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, to furnish participants with a Summary of Benefits and Coverage or "SBC." The Summary of Benefits and Coverage is a summary of material provisions of a health plan in a uniform format.

Enclosed please find the Summary of Benefits and Coverage 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, and must conform to the PPACA's required language. You can use this summary in the event that you need to find other comparative insurance. **Please note that while such terms as "premiums," "co-insurance" and "deductibles" are required, they do not apply to your plan.**

For a more complete explanation of your plan's rules, covered benefits, cost-sharing provisions and exclusions, please refer to your Summary Plan Description, which can 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,

Joint Industry Board of the Electrical Industry

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, 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	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 plan 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 plan 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. Preauthorization is required for some drugs or coverage could be lost. 90-day supply available via mail order only. Medicare Part D benefit: After total costs (what you and the plan pay) reach $6,550, you will pay the greater of 5% coinsurance or a $3.70 copayment for covered generic drugs (including drugs treated as generics), or a $9.20 copayment for all other covered drugs. Neither copayment 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. Preauthorization is required for some drugs or coverage could be lost. If enrolled in the SaveOn program, the co-pay for specialty drugs may be reduced to $0.
	Preferred brand drugs (including Specialty drugs)	$25 retail (up to 34-day supply) or $65 (90-day supply) /prescription.	
	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 plan 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 plan reimburses the inpatient hospital deductible not paid by Medicare Part A.
	Physician/surgeon fees	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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	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
	Inpatient services	No charge	The plan reimburses the inpatient hospital deductible not paid by Medicare Part A.
If you are pregnant	Office visits	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
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	No charge	The plan 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 plan 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 plan 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**

In this example, Peg would pay:

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$520
Coinsurance	$0
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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.