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.

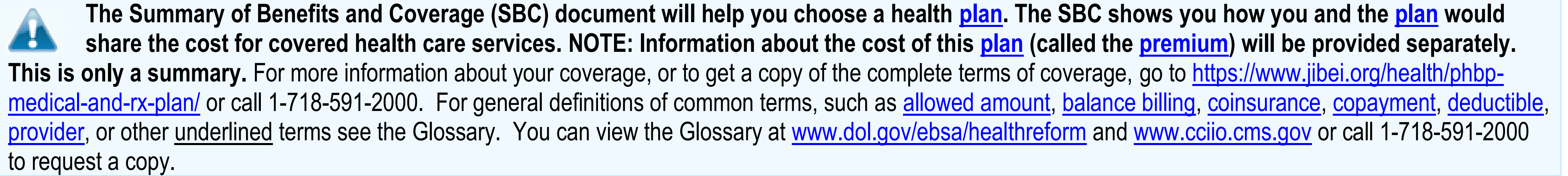
Please note that while such terms as "premiums" and "co-insurance" are required by federal regulations to appear in the SBC, they may not apply to your Plan.

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.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?	**2024** $375/individual **2025** $750/individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, services that Medicare covers 100%, such as preventive care, prescription drugs, services rendered at JIB Medical P.C., and telehealth services approved by Medicare are covered before you meet your deductible.	Yes. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-carebenefits/.
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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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 covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge Deductible does not apply.*	*If 100% covered by Medicare Part B For services not 100% covered by Medicare Part B, after the annual plan deductible is met, the plan reimburses the Medicare Part B annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Specialist visit	No charge	After the annual plan deductible is met, the plan reimburses the Medicare Part B 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 Deductible does not apply.	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 Deductible does not apply.*	*If 100% covered by Medicare Part B For services not 100% covered by Medicare Part B, after the annual plan deductible is met, the plan reimburses the Medicare Part B 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	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling Express Scripts at (800) 818-0883 or Accredo Specialty at (800) 803-2523.	Generic drugs	$15 retail (up to 34-day supply) or $35 (90-day supply)/prescription. Deductible does not apply.*	*If covered 100% by Medicare Part D Preauthorization is required for some drugs or coverage could be lost. Medicare Part D benefit: 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. If you reach the Catastrophic Coverage stage, you pay nothing for covered Medicare Part D drugs. You may have cost sharing for excluded drugs that may be covered under Part D's enhanced benefit, if the plan covers additional drugs not normally covered by Medicare Part D. If you are not enrolled in the Medicare Part D Program, you pay the difference between the cost of the non-generic and the generic equivalent, if available. 90-day supply available via mail order only. Your costs for some specialty drug prescriptions may be as low as $0 through the SaveOn Program. For more information, contact a SaveOn representative at (800) 683-1074. Retirees enrolled in the Medicare Part D benefit are not eligible to enroll in the SaveOn program.
	Preferred brand drugs	$30 retail (up to 34-day supply) or $70 (90-day supply)/prescription. Deductible does not apply.*	
	Non-preferred brand drugs	$60 retail (up to 34-day supply) or $165 (90-day supply)/prescription. Deductible does not apply.*	
	Specialty drugs	$45 retail (up to 34-day supply) or $105 (90-day supply)/prescription Deductible does not apply.*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	After the annual plan deductible is met, the plan reimburses the Medicare Part B 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 immediate medical attention	Emergency room care	No charge	
	Emergency medical transportation	No charge	
	Urgent care	No charge	

For more information about limitations and exceptions, see plan or policy document at https://www.jibei.org/health/phbp-medical-and-rx-plan/

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge Deductible does not apply.*	* If covered 100% by Medicare Part A For admissions not 100% covered by Medicare Part A, after the annual plan deductible is met, the plan reimburses the inpatient hospital deductible not paid by Medicare Part A.
	Physician/surgeon fees	No charge	After the annual plan deductible is met, the plan reimburses the Medicare Part B 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 Deductible does not apply.*	* If covered 100% by Medicare Part B For services not covered 100% by Medicare Part B, after the annual plan deductible is met, the plan reimburses the Medicare Part B annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Inpatient services	No charge Deductible does not apply.*	* If covered 100% by Medicare Part A For services not 100% covered by Medicare Part A, after the annual plan deductible is met, the plan reimburses the inpatient hospital deductible not paid by Medicare Part A.
If you are pregnant	Office visits	No charge	After the annual plan deductible is met, the plan reimburses the Medicare Part B annual deductible and pays 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	No charge Deductible does not apply.*	* If covered 100% by Medicare Part A For services not 100% covered by Medicare Part A, after the annual plan deductible is met, the plan reimburses the inpatient hospital deductible not paid by Medicare Part A.

For more information about limitations and exceptions, see plan or policy document at https://www.jibei.org/health/phbp-medical-and-rx-plan/

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge Deductible does not apply.*	* If covered 100% by Medicare Part A For services not covered 100% by Medicare Part A, after the annual plan deductible is met, the plan reimburses the inpatient hospital deductible not paid by Medicare Part A or the Medicare Part B annual deductible and 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Rehabilitation services	No charge Deductible does not apply.*	
	Habilitation services	Not covered	None.
	Skilled nursing care	No charge Deductible does not apply.*	* If covered 100% by Medicare Part A or Medicare Part B For services not covered 100% by Medicare Part A or Medicare Part B, after the annual plan deductible is met, the plan reimburses the inpatient hospital deductible not paid by Medicare Part A or Medicare Part B the annual deductible and 20% of customary & reasonable charges approved but not paid or reimbursed under Medicare Part B.
	Durable medical equipment	No charge Deductible does not apply.*	
	Hospice services	No charge Deductible does not apply.*	
If your child needs dental or eye care	Children's eye exam	No Charge	1 exam limit every 12 months.
	Children's glasses	No Charge	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	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
- 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
- Chiropractic care (30 visit limit)
- Non-emergency care when traveling outside the U.S.
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) through Jena Optical or, for non-New York City 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. 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? Not Applicable
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 pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$0**
- **Hospital (facility) cost sharing** **$0**
- **Prescription Drugs copayment** **$15**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$820**

Managing Joe's type 2 Diabetes
(a year of routine care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$0**
- **Primary care cost sharing** **$0**
- **Prescription Drugs copayment** **$45**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,470**

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

- **The plan's overall deductible** **$750**
- **Specialist cost sharing** **$0**
- **Emergency room cost sharing** **$0**
- **Prescription Drugs cost sharing** **$15**

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$800**

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