



JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741 • www.jibei.org

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October 2025

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, 2025. 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 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 <u>deductible</u> ?	2025–2026 \$750/individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes, services that Medicare covers 100%, such as preventive care, <u>prescription drugs</u> , services rendered at JIB Medical P.C., and telehealth services approved by Medicare are covered before you meet your <u>deductible</u> .	Yes. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Not Applicable.	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge <u>Deductible</u> does not apply.*	*If 100% covered by Medicare Part B For services not 100% covered by Medicare Part B, after the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the Medicare Part B annual <u>deductible</u> and pays 20% of <u>usual, customary & reasonable (UCR)</u> charges approved but not paid or reimbursed under Medicare Part B.
	<u>Specialist</u> visit	No charge	After the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the Medicare Part B annual <u>deductible</u> and pays 20% of <u>UCR</u> charges approved but not paid or reimbursed under Medicare Part B.
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge <u>Deductible</u> does not apply.*	*If 100% covered by Medicare Part B For services not 100% covered by Medicare Part B, after the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the Medicare Part B annual <u>deductible</u> and pays 20% of <u>UCR</u> 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	Generic drugs	\$15 retail/prescription \$35 mail order/prescription. <u>Deductible</u> does not apply.*	* If covered 100% by Medicare Part D If you became a Medicare-eligible retiree (or a Medicare-eligible dependent) on or after January 1, 2025 , you will be automatically

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
about prescription drug coverage is available at www.express-scripts.com/documents or by calling Express Scripts at (800) 808-1596 or Accredo Specialty at (800) 803-2523.	Preferred brand drugs	\$30 retail/prescription \$70 mail order/prescription. <u>Deductible</u> does not apply.*	<p>enrolled in Express Scripts Medicare® program. If you or your spouse's former employer provided a Medicare Advantage-only ("MA") plan with prescription drug coverage ("MA-PD"), then you may choose to opt out of the Express Scripts Medicare® program and receive <u>prescription drug coverage</u> under the MA Plan. Otherwise, if you choose to opt out of Express Scripts Medicare®, you will keep your medical coverage under the plan but will not be provided with <u>prescription drug coverage</u>. Please see the October 2024 Summary of Material Modifications (SMM) for more information.</p> <p><u>Preauthorization</u> is required for some drugs or coverage could be lost.</p> <p>Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the <u>plan's</u> service area where there is no <u>network</u> pharmacy.</p> <p>If you reach the Catastrophic Coverage stage, you pay nothing for covered Medicare Part D drugs. You may have <u>cost sharing</u> for excluded drugs that may be covered under Part D's enhanced benefit, if the <u>plan</u> covers additional drugs not normally covered by Medicare Part D.</p> <p>90-day supply available via Express Scripts mail order and CVS and Walgreens pharmacies only. Retail prescriptions are otherwise limited up to a 34-day supply.</p> <p>A Part D Income Related Monthly Adjustment Amount may apply if your income is above the Medicare-defined income threshold.</p>
	Non-preferred brand drugs	\$60 retail/prescription \$165 mail order/prescription. <u>Deductible</u> does not apply.*	
	Specialty drugs	\$45 retail/prescription \$105 mail order/prescription <u>Deductible</u> does not apply.*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	After the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the Medicare Part B annual <u>deductible</u> and pays 20% of <u>UCR</u> charges approved but not paid or reimbursed under Medicare Part B.
	Physician/surgeon fees	No charge	

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

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
			For services not 100% covered by Medicare Part A, after the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the inpatient hospital <u>deductible</u> not paid by Medicare Part A.
If you need help recovering or have other special health needs	Home health care	No charge <u>Deductible</u> does not apply.*	* If covered 100% by Medicare Part A
	Rehabilitation services	No charge <u>Deductible</u> does not apply.*	For services not covered 100% by Medicare Part A, after the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the inpatient hospital <u>deductible</u> not paid by Medicare Part A or the Medicare Part B annual <u>deductible</u> and 20% of <u>UCR</u> charges approved but not paid or reimbursed under Medicare Part B.
	Habilitation services	Not covered	None.
	Skilled nursing care	No charge <u>Deductible</u> does not apply.*	* If covered 100% by Medicare Part A or Medicare Part B
	Durable medical equipment	No charge <u>Deductible</u> does not apply.*	For services not covered 100% by Medicare Part A or Medicare Part B, after the annual <u>plan deductible</u> is met, the <u>plan</u> reimburses the inpatient hospital <u>deductible</u> not paid by Medicare Part A or Medicare Part B the annual <u>deductible</u> and 20% of <u>UCR</u> charges approved but not paid or reimbursed under Medicare Part B.
	Hospice services	No charge <u>Deductible</u> 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Children's dental check-up Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) <u>Habilitation Services</u> 	<ul style="list-style-type: none"> 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 resident dependents, 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:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
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:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
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:	
<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
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.

