



# JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

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October 2024

Dear Participant:

The Patient Protection and Affordable Care Act (“PPACA”) requires group health plans, such as the Pension, Hospitalization and Benefit Plan (“PHBP”) of the Electrical Industry, to furnish participants with a Summary of Benefits and Coverage or “SBC.” The SBC is a summary of material provisions of a health plan in a uniform format.

Enclosed please find the SBC for the PHBP for the coverage period beginning on October 1, 2024. This document summarizes the key features of the Plan such as covered benefits, cost-sharing provisions, coverage limitations, and coverage examples and exceptions. We recommend you retain a copy of the SBC with your other PHBP records.

**Please note that while such terms as “premiums” and “co-insurance” are required by federal regulations to appear in the SBC, they may not apply to your Plan.**


For a more complete explanation of the PHBP’s rules, covered and excluded benefits and cost-sharing provisions, please refer to your Summary Plan Description (“SPD”) and Summaries of Material Modifications (“SMMs”), all of which can be found at <https://www.jibei.org/health/phbp-medical-and-rx-plan/>.

If you have any questions concerning the SBC, 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.jibe.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](http://www.dol.gov/ebsa/healthreform) and [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-718-591-2000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>2024</b> \$500 individual / \$1000 family <b>2025</b> \$1,000 individual/ \$2,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive services</u> , <u>prescription drugs</u> , services rendered at JIB Medical P.C. or by internal medicine, primary care, pediatrics, obstetrics/gynecology (OB/GYN), behavioral health and physical therapy <u>providers</u> , telehealth visits, and MDLive <u>urgent care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>Network providers</u> : <b>2024</b> \$9,450 individual / \$18,900 family <b>2025</b> \$9,200 individual/ \$18,400 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Out-of-pocket costs for non- <u>Network providers</u> , <u>balance-billing</u> charges (where permitted by law), penalties for failure to obtain <u>preauthorization</u> and health care this <u>plan</u> does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <a href="#">Network provider</a> ?	Yes. See <a href="http://www.magnacare.com">www.magnacare.com</a> or call 1-877-624-6210 for a list of <a href="#">Network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider Network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's Network</a> . You will pay the most if you use a <a href="#">non-Network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">Network provider</a> might use an <a href="#">out-of-Network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Non-Network Provider</a> (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /visit* <a href="#">Deductible</a> does not apply.	\$35 <a href="#">copay</a> /visit* <a href="#">Deductible</a> does not apply.	* Higher <a href="#">copayment</a> applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical. See the <a href="#">March 10, 2023 Summary of Material Modifications (SMM) to the SPD</a> for more information. \$25 <a href="#">copayment</a> for acute care visits to JIB Medical, PC.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit*	\$50 <a href="#">copay</a> /visit*	
	<a href="#">Preventive care/screening/immunization</a>	No charge	\$35 <a href="#">copay</a> /visit	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray blood work*)	\$35 <a href="#">copay</a> /test <a href="#">Deductible</a> does not apply. **	\$35 <a href="#">copay</a> /test <a href="#">Deductible</a> does not apply. **	When required by law, non- <a href="#">Network diagnostic tests</a> and imaging will be covered as <a href="#">Network</a> . * No <a href="#">copayment</a> for blood work
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> /test	\$100 <a href="#">copay</a> /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)	
				provided at JIB Medical, PC. ** Check the “Are there services covered before you meet your deductible?” section on page 1 of this SBC for more information.
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or by calling Express Scripts at (800) 818-0883 or Accredo Specialty at (800) 803-2523.</p>	Generic drugs	<p><b>For active Participants:</b> \$20 retail/prescription \$40 mail order/prescription</p> <p><b>For retired Participants:</b> \$15 retail/prescription \$35 mail order/prescription</p>	<p><b>For active Participants:</b> \$20 retail/prescription \$40 mail order/prescription</p> <p><b>For retired Participants:</b> \$15 retail/prescription \$35 mail order/prescription</p>	<p>You pay the difference between the cost of the non-generic and the generic equivalent, if available.</p> <p>You may make one fill and one refill for maintenance medication at an in-person pharmacy before they must be filled via Mail Order.</p> <p><u>Preauthorization</u> is required for some drugs or coverage could be lost.</p>
	Preferred brand drugs	<p><b>For active Participants:</b> \$40 retail/prescription \$90 mail order/prescription</p> <p><b>For retired Participants:</b> \$30 retail/prescription \$70 mail order/prescription</p>	<p><b>For active Participants:</b> \$40 retail/prescription \$90 mail order /prescription</p> <p><b>For retired Participants:</b> \$30 retail/prescription \$70 mail order/prescription</p>	<p>Your costs for some <u>Specialty drugs</u> could be as low as \$0 if enrolled in the SaveOn Program. For more information, contact a SaveOn representative at (800) 683-1074.</p>
	Non-preferred brand drugs	<p><b>For active Participants:</b> \$80 retail/prescription \$160 mail order /prescription</p> <p><b>For retired Participants:</b> \$60 retail/prescription \$165 mail order/prescription</p>	<p><b>For active Participants:</b> \$80 retail/prescription \$160 mail order/prescription</p> <p><b>For retired Participants:</b> \$60 retail/prescription \$165 mail order/prescription</p>	<p>Retail prescriptions are limited up to a 34-day supply. Mail orders prescriptions are limited up to a 90-day supply.</p>
	Specialty brand drugs	<p><b>For active Participants:</b> \$60 retail/prescription \$120 mail order/prescription</p> <p><b>For retired Participants:</b> \$45 retail/prescription \$105 mail order/prescription</p>	<p><b>For active Participants:</b> \$60 retail/prescription \$120 mail order /prescription</p> <p><b>For retired Participants:</b> \$40 retail/prescription \$105 mail order /prescription</p>	<p>You will pay the same mail order <u>copayment</u> regardless of whether the quantity is 90 days or a lesser amount.</p>

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /procedure	\$100 <u>copay</u> /procedure	<u>Preauthorization</u> required or coverage could be lost.
	Physician/surgeon fees	\$500 <u>copay</u> /procedure	\$500 <u>copay</u> /procedure with a \$1,000 <u>out-of-pocket limit</u> *	<u>Preauthorization</u> required or coverage could be lost. * \$500 <u>copayment</u> is not included in this limit. When required by law, non- <u>Network</u> physician and surgeon fees will be covered as <u>Network</u> .
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit	\$250 <u>copay</u> /visit	ER <u>copayment</u> waived and \$500 inpatient <u>copayment</u> applies if admitted to inpatient hospital care.
	<u>Emergency medical transportation</u>	\$100 <u>copay</u>	\$100 <u>copay</u>	If air ambulance is needed, <u>preauthorization</u> required or coverage could be lost.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit	\$75 <u>copay</u> /visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	<u>Preauthorization</u> required or coverage could be lost. <u>Copayments</u> for certain ancillary services are not included in this limit. See the Hospital and Facility Based Benefits section of the current SPD for more information.
	Physician/surgeon fees	\$500 <u>copay</u> /procedure	\$500 <u>copay</u> /procedure with a \$1,000 <u>out-of-pocket limit</u> *	<u>Preauthorization</u> required or coverage could be lost. * \$500 <u>copayment</u> is not included in this limit. When required by law, non- <u>Network</u> <u>physician</u> and surgeon fees will be covered as <u>Network</u> .

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$35 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$50 <u>copayment</u> applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical.
	Inpatient services	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	<u>Preauthorization</u> required or coverage could be lost. No <u>copayment</u> for elective inpatient substance abuse rehabilitation. <u>Copayments</u> for certain ancillary services are not included in this limit.
If you are pregnant	Office visits	\$35 <u>copay</u> /visit* <u>Deductible</u> does not apply.**	\$35 <u>copay</u> /visit* <u>Deductible</u> does not apply.**	* \$50 <u>copayment</u> applies if you or your spouse has not received an annual physical. ** If services are billed by an OB/GYN or <u>primary care provider</u> . <u>Copayments</u> for certain ancillary services are not included in this limit. Depending on the type of services, a <u>copayment</u> or <u>deductible</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery professional services	\$500 <u>copay</u> /delivery <u>Deductible</u> does not apply.**	\$500 <u>copay</u> /delivery <u>Deductible</u> does not apply.**	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	\$500 <u>copay</u> /admission plus \$200/day (up to \$1,000)	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	<p><u>Preauthorization</u> of service and number of visits required or coverage could be lost.</p> <p>\$50 <u>copayment</u> applies to you and your spouse (but not your dependent children) if you or your spouse has not received an annual physical.</p> <p>* See the Limitations of Benefits section of the current SPD for more information on limits for occupational, speech and physical therapy.</p> <p>** Check the “Are there services covered before you meet your deductible?” section on page 1 of this SBC for more information.</p> <p>*** First 4 visits require <u>copayment</u>; no <u>copayment</u> required after 4 visits.</p>
	<a href="#">Rehabilitation services*</a>	\$35 <u>copay</u> /visit*** <u>Deductible</u> does not apply.**	\$35 <u>copay</u> /visit*** <u>Deductible</u> does not apply.**	
	<a href="#">Habilitation services</a>	Not covered	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	No charge	
	<a href="#">Durable medical equipment</a>	\$100 <u>copay</u> *	\$100 <u>copay</u> *	
	<a href="#">Hospice services</a>	No charge	No charge	
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge	Not covered	1 exam limit every 12 months.
	Children’s glasses	No charge	Not covered	Out-of-pocket expenses may be incurred for extra items. See the Optical Benefits section of your current SPD for further limitations.
	Children’s dental check-up	Not covered	Not covered	None.

**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 dependent children
- Private-duty nursing

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)**

- Acupuncture (through JIB Medical, PC only)
- Bariatric surgery ([preauthorization](#) required)
- Chiropractic care (30 visit limit)
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment
- Routine eye care (Adults) through Jena Optical for all Participants or, for those who are non-NYC residents, General Vision Services or Vision Screening (non-NYC resident retirees may go to any [provider](#) and receive up to a \$56 reimbursement)
- Routine foot care
- Weight loss programs (through JIB Medical, PC only)

**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](http://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](http://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](http://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? 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](#) \$1,000
- [Office visits](#) [copayment](#) \$35
- Hospital (facility) [cost-sharing](#) \$700
- Delivery services [copayment](#) \$500

This EXAMPLE event includes services like:

- OB/GYN office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Prescription drugs](#)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$2,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,260</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-[Network](#) care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) [copayment](#) \$50
- Primary care [copayment](#) \$35
- [Prescription drugs](#) [copayment](#) \$60

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits
- [Specialist](#) care (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#) (*insulin*)
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,220</b>

**Mia's Simple Fracture**  
(in-[Network](#) emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) [copayment](#) \$50
- Emergency room [copayment](#) \$250
- [Rehabilitation services](#) [copayment](#) \$35

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic tests](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
<b>The total Mia would pay is</b>	<b>\$1,940</b>