost sharing	$0
Other no cost sharing	$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$3,690**

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

The plan's overall deductible	$100
Specialist copayment	$25
Hospital (facility) no cost sharing	$0
Other no cost sharing	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$610**

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