**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 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. 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. |

| 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 pre-approved by plan 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 pre-approved by plan or coverage could be lost; copayment does not count toward out-of-pocket limit applicable to non-Network providers. |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit | $100 copay/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 copay/visit | $50 copay/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay | Not covered | Service must be pre-approved by plan or coverage could be lost. |
| | Physician/surgeon fees | No charge | Not covered | Service must be pre-approved by plan or coverage could be lost. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 copay/visit | $50 copay/visit | None |
| | Inpatient services | $500 copay; no copay for inpatient substance abuse rehabilitation | Not covered | Must be pre-approved by the plan or coverage could be lost. |
| **If you are pregnant** | Office visits | $50 copay/visit | Not covered | Covers Participant or Participant's spouse only, not dependent children. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Facility services must be pre-approved by the plan 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 copay/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 pre-approved by plan 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 pre-approved by plan 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 pre-approved by plan 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 | 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 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
- 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<br>• 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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,165 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $620 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $185 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $630 |
| **The total Mia would pay is** | **$815** |

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