Pension, Hospitalization and Benefit Plan Of the Electrical Industry:

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 9/30/2017
Coverage for: Family **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.jibei.org/medical.asp or by calling 1-718-591-2000

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 0	See the chart on page 2 for your costs for services this Plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. There is a **$1,000** **out-of-pocket limit** for any surgical procedure performed by a non-Network provider and a **$500** **out-of-pocket limit** for hospital room and board charges.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Co-payments, balance-billed charges, penalties for failure to obtain pre-certification of services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.magnacare.com or call 1-877-624-6210 for a list of participating providers.	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 in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart on page 2 for how this Plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this Plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 5. See your Summary Plan Description for additional information about **excluded services**.

Questions: Call (718) 591-2000 or visit us at www.jibei.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call (718) 591-2000 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $35) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-Network** **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
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.	$5 co-payment for acute care visits to JIB Medical, PC.
	Specialist visit	$35 copay/visit.	$35 copay/visit.	$5 co-payment for acute care visits to JIB Medical, PC.
	Other practitioner office visit	$35 copay/visit for chiropractor.	For chiropractor, $35 co-pay/visit for chiropractor.	$5 co-payment for acute care visits to JIB Medical, PC; 30 visit maximum for chiropractor. Acupuncture covered only if provided at JIB Medical, PC.
	Preventive care/ screening/immunization	$35 copay/visit.	$35 copay/visit.	No co-payment if performed at JIB Medical, PC or PHBP Area Group Practices.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/test.	$35 copay/test.	$5 copay for x-rays related to an acute care visit at JIB Medical, PC. No co-payment for blood work at JIB Medical, PC.
	Imaging (CT/PET scans, MRIs)	$35 copay/test.	$35 copay/test.	

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
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	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. Prior authorization is required for some drugs or coverage could be lost.
	Preferred brand 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	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90 day supply) /prescription. For retired Participants: $40 retail (up to 34-day supply) or $110 mail order (90 day supply) /prescription.	For active Participants: $45 retail (up to 34-day supply) or $125 mail order (90 day 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 pre-certified by Plan or coverage could be lost.
	Physician/surgeon fees	$250 copay/procedure.	Up to $1,000 plus $250 copay/procedure.	Must be pre-certified by Plan or coverage could be lost.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copay/visit.	$100 copay/visit.	Service must be approved by Plan or coverage could be lost.
	Emergency medical transportation	No charge.	No charge.	
	Urgent care	$35 copay/visit.	$35 copay/visit.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day ($500 maximum).	$100 copay/day ($500 maximum).	Must be pre-certified by Plan or coverage could be lost.
	Physician/surgeon fee	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.	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit.	$35 copay/visit.	—none--
	Mental/Behavioral health 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 pre-certified by Plan or coverage could be lost.
	Substance use disorder outpatient services	$35 copay/visit.	$35 copay/visit.	–none--
	Substance use disorder inpatient services	No charge	No charge	Must be pre-certified by Plan or coverage could be lost.
If you are pregnant	Prenatal and postnatal care	$35 copay/diagnostic test.	$35 copay/diagnostic test.	Covers Participant or Participant's spouse only, not dependent children.
	Delivery and all inpatient services	$250 copay/delivery $100 copay/day in hospital up to a maximum of $500.	$250 copay/delivery $100 copay/day in hospital up to a maximum of $500.	

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
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 **pre-authorized** 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 **pre-authorized** by the Plan or coverage could be lost.
	Durable medical equipment	No charge.	No charge.	
	Hospice service	No charge.	No charge.	
If your child needs dental or eye care	Eye exam	No charge.	Not covered.	Limit one visit every 12 months. See page 5 for coverage imitations.
	Glasses	No charge.	Not covered.	Out of pocket expenses may be incurred for extra services. 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).
	Dental check-up	Not covered.	Not covered.	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery unless it is deemed to be medically necessary by the Plan
- Cosmetic surgery
- Dental care (Adult)
- Genetic testing
- Habilitation services
- Infertility treatment
- Long-term care
- Maternity benefits for children of participants who receive dependent coverage
- Private Duty Nursing
- Routine eye care (Adult and Children) unless 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).
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture only if it is provided at the JIB Medical, PC
- Chiropractic care
- Hearing aids
- Emergency and Non-emergency care when traveling outside the U.S.
- Routine foot care

Your Rights to Continue Coverage:

If you lose coverage under the Plan, then, depending upon the circumstances, Federal law may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (718) 591-2000, ext. 2491. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Joint Industry Board of the Electrical Industry, (718) 591-2000. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,950
- **Patient pays**: $590

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

***Patient pays:**

Deductibles	$0
Co-pays	$440
Co-insurance	$0
Limits or exclusions	$150
Total	**$590**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3,050
- **Patient pays** $1,050

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

***Patient pays:**

Deductibles	$0
Co-pays	$970
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,050**

These examples are based upon the patient using in-network providers and do not necessarily reflect benefits actually covered by the Plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

NONDISCRIMINATION

Discrimination is Against the Law

The Pension, Hospitalization, and Benefit Plan of the Electrical Industry (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call 718-591-2000 or write to: The Joint Industry Board, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-718-591-2000.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1−718-591-2000。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-718-591-2000.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-718-591-2000.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-718-591-2000 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-718-591-2000.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט
1-718-591-2000

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-718-591-2000

UWAGA: Jezeli mówisz po polsku, mozesz skorzystac z bezplatnej pomocy jezykowej. Zadzwon pod numer 1-718-591-2000.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
1-718-591-2000

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-718-591-2000.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-718-591-2000

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-718-591-2000.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-718-591-2000.

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-718-591-2000 まで、お電話にてご連絡ください

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-718-591-2000.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-718-591-2000.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-718-591-2000

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-718-591-2000 पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-718-591-2000