



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.iibe.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, 2022 \$8,700 individual / \$17,400 family, 2023 \$9,100 individual / \$18,200 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 ?	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 ?	Not Applicable.	This plan does not use a provider network . You can receive services from any provider .
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
		No charge	The plan reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Specialist visit	No charge	30-visit limit for Chiropractor. Acupuncture covered only if provided at JIB Medical, PC. For other specialists, the <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Preventive care/screening/immunization	No charge	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)	No charge	The <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Imaging (CT/PET scans, MRIs)	No charge	
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 \$35 (90day supply)/ prescription.	Commercial plan: You pay the difference between the cost of the non-generic and the generic equivalent, if available. <u>Preauthorization</u> is required for some drugs or coverage could be lost. 90-day supply available via mail order only.
	Preferred brand drugs (including Specialty drugs)	\$25 retail (up to 34-day supply) or \$65 (90-day supply) /prescription.	Medicare Part D benefit: After total costs (what you and the plan pay) reach \$6,550, you will pay the greater of 5% <u>coinsurance</u> or a \$3.70 <u>copayment</u> for covered generic drugs (including drugs treated as generics), or a \$9.20 <u>copayment</u> for all other covered drugs. Neither <u>copayment</u> will exceed standard that applies before you reach \$6,550 in total costs; Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. <u>Preauthorization</u> is required for some drugs or coverage could be lost.
	Non-preferred brand drugs (including Specialty drugs)	\$40 retail (up to 34-day supply) or \$110 (90-day supply) /prescription.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	The <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Physician/surgeon fees	No charge	
If you need	Emergency room care	No charge	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
immediate medical attention	Emergency medical transportation	No charge	
	Urgent care	No charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	The <u>plan</u> reimburses the inpatient hospital deductible not paid by Medicare Part A.
	Physician/surgeon fees	No charge	The <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	The <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B
	Inpatient services	No charge	The <u>plan</u> reimburses the inpatient hospital deductible not paid by Medicare Part A.
If you are pregnant	Office visits	No charge	The <u>plan</u> reimburses the annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	No charge	The <u>plan</u> reimburses the inpatient hospital deductible not paid by Medicare Part A.
If you need help recovering or have other special health needs	Home health care	No charge	The <u>plan</u> reimburses the inpatient hospital deductible not paid by Medicare Part A or the annual deductible and 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Rehabilitation services	No charge	
	Habilitation services	Not covered	None
	Skilled nursing care	No charge	The <u>plan</u> reimburses the inpatient hospital deductible not paid by Medicare Part A or the annual deductible and 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Durable medical equipment	No charge	
	Hospice services	No charge	
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	
	Children's dental check-up	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
- Children’s eye exam
- Children’s glasses
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- 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
- Chiropractic care
- Emergency and Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) only if provided at JIB Medical, PC or General Vision Services (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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? N/A

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](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] %0
- Other [*cost sharing*] %0

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	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] %0
- Other Prescription Drugs [*cost sharing*] \$65

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$520
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$520

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] %0
- Other [*cost sharing*] %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
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In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.