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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses
Will you pay less if you use a network provider?	Yes. See http://www.ddsinc.net/ or call 800-255-5681 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 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 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	Specialist visits are not covered, other than for some dental services.

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	Not covered	Not covered	Excluded service
	Preventive care/screening/ immunization	No charge	No charge	Plan pays for one annual diagnostic 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. Immunizations are only covered for dependents up to age 18.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Limited to those services provided as part of the annual diagnostic visit.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not covered	Excluded service
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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery	Not covered	Not covered	Excluded service

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)	
	center)			
	Physician/surgeon fees	Not covered	Not covered	Excluded service.
If you need immediate medical attention	Emergency room care	Not Covered	Not covered	Excluded service
	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)	Not covered	Not covered	Excluded service
	Physician/surgeon fees	Not covered	Not covered	Excluded service
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Excluded service
	Inpatient services	Not covered	Not covered	Excluded service
If you are pregnant	Office visits	Not covered	Not covered	Excluded service
	Childbirth/delivery professional services	Not covered	Not covered	Excluded service
	Childbirth/delivery facility services	Not covered	Not covered	Excluded service
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Excluded service
	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
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- Chiropractic care
- Cosmetic surgery
- Delivery and all inpatient services (pregnancy)
- Durable medical equipment
- Emergency room services
- Emergency medical transportation
- Genetic testing
- Habilitation services
- Hearing Aids
- Home health care
- Hospice services
- Hospital facility fee (e.g., hospital room)
- Hospital physician/surgeon fee
- Imaging (CT/PET scans, MRI's)
- Infertility treatment
- Long-term care
- Mental/behavioral health inpatient services
- Mental/ behavioral health outpatient services Non- Emergency care when traveling outside the U.S.
- Outpatient surgery facility fee (e.g., ambulatory surgery center)
- Outpatient surgery physician/surgeon fee
- Prenatal and postnatal office visits
- Preventive care/screening/immunizations, other than services provided under annual diagnostic visit benefit
- Primary care visit to treat an injury or illness
- Private duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing care
- Specialist visit
- Substance use disorder inpatient services
- 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

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

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	$
Copayments	$135
Coinsurance	$
What isn't covered	
Limits or exclusions	$20,275
The total Peg would pay is	**$20,410**

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**	**$0**
■ **Hospital (facility)**	**$0**
■ **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	$
Copayments	$360
Coinsurance	$
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**	**$0**
■ **Hospital (facility)**	**$0**
■ **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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$4,745
The total Mia would pay is	**$4,745**

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