



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:
<p>What is the overall deductible?</p>	<p>Tier 1: Jefferson & Affiliates Network \$1,800 person / \$4,500 family, Tier 2: Preferred Pediatric Network \$1,800 person / \$4,500 family. Tier 3: Independence Administrators \$2,500 person / \$6,250 family. Tier 4: Out-of-Network \$6,000 person / \$18,000 family.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care is covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Tier 1: Jefferson & Affiliates Network \$3,600 person / \$9,000 family, Tier 2: Preferred Pediatric Network \$3,600 person / \$9,000 family, Tier 3: Independence Administrators \$5,000 person / \$12,500 family, Tier 4: Out-of-Network unlimited.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.ibx.com or call: 1-844-864-4352 for a list of Preferred providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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	No Charge after deductible	No Charge after deductible	\$10 copay per visit after deductible	50% coinsurance	---None---
	Specialist visit	\$20 copay per visit after deductible	\$30 copay per visit after deductible	\$40 copay per visit after deductible	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 after deductible	10% coinsurance	30% coinsurance	50% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	10% coinsurance	30% 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 after deductible Retail Pharmacy Non-Maintenance: \$20 copay after deductible Maintenance medications (Jefferson-owned): \$30 copay after deductible Maintenance Medications (Non-Specialty): \$40 copay after deductible			Not covered	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	
	Specialty drugs	30% coinsurance after deductible			Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates <u>Network</u>	Tier 2: Preferred Pediatric <u>Network</u>	Tier 3: Independence Administrators <u>Network</u>	Tier 4: <u>Out-of-Network Providers</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	10% coinsurance	30% coinsurance	50% coinsurance	---None---
	Physician/surgeon fees	No Charge after deductible	10% coinsurance	30% coinsurance	50% coinsurance	---None---
If you need immediate medical attention	Emergency room care	\$250 copay per visit after deductible	\$250 copay per visit after Tier 1 deductible	\$250 copay per visit after Tier 1 deductible	\$250 copay per visit after Tier 1 deductible	Copay is waived if admitted. Tier 4 provider network emergency use paid the same as in-network (Tier 1, Tier 2, Tier 3). No coverage for non-emergency use.
	Emergency medical transportation	No Charge after deductible	No Charge after Tier 1 deductible	No Charge after Tier 1 deductible	No Charge after Tier 1 deductible	Non-emergency: no charge after deductible (Tier 1); 10% coinsurance after deductible (Tier 2); 30% coinsurance after deductible (Tier 3); and 50% coinsurance out-of-network (Tier 4).
	Urgent care	No Charge after deductible	10% coinsurance	30% coinsurance	50% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	10% coinsurance	30% 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	30% coinsurance	50% coinsurance	---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible for office counseling & other outpatient services. \$20 copay per visit after deductible for medication management.	No Charge after deductible \$30 copay per visit after deductible for medication management.	\$10 copay per visit after deductible. \$40 copay per visit after deductible for medication management.	50% coinsurance	---None---
	Inpatient services	No Charge after deductible	10% coinsurance	30% 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.

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		Tier 1: Jefferson & Affiliates <u>Network</u>	Tier 2: Preferred Pediatric <u>Network</u>	Tier 3: Independence Administrators <u>Network</u>	Tier 4: <u>Out-of-Network Providers</u>	
If you are pregnant	Office visits	No Charge after <u>deductible</u> for initial visit only.	10% <u>coinsurance</u> for initial visit only	30% <u>coinsurance</u> for initial visit only	50% <u>coinsurance</u>	<p><u>Cost-sharing</u> does not apply for <u>preventive services</u>. 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 <u>allowed amount</u> for failure to precertify for out-of-network care.</p>
	Childbirth/delivery professional services	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 visits per calendar year. Precertification may be required. There is a penalty of 50% of <u>allowed amount</u> for failure to precertify for out-of-network care.
	<u>Rehabilitation services</u>	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 60 visits per calendar year for Physical, Occupational, & Speech therapies combined, including outpatient hospital services.
	<u>Habilitation services</u>	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---None---
	<u>Skilled nursing care</u>	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 days per calendar year. Precertification may be required. There is a penalty of 50% of <u>allowed amount</u> for failure to precertify for out-of-network care.
	<u>Durable medical equipment</u>	No Charge after <u>deductible</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Durable medical equipment</u> 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1: Jefferson & Affiliates <u>Network</u>	Tier 2: Preferred Pediatric <u>Network</u>	Tier 3: Independence Administrators <u>Network</u>	Tier 4: <u>Out-of-Network Providers</u>	
	Hospice services	No Charge after deductible	10% coinsurance	30% 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.
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](#).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing Aids • Long Term Care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery (One surgery per lifetime for Jefferson providers only) • Chiropractic care (30 visits per calendar year) | <ul style="list-style-type: none"> • Infertility Treatment (Limited to diagnosis & treatment of underlying medical condition) | <ul style="list-style-type: none"> • 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, kwijigo 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](#) \$1,800
- [Specialist copayment](#) \$20
- 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	\$1,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$1,870

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist copayment](#) \$20
- 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	\$1,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,500
The total Joe would pay is	\$5,300

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

- The [plan's](#) overall [deductible](#) \$1,800
- [Specialist copayment](#) \$20
- 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	\$1,800
Copayments	\$60
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,870

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