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.jibei.org/health/phbp-medical-and-rx-plan/ 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 deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have a deductible.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers, $8,200 individual / $16,400 family. The overall out-of-pocket limits do not apply to services provided by non-network providers.	The out-of-pocket limit is the most you could pay in a year for covered essential health benefit services provided by network providers. 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?	Out-of-pocket costs for non-network providers, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan does not cover.	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.magnacare.com or call 1-877-624-6210 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 non-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. 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.

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	$35 copay/visit	$35 copay/visit	$15 copayment for acute care visits to JIB Medical, PC.
	Specialist visit	$35 copay/visit	$35 copay/visit	$15 copayment for acute care visits to JIB Medical, PC; 30 visit limit for Chiropractor. Acupuncture covered only if provided at JIB Medical, PC.
	Preventive care/screening/ immunization	None	$35 copay/visit	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)	$35 copay/test	$35 copay/test	$15 copayment for x-rays related to an acute care visit at JIB Medical, PC. No copayment for blood work at JIB Medical, PC.
	Imaging (CT/PET scans, MRIs)	$35 copay/test	$35 copay/test	
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)	For active Participants: $20 retail (up to 34-day supply) or $41 mail order (90 day supply)/ prescription. For retired Participants: $15 retail (up to 34-day supply) or $35 mail order (90 day supply)/ prescription.	For active Participants: $20 retail (up to 34-day supply) or $41 mail order (90 day supply)/ prescription. For retired Participants: $15 retail (up to 34-day supply) or $35 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. Preauthorization is required for some drugs or coverage could be lost.
	Preferred brand drugs (including Specialty drugs)	For active Participants: $30 retail (up to 34-day supply) or $78 mail order (90 day supply) /prescription. For retired Participants: $25 retail (up to 34-day supply) or $65 mail order (90 day supply) /prescription.	For active Participants: $30 retail (up to 34-day supply) or $78 mail order (90 day supply) /prescription. For retired Participants: $25 retail (up to 34-day supply) or $65 mail order (90 day supply) /prescription.	
	Non-preferred brand drugs (including Specialty drugs)	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90 day supply)	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90 day	

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)	
		/prescription. For retired Participants: $40 retail (up to 34-day supply) or $110 mail order (90 day supply) /prescription.	supply) /prescription. For retired Participants: $40 retail (up to 34-day supply) or $110 mail order (90 day supply) /prescription.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Must be preauthorized by plan or coverage could be lost
	Physician/surgeon fees	$250 copay/procedure	$250 copay/procedure	Must be preauthorized by plan or coverage could be lost; $1,000 limit on out-of-pocket expenses (not including copayment) for any surgical procedure performed by a non-network provider.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Service must be approved by plan or coverage could be lost
	Emergency medical transportation	No charge	No charge	Service must be approved by plan or coverage could be lost
	Urgent care	$35 copay/visit	$35 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day ($500 maximum)	$100 copay/day ($500 maximum)	Service must be preauthorized by plan or coverage could be lost.
	Physician/surgeon fees	No charge for physician $250 copay/procedure for surgeon	No charge for physician $250 copay/procedure for surgeon plus $1,000 out-of-pocket limit	Service must be preauthorized by plan or coverage could be lost; copayment does not count toward out-of-pocket limit applicable to non-Network providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit	$35 copay/visit	None
	Inpatient services	$100 copay/day with a $500 out-of-pocket limit for hospital room and board charges.	$100 copay/day with a $500 out-of-pocket limit for hospital room and board charges.	Must be preauthorized by the plan or coverage could be lost. There is no copayment for inpatient substance abuse rehabilitation.
If you are pregnant	Office visits	$35 copay/visit	$35 copay/visit	Covers Participant or Participant's spouse only, not dependent children. Depending on the type of services, a copayment may apply. Cost sharing
	Childbirth/delivery professional services	$250 copay/delivery	$250 copay/delivery for surgeon plus $1,000 out-of-pocket limit	
	Childbirth/delivery	$100 copay/day with a $500 out-	$100 copay/day with a $500 out-	

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)	
	facility services	of-pocket limit for hospital room and board charges.	of-pocket limit for hospital room and board charges.	does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Service and number of visits must be preauthorized by the plan or coverage could be lost.
	Rehabilitation services	$35 copay for first 4 out-patient visits	$35 copay for first 4 out-patient visits	
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	No charge	Service and number of visits must be preauthorized by the plan or coverage could be lost. Occupational, physical therapy not covered unless expected to restore function lost due to disease or injury.
	Durable medical equipment	No charge	No charge	
	Hospice services	No charge	No charge	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit one exam every 12 months.
	Children's glasses	No charge	Not covered	Out-of-pocket expenses may be incurred for extra items. Only covered if provided at JIB Medical, PC (all participants) or General Vision Services (active and retired participants who live outside of New York City and Nassau County only).
	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.)

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Maternity benefits for children of participants who receive dependent coverage
- Private duty nursing

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

- Acupuncture only if it is provided at JIB Medical, PC
- Bariatric surgery unless it is deemed to be medically necessary by the plan
- Chiropractic care
- Emergency and Non-emergency care when traveling outside the U.S.
- Genetic testing
- Hearing aids
- Infertility treatment
- Routine eye care (Adult and Children) only if provided at JIB Medical, PC (all participants) or General Vision Services (active and retired participants who live outside of New York City and Nassau County only).
- Routine foot care
- Weight loss programs, but only when provided at JIB Medical, PC.

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	$250
Hospital (facility) copayment	$300
Other copayment	$210

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$760
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$760**

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	$140
Hospital (facility) copayment	$0
Other copayment	$624

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	**$8,780**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$764
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$764**

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

The plan's overall deductible	$0
Specialist copayment	$210
Hospital (facility) copayment	$100
Other	$0

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$310**

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