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/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, $7,900 individual / $15,800 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?	Out-of-pocket costs for non-network providers, balance-billing charges, penalties for failure to obtain preauthorization and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.magnacare.com or call 1-877-624-6210 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 non-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). 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	$35 copay/visit	$35 copay/visit	$15 copayment for acute care visits to JIB Medical, PC.
	Specialist visit	$35 copay/visit	$35 copay/visit	$15 copayment for acute care visits to JIB Medical, PC; 30 visit limit for Chiropractor. Acupuncture covered only if provided at JIB Medical, PC.
	Preventive care/screening/ immunization	None	$35 copay/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.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/test	$35 copay/test	$15 copayment for x-rays related to an acute care visit at JIB Medical, PC. No copayment 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	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 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)	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. Preauthorization is required for some drugs or coverage could be lost.
	Preferred brand drugs (including Specialty 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 (including Specialty 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 preauthorized by plan or coverage could be lost
	Physician/surgeon fees	$250 copay/procedure	$250 copay/procedure	Must be preauthorized by plan or coverage could be lost; $1,000 limit on

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)	
				out-of-pocket expenses (not including copayment) for any surgical procedure performed by a non-network provider.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Service must be approved by plan or coverage could be lost
	Emergency medical transportation	No charge	No charge	Service must be approved by plan or coverage could be lost
	Urgent care	$35 copay/visit	$35 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day ($500 maximum)	$100 copay/day ($500 maximum)	Service must be preauthorized by plan or coverage could be lost.
	Physician/surgeon fees	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	Service must be preauthorized by plan or coverage could be lost; copayment does not count toward out-of-pocket limit applicable to non-Network providers.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit	$35 copay/visit	None
	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 preauthorized by the plan or coverage could be lost. There is no copayment for inpatient substance abuse rehabilitation.
If you are pregnant	Office visits	$35 copay/visit	$35 copay/visit	Covers Participant or Participant's spouse only, not dependent children. Depending on the type of services, a copayment may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$250 copay/delivery	$250 copay/delivery for surgeon plus $1,000 out-of-pocket limit	
	Childbirth/delivery facility 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.	
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 preauthorized 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

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)	
	Skilled nursing care	No charge	No charge	Service and number of visits must be preauthorized by the plan or coverage could be lost. Occupational, physical therapy not covered unless expected to restore function lost due to disease or injury.
	Durable medical equipment	No charge	No charge	
	Hospice services	No charge	No charge	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limit one exam every 12 months.
	Children's glasses	No charge	Not covered	Out-of-pocket expenses may be incurred for extra items. 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).
	Children's dental check-up	Not covered	Not covered	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
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Maternity benefits for children of participants who receive dependent coverage
- 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
- Bariatric surgery unless it is deemed to be medically necessary by the plan
- Chiropractic care
- Emergency and Non-emergency care when traveling outside the U.S.
- Genetic testing
- Hearing aids
- Infertility treatment
- Routine eye care (Adult and Children) only 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).
- 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**
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*** **$250**
- **Hospital (facility) *copayment*** **up to $500**
- **Other (*Ultrasounds) copayment*** **$35**

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	$873
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$873**

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*** **$35**
- **Hospital (facility) *copayment*** **up to $500**
- **Other (prescription drugs) *copayment*** **$35**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$764
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$764**

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

- **The plan's overall deductible** **$0**
- **Specialist *copayment*** **$35**
- **Hospital (facility) *copayment*** **$100**
- **Other *(Diagnostic test) copayment*** **$35**

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	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$310**

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

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 برق
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