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/ 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?	This plan has no overall out-of-pocket limit. There is an annual $1,000 cap on copayments for network surgeon fees.	This plan does not have an overall out-of-pocket limit on your expenses. The out-of-pocket limit on network surgeon fees is the most you could pay in a year for covered network surgeon fees.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an overall out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	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 plan uses a provider network for certain services. 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). If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. 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. However, the plan only covers specialists for maternity, surgery or wellness exams.

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	Not covered	Not covered	Excluded service
	Specialist visit	No charge	No charge	Plan only covers specialist visits for maternity, surgery, or annual wellness exams. Paid at network fee schedule.
	Preventive care/screening/ immunization	No charge	No charge	Limited to one annual diagnostic or routine gynecological visit. No copayment for visits to JIB Medical, PC., Morristown Hospital or PEMG. 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. Immunization only covered to age 18.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Only covered where included in hospital bill for hospital-based procedures or where tests are performed in conjunction with pregnancy at a free-standing facility, or when included as part of an annual diagnostic exam or for diagnosis of cancer. Paid at network fee schedule
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Only covered where included in hospital bill for hospital-based procedures or where tests are performed in conjunction with pregnancy at a free-standing facility or for diagnosis of cancer. Paid at network fee schedule
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-authorization 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	$40 retail (up to 34-day supply) or $120 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)	
		supply)/prescription	supply)/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, unless fee exceeds $400/day plan limit	No charge, unless fee exceeds $400/day plan limit	Limited to $400 per day for both Network and non-Network providers.
	Physician/surgeon fees	$1,000 copay/procedure	$1,000 copay/ procedure	Copayment does not count toward out-of-pocket limit applicable to non-Network providers. Covers one pre-surgical consultation visit per year.
If you need immediate medical attention	Emergency room care	No charge, unless fee exceeds $400/day plan limit	No charge, unless fee exceeds $400/day plan limit	Emergency room services are only covered if patient is admitted to the hospital through the emergency room. Limited to $400 per day for both Network and non-Network providers.
	Emergency medical transportation	Not covered	Not covered	Excluded service.
	Urgent care	Not covered	Not covered	Excluded service
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay/ admission	$1,000 copay/ admission	Limited to $400 per day for both Network and non-Network providers.
	Physician/surgeon fees	$1,000 copay/procedure	$1,000 copay/procedure	Copayment does not count toward out-of-pocket limit on Network providers; anesthesia benefit is 100% of network fee schedule. There is a $1,000 annual cap on Network surgical copayments.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Limited to one annual diagnostic psychiatric or substance abuse office visit. No coverage for outpatient hospital services.
	Inpatient services	$1,000 copay/ admission	$1,000 copay/ admission	Limited to $400 per day for both Network and non-Network providers. There is no copayment for inpatient substance abuse rehabilitation. Copayment does not count toward out-of-pocket limit applicable to non-Network providers
If you are pregnant	Office visits	No charge when part of global services	No charge when part of global services	Covers Participant or Participant's spouse only, not dependent children. Plan pays up to $400 per day for facility. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$1,000 copay	$1,000 copay	
	Childbirth/delivery facility services	$1,000 copay	$1,000 copay	
If you need help recovering or have	Home health care	No charge	No charge	Covered only if immediately following a hospital admission for diagnosis of cancer. Paid at network fee schedule

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)	
other special health needs	Rehabilitation services	Not covered	Not covered	Excluded service
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service
	Durable medical equipment	Not covered	Not covered	Excluded service
	Hospice services	Not covered	Not covered	Excluded service
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	No 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
- Diagnostic test, other than where included in hospital, pregnancy, or annual exam
- Durable medical equipment
- Emergency room care, other than with hospital admission.
- Emergency medical transportation
- Genetic testing
- Habilitation services
- Hearing Aids
- Home health care
- Hospice service
- Imaging, other than where included in hospital, pregnancy, or annual exam
- Infertility treatment
- Long-term care
- Mental/behavioral outpatient services
- Non- Emergency care when traveling outside the U.S.
- Private-duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing care
- Specialist visit, other than for maternity, surgery, or wellness exams
- Substance use disorder outpatient services
- Urgent 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
- Routine eye care, limited to one exam per year

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? No
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 Delivery *copayment*** **$1000**
- **Hospital (facility) *copayment*** **$1000**
- **Other (*Ultrasounds) copayment*** **$00**

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	$2,135
Coinsurance	$0
What isn't covered	
Limits or exclusions	$900
The total Peg would pay is	**$14,635**

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*** **$0**
- **Hospital (facility) *copayment*** **$1000**
- **Other (prescription drugs) *copayment*** **$15**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,240
The total Joe would pay is	**$5,600**

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

- **The plan's overall deductible** **$0**
- **Specialist *copayment*** **$0**
- **Hospital (facility) *copayment*** **$0**
- **Other *(Diagnostic test) copayment*** **$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: $4,745 (This condition is not covered, so patient pays 100 percent)

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