JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

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Dear Participant:

The Patient Protection and Affordable Care Act ("PPACA") requires group health plans such as the Pension, Hospitalization and Benefit Plan of the Electrical Industry ("PHBP") to furnish participants with a Summary of Benefits and Coverage or "SBC." The Summary of Benefits and Coverage is an 8-page summary of material provisions of a health plan in a uniform format and must conform to the PPACA's required language.

Enclosed please find the SBC for the PHBP. This document summarizes the key features of the plan such as covered benefits, cost-sharing provisions, and coverage limitations, coverage examples and exceptions. **Please note that while such terms as "premiums," "co-insurance" and "deductibles" are required, they do not apply to the PHBP.**

For a more complete explanation of the PHBP's rules, covered benefits, cost-sharing provisions and exclusions, please refer to your Summary Plan Description, a copy of which was recently mailed to you and which can also be found at www.jibei.org.

If you have any questions concerning this document, please contact the Hospitalization Department at the Joint Industry Board at (718) 591-2000, ext. 1350.

Sincerely,

The Joint Industry Board of the Electrical Industry

Pension, Hospitalization and Benefit Plan of the Electrical Industry:

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

Coverage Period: 10/01/2012 – 9/30/2013
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?	Yes. Four visits for mental health physician services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
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?	Yes. A **$2,000,000** annual limit applies to the Participant and separately for each eligible dependent.	This Plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on number of 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, $25) 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		Limitations & Exceptions
		In-Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit.	$25 copay/visit.	No co-payment for JIB Medical Department visits.
	Specialist visit	$25 copay/visit.	$25 copay/visit.	No co-payment for JIB Medical Department visits.
	Other practitioner office visit	$25 copay/visit for chiropractor.	For chiropractor, $25 co-pay/visit for chiropractor.	No co-payment for JIB Medical Department visits; 30 visit maximum for chiropractor. Acupuncture covered only if provided at JIB Medical Department.
	Preventive care/screening/immunization	$25 copay/visit.	$25 copay/visit.	No co-payment for JIB Medical Department or PHBP Area Group Practices visits
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/test.	$25 copay/test.	No co-payment for blood work or for JIB Medical Department visits.
	Imaging (CT/PET scans, MRIs)	$25 copay/test.	$25 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.medco.com	Generic drugs	$10 retail (up to 34-day supply) or $30 mail order (90 day supply)/ prescription.	$10 retail (up to 34-day supply) or $30 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.
	Preferred brand drugs	$20 retail (up to 34-day supply) or $60 mail order (90 day supply) /prescription.	$20 retail (up to 34-day supply) or $60 mail order (90 day supply)/prescription.	
	Non-preferred brand drugs	$35 retail (up to 34-day supply) or $105 mail order (90 day supply) /prescription.	$35 retail (up to 34-day supply) or $105 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.
If you need immediate medical attention	Emergency room services	$100 copay/visit.	$100 copay/visit.	Service must be approved by Plan within 24 hours or coverage could be lost.
	Emergency medical transportation	No charge.	No charge.	
	Urgent care	$25 copay/visit.	$25 copay/visit.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day ($500 maximum).	$100/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---

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit.	$25 copay/visit.	Limited to 30 (20 to a psychiatrist) annual visits per family, subject to annual 4-visit deductible.
	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.	Limited to 30 days in any 12-month period.
	Substance use disorder outpatient services	Not covered.	Not covered.	–none--
	Substance use disorder inpatient services	No charge.	Not covered.	Must be pre-certified through Members Assistance Program or coverage could be lost. Benefit limited to once per lifetime.
If you are pregnant	Prenatal and postnatal care	$25 copay/diagnostic test.	$25/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.	
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	$25 copay for first 4 out-patient visits.	$25 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.

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
	Glasses	No charge.	Not covered.	Out of pocket expenses may be incurred for extra services. Only covered if provided at the JIB Medical Department for all participants or General Vision Services for active and retired participants who live outside of New York City and Nassau County.
	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
- Substance Use Disorder Outpatient Services
- Routine eye care (Adult and Children) unless provided at the JIB Medical Department for all participants or General Vision Services for active and retired participants who live outside of New York City and Nassau County.
- 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 Department
- Chiropractic care
- Hearing aids
- 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.

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:** $6,960
- **Patient pays**: $580

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	$430
Co-insurance	$0
Limits or exclusions	$150
Total	**$580**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $3,300
- **Patient pays** $800

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	$720
Co-insurance	$0
Limits or exclusions	$80
Total	**$800**

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.