



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, go to <https://www.jibe.org/> or call 1-718-591-2000. 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 www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-718-591-2000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable.	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.empireblue.com or call 844-243-5566 for a list of in-network hospitals effective 1/1/17. See www.magnacare.com or call 1-800-548-0138 for a list of in-network doctors and other 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 <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). If you use an in-network doctor or other health care provider, this <u>plan</u> will pay some or all of the costs of covered services. Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services. 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 <u>specialist</u> you choose without a <u>referral</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	\$50 copay /visit	\$50 copay /visit	None
	Specialist visit	\$50 copay /visit	\$50 copay /visit	None
	Preventive care/screening/immunization	\$50 copay /visit; no copay for visits to JIB Medical, PC., Morristown Hospital or PEMG	\$50 copay /visit	Plan pays for one annual diagnostic visit; injection treatment for allergies is not covered. 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)	\$30 copay/lab or pathology tests; \$50 copay/radiology, x-ray or ultrasound; \$75 copay/EKG, EEG, EMG	Not Covered	Allergy testing is not covered
	Imaging (CT/PET scans, MRIs)	\$100 copay/test	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (including Specialty drugs)	\$15 retail (up to 34-day supply) or \$45 mail order (90 day supply)/prescription	\$15 retail (up to 34-day supply) or \$45 mail order (90 day supply)/prescription	You pay the difference between the cost of the non-generic and the generic equivalent, if available. Maintenance medication must be filled via Mail Order after one original fill and one refill at a local pharmacy. Pre-approval is required for some drugs or coverage could be lost.
	Preferred brand drugs (including Specialty drugs)	\$25 retail (up to 34-day supply) or \$75 mail order (90 day supply)/prescription	\$25 retail (up to 34-day supply) or \$75 mail order (90 day supply)/prescription	
	Non-preferred brand drugs (including Specialty drugs)	\$40 retail (up to 34-day supply) or \$120 mail order (90 day supply)/prescription	\$40 retail (up to 34-day supply) or \$120 mail order (90 day supply)/prescription	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay	Not covered	Must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost
	Physician/surgeon fees	No charge copay/procedure	No Charge (but subject to balance billing, as with all non-network providers)	Must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost; <u>copayment</u> does not count toward <u>out-of-pocket limit</u> applicable to non- <u>Network providers</u> .
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	Limited to care provided by a hospital, surgi-center or other licensed medical facility due to an injury or other sudden illness for which any delay in obtaining medical care would seriously jeopardize the life or health of the individual; \$100 copay waived if admitted
	Emergency medical transportation	\$100/trip	\$100/trip	None
	Urgent care	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay	Not covered	Service must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
	Physician/surgeon fees	No charge	Not covered	Service must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	None
	Inpatient services	\$500 <u>copay</u> ; no <u>copay</u> for inpatient substance abuse rehabilitation	Not covered	Must be <u>pre-approved</u> by the <u>plan</u> or coverage could be lost.
If you are pregnant	Office visits	\$50 <u>copay</u> /visit	Not covered	Covers Participant or Participant's spouse only, not dependent children. Depending on the type of services, a <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Facility services must be <u>pre-approved</u> by the <u>plan</u> or coverage could be lost
	Childbirth/delivery professional services	\$50 copay for first office visit; No Charge thereafter	Not covered	
	Childbirth/delivery facility services	\$500 <u>copay</u> /delivery	Not covered	

If you need help recovering or have other special health needs	Home health care	No charge	No charge	Covered only if immediately following a hospital admission and only if <u>pre-approved</u> by <u>plan</u> for diagnosis of cancer, otherwise coverage could be lost.
	Rehabilitation services	No charge	Not covered	Inpatient coverage only, and only if immediately following a hospital admission; limited to 15 days per incident, 45 days per year; must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service.
	Durable medical equipment	No charge	Not covered	Limited to oxygen for cancer diagnosis.
	Hospice services	Not covered outpatient ; \$500 copay for inpatient	Not covered	Inpatient facility must be <u>pre-approved</u> by <u>plan</u> or coverage could be lost.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limit one exam every 12 months.
	Children's glasses	No charge	No charge	Limit one exam every 12 months.
	Children's dental check-up	Not charge	No charge	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
- Allergy testing and injection treatment
- Bariatric surgery unless it is deemed to be medically necessary by the Plan
- Chiropractic care
- Cosmetic surgery except treatment of accidental injuries sustained by a covered individual if the surgery begins within 90 days of accident or reconstructive surgery necessitated by major surgery
- Durable medical equipment
- Genetic testing
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

- Dental care
- Emergency care when traveling outside the U.S.
- Private duty nursing, but only if immediately following a hospital admission and only if pre-certified by plan for diagnosis of cancer
- Routine eye care

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: the Department of Labor's 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 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 1-718-591-2000 or 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 718-591-2000.

—————*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](#) \$50
- Hospital (facility) [copayment](#) \$500
- Other (*Ultrasounds*) [copayment](#) \$50
- (*Blood work*) [copayment](#) \$30

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	\$21,625
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,165
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$1,165

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](#) \$50
- Hospital (facility) [copayment](#) \$500
- Other (prescription drugs) [copayment](#) \$15
- (*Blood work*) [copayment](#) \$30

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	\$8,840
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$620
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3740
The total Joe would pay is	\$4360

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$100
- Other (*Diagnostic test*) [copayment](#) \$50
- (*Blood work*) [copayment](#) \$30

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	\$4,745
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$185
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$630
The total Mia would pay is	\$815